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NURSING PRACTICE IN A HOSPITAL CONTEXT:
THE SUBJECTIVE EXPERIENCES OF
FOUR FEMALE NURSES

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ABSTRACT

This thesis focusses on the practice of four female registered nurses in a hospital context. It examines the degree of control these nurses feel they have over what they do and how they practise. The influence of other members of the health team on that practice is explored.

Socialist feminist theory has provided the framework and feminist research the methodology for the investigation of female nurses' perceptions of their work and the forces that shape and control the practise of nursing at present.

That the structure within which nurses work constrains their practice is demonstrated in this study. It is however the structure of the nursing profession and the relations between nurses which is seen to have the most impact on nursing practice.

PREFACE

The impetus for this study came from my own experience as a registered nurse, both in clinical practice and in nursing education, and from endless discussions with nursing colleagues. The frustrations and declarations of powerlessness by some of my female colleagues began my investigations into nursing as an occupation and profession. A frequently expressed frustration was over the domination of nurses and nursing by of some members of the medical profession. Nurses, it appeared, felt that the doctors were the biggest problem facing any reforms in nursing and in health care.

Nursing education has changed in emphasis from a biomedical model to a holistic health model. Nurses plan their care of patients taking into consideration the totality of the individual. Recent changes in schooling and society mean that new nursing graduates are likely to be more assertive and less submissive than was previously the situation of nurses. These graduates are likely to encounter some difficulties when they enter hospital employment from their nursing colleagues and from the hospital organisation. This thesis provides some insight into the practice of nursing and its relation to the organisation.

Nursing is a female dominated occupation. I believe that feminist research is the appropriate vehicle through which to examine the experience of female nurses in a male dominated organisation.

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CHAPTER ONE

INTRODUCTION

Registered nurses, no matter how well educated and skilled they may be, find that the way in which they practice is influenced not only by the setting in which they work, but also by other members of the multidisciplinary health team with whom they work. Thus any consideration of contemporary nursing practice must take into account the social forces that can affect that practice. This study focusses on the practice of four female registered nurses in a hospital context. It examines the degree of control these nurses feel they have over what they do and how they practise. The influences of other members of the health team on that practice is explored.

Nursing is a predominantly female profession, some seventy seven percent of its members work in hospitals (Fletcher & Gallon, 1983:16). The history of modern nursing shows that within the hospital setting, both the education and practice of nurses has been affected and controlled by a male medical profession and male hospital administrators (Lambie, 1951; Ashley, 1976; Gamarnikow, 1978). Recent nurse historians have challenged the commonly held view that Nightingale substantially changed nursing in the

Victorian era and that this change was sudden and dramatic (Davies,1980; Baly,1986). Instead it is argued the reforms within nursing have been slow and painful. Baly argues that the Nightingale system was:

... [a] pragmatic experiment and the result of enforced compromise. The compromise between the hospital authorities who wanted the probationers as pairs of hands, the doctors who wished to keep nurses accountable to them, and the Council who wished to instigate a system of planned training with nurses accountable to trained nurses gave the twentieth century its nursing legacy.

Baly,1986:4

In recent years nursing education in New Zealand has changed. Nurses no longer receive their education in a hospital-based apprenticeship type training system. They are educated at tertiary educational institutions, for example, technical institutes in programmes leading to registration (Carpenter, 1971). This change has also included the development in universities of post-registration degree programmes majoring in nursing studies (Kinross,1984). Students of nursing in technical institutes are full-time students undertaking a three academic year programme. Student nurses in hospital schools were employees of hospital boards and were released from the wards in which they worked either on a daily or weekly basis to attend lectures.

Contemporary nursing education has as its primary intent the entry into the workforce of a knowledgeable, skilled beginning practitioner who is competent to work in any area of the hospital or community. For students of nursing the emphasis has shifted from training to education, and the expected result is autonomous professionals who work as members of a multidisciplinary health team and are accountable for the care they give.

The changes in nursing education have had implications for both the nursing workforce in public hospitals and for nursing practice. Where much of the nursing care in public hospitals was previously given by student nurses, now it is more often given by registered nurses. The registered nurse, who in the past primarily supervised the work of student nurses, now enters the workforce with the intention of planning and giving patient care.

In the past, nursing care was predominantly given as a series of tasks to be completed each duty. The complexity of the task depended on the degree of training the nurse had received. In contemporary nursing registered nurses have the educational background which allows them to give total nursing care for the patients they are assigned. Such care is individualized for each patient's needs and

condition, and its effectiveness is determined through the use of quality assurance programmes.

The practice of any profession is determined by the education received and, importantly, by the structures of the society in which it is practised. Registered nurses are prepared in educational settings to use their knowledge and skills to plan and evaluate the care they give, to take cognisance of the other forms of treatment the patient is receiving, and to practise as colleagues of other members of the multidisciplinary health team. The preparation of nurses to work in this manner will only be effective if the structure in which they practise facilitates it.

Modern nursing was developed as a paid occupation for women and situated in institutions which were under the direct control of the male medical profession (Gamarnikow, 1978). The history of nursing has long been allied with domestic labour and dedication to service. Diamond, in an unpublished paper, writes:

The mode of human service for the nurse becomes indistinguishable from that of the wife, the mother or the nun. In the case of health services, the woman's world is, once again the emotive, the man's world, the instrumental, the nursing model is feminine, the medical model is masculine.

cited in Jagger, 1983:325.

Nursing in its early development was a rigid hierarchy. The matron was responsible for the nursing and domestic service of the hospital. She invariably had one or two assistant matrons. The next level comprised the supervisors who were responsible for a number of wards and/or units. Beneath the supervisors in the hierarchy were the ward sisters (charge nurses) who were in charge of single wards. The nursing staff in the wards were staff sisters, staff nurses and student nurses, both in the three year and from the nineteen-sixties, eighteen-month programme. This latter training is now a one year course. The military background of nursing development is shown not only in the uniform complete in most cases with epaulets, but also in this rigid hierarchical structure.

In contemporary nursing only some elements of this hierarchical structure remain. The matron is now a principal nurse and she has one or two assistants. Nursing supervisors as a rank remain although their title is somewhat of a misnomer. They rarely actively supervise junior nursing staff. These senior members of the nursing staff have specialist areas of work, for example, as nurse specialists in infection control and as nursing personnel supervisors. The afternoon and night duty nursing supervisors act as resources for the nursing staff. They can, for example, obtain medications from the

pharmacy or equipment from the central sterilizing department outside the normal working hours of these departments.

Recent changes in nursing education mean that the nursing workforce in public hospitals contains a higher proportion of registered nurses. These nurses work within a bureaucratic organisation that can stifle individuality and rewards conformity. Nurses have divested themselves of the domestic chores of their history. Domestic cleaners have taken over the household chores, dietitians provide balanced diets which dietary staff prepare and deliver to the patients. Nurses have thus been freed to concentrate on the work they are educated for - the delivery of nursing care.

The organisation of nursing practice affects the amount of care a nurse can give. In task-oriented nursing, each nurse performs various tasks for different patients and may never have a total perception of one patient's entire care. This form of organisation worked well when the nursing workforce comprised nurses at different levels of training. Now with a more qualified workforce nurses are more likely to work in teams, as primary nurses or in a derivative form of these two organisational processes. There remains a discrete skill hierarchy within contemporary nursing. Registered nurses are

the most skilled followed by enrolled nurses and students for enrolment. Any technical institute nursing students undertaking their clinical experience in hospital wards do not fit within the hierarchy and are likely to be supervised by their own tutors.

Bellaby & Oribor (1980) describe the mode of production in nursing care from the Nightingale era in three phases which they link to industrial revolutions. The first phase occurred with lady nurses as housekeepers. Nurses were members of a disciplined corps who worked alongside the medical professional who were emerging as individual professionals. The relationship between medicine and nursing was rooted in the class and gender relations of late Victorian England. The second phase which began between the world wars exemplified the contradictions between nursing and medical models. This phase saw the development of specialist areas in medicine and concomitantly in nursing. The result was a subordination of nursing to medicine within a technical division of labour which also saw the organisation of other occupations in health care, including X-ray and pharmacy. The third phase occurred in the nineteen-thirties with the advent of state intervention in health care and with the adoption in the nineteen-sixties of a corporate

management structure which has the effect of splitting management from the workers.

Any investigation into contemporary nursing must take cognisance of the historical factors that have shaped the development of nursing and the social forces that have shaped the position of women in society. Nursing as a female occupation demonstrates these factors and forces in a more or less discrete manner. It is therefore appropriate to examine the practice of nursing from a feminist perspective.

Early feminists alienated nurses by suggesting that in being nurses they were perpetuating their inferior status as women (Edelstein,1971). Women were instead encouraged to seek a career in medicine. In this way it was felt the discriminating effects of the male profession of medicine would be removed.

Liberal feminists further this view by advocating an equal number of men and women in medicine, this they suggest would alter the male monopoly in the upper reaches of the medical hierarchy. A counter proposition also exists for nursing:

...a corresponding invasion of nursing by men that would erode the artificial income and status distinctions between physicians and nurses...

Bermosk & Porter,1979:88

On the surface the liberal feminist view would have some merit in that equalizing of numbers will bring about changes in attitude. However, in reality there exists a quite explicit sexual division of labour within medicine. Bullough & Bullough (1977) use 1970 census data to describe differentials in status and salary in all health professions. Registered nurses were predominantly female, 97.3 per cent, compared to 2.7 per cent of males and yet the median income in dollars for males was seven thousand compared to five and a half thousand for female nurses. In a comparison of gender distribution among health care professional and health service workers these writers found a sex discrimination both in occupational groups and in salary range. Bullough & Bullough, 1977:304 state:

Though women enter medicine and dentistry, they usually do so on a subordinate level, continually playing the traditional role of the inferior female. ... women have been hesitant to break through this world of masculine bias because those who attempted to do so were labelled as lacking in femininity; the self-image of women in the helping professions has worked to keep the status quo that has proved disastrous to women

In 1981 in a survey of New Zealand medical practitioners it was found of 5,037 replies that 836 were women. The two largest groups of doctors were

in general practice (38 percent) or as resident medical officers in hospitals (26 percent). The largest proportion of women were found in these two areas (Fletcher & Gallon,1983:22). In this report it was noted that nearly one-third of the women were in general practice. Fletcher and Gallon suggest possible reasons for this. General practice offers more opportunity for part-time work; it allows for flexibility in work arrangements (hours worked) and psychological factors affect the women's choice of specialty. General practice is more compatible with the traditional women's role. Young (1981) suggests that women become general practitioners because they find hospitals alienating. The relationship between the doctor and the patient is "more intimate, more trusting and more lasting and because GPs [sic] work one-to-one with their patients and are asked to meet very real demands day-to-day, whether 'trivial' or not, whether emotional, social or physical" (Young,1981:155).

Similarly New Zealand statistics related to men in nursing show that males are concentrated in specific areas of nursing, in psychiatry, in medical, surgical, orthopaedic and paediatric areas. The distribution of males in hospital administration is 4.9 percent compared with 2.1 percent females (King & Fletcher,1981:64).

Thus, although modern medicine and nursing started as gender-specific professions, inclusion of females in medicine and males in nursing has not had the effect that liberal feminists had hoped. Each gender has continued to focus on separate specialties within these fields. Males continue to hold the higher paid, more prestigious jobs.

Radical feminists see the oppressive structures existing in society as a result of patriarchy. They argue that this oppression is maintained through family socialising power. Thus the power in health care lies with the patriarch (doctor) and it is he who decides what care the patient will receive. The patient becomes a passive recipient of doctor-defined health care. Radical feminists do not agree with liberal feminists arguing that increasing the numbers of women in medicine does not remove the paternalism and authoritarianism of the medical practitioner. This behaviour is learnt and entrants to medical schools become socialised into such a role (Bermsk & Porter, 1979; Young, 1981).

Marxist feminism allies the sexism in health care to the sexism implicit in capitalism. Bermsk & Porter (1979:92) note:

Marxist feminists are concerned with the social context of health care and with who defines and

controls the realities of providing medical services. The people with the most power can define and enforce their view of reality, and they can create the consensus in society that it is necessary for the adoption of their perspective as the true one.

The control in this perspective lies with a coalition of Medical Association, public and private hospitals.

Gamarnikow (1978) illustrates the socialist feminist perspective in her historical analysis of nursing. She argues that the sexual division of labour within health care, that is, between male/doctor and female/nurse, is a manifestation of the patriarchal relations of the family transferred to a social (occupational) setting. Such a division, Gamarnikow argues is not biologically based but centres on an ideology of male dominance and control over women. This ideology manifests as power relations and results in the dominance of the medical profession over the nursing profession.

Nursing remains a female occupation which has a long history of performing a traditional female role in society. Ashley (1976) describes the analogy of the hospital family with the doctor as father/decision-maker, the nurse as mother/housekeeper and nurturer, and the patient as child/passive recipient of the ministrations of doctor/father and nurse/mother.

As long as structures remain which legitimize the control of a male medical profession over a female nursing profession it matters not how knowledgeable and skilled nurses are, their practice will be constrained within the terms of what is acceptable to the medical profession.

Feminist theory, therefore, provides the most effective framework within which to investigate female nurses' views of their practice. Socialist feminist theory provides the framework and feminist research the methodology which structures this study of nursing practice.

Feminist research denotes a paradigm shift. It is predicated on an ideology which challenges the position of women in society. It provides a specific methodology for investigating the subjective experiences of women. Such research accepts and makes explicit both the ideology and biases. Feminist research offers potential for social change by making the position of women visible, by challenging the status quo and by making information from research projects available. Patai (1984:188) suggests:

**Feminist research is rethinking
the world and generating an
immense body of new work which
is transforming our sense of
the possible and the desirable.**

I think that, from the perspective of some future time, it will be clear that feminism produced the major paradigm shift of the twentieth century.

Most nursing research shows a preponderance of quantitative research methodology. Only in recent years have nurse researchers turned instead to qualitative methodology. Swanson & Chenitz (1982: 241) argue:

The consequences of the traditional alliance between nursing research and quantitative methods are:
... the production of research that falls short of meaning for the world of practice ...

MacPherson (1983) argues that feminist methods provide a new paradigm for nursing research particularly in the field of women's health. She suggests:

Nurses will need to utilize feminist research methods to get beyond the sex biases characterizing the existing research on women's health issues such as, for example, much of the biomedical research on menopause.

MacPherson, 1983:24

Feminist research methods can equally be applied to studies of nurses and nursing.

In this study into nursing practice, socialist feminist theory has provided the framework and is described in Chapter Two. Nursing as a female occupation has rather surprisingly, only in recent years taken any consideration of feminism. Possible reasons for this are discussed in Chapter Three. Feminist research has structured the methodology of this study. Chapter Four outlines the salient features of feminist research and describes the methodology used in this study. In Chapter Five the participants' responses to questions regarding their practice are recorded. Chapter Six contains an analysis of the research and discusses the implications resulting from this study.

CHAPTER TWO

SOCIALIST FEMINIST THEORY

Early feminist writers focussed on equality of the sexes. These liberal feminists had as their aim changed behaviour of women, working within the current society (Delmar, 1986). With the resurgence of the women's movement in the nineteen-sixties and seventies, analyses became concerned with understanding and examining the social structures which created and enforced the oppression of women.

The writings of Firestone (1970), de Beauvoir (1972), Mitchell (1977), Millet (1977) and Friedan (1982) among others have done much to shape the current theoretical stances within feminist theory. Their work, combined with the works of Marx and Engels, has led to the development of socialist feminism as theory and method. In this chapter I will describe the theory as it has developed to date and demonstrate its relevance as a framework for an investigation into the practice of nursing.

Socialist feminism is the most recent analytical theory of the situation of women in society. It is an attempt to synthesize traditional Marxism and radical feminism. There are some tensions among feminists regarding the success that socialist

feminists have had in formulating a cohesive theory and these are discussed toward the end of this chapter.

Eisenstein (1979:5) comments that "socialist feminists are committed to understanding the system of power deriving from capitalist patriarchy". Capitalist patriarchy is a term she uses " to emphasize the mutually reinforcing dialectical relationship between capitalist class structure and hierarchical sexual structuring". Socialist feminists take cognisance of the historical materialist and economic determinism within Marxist theory. Marx in his analysis of capitalist society only identified women as they related to class. Socialist feminists have superimposed radical feminist theory on marxist method. In this way, feminists would argue, they have a more effective understanding of the structure of women's oppression, particularly in terms of sex-class structure, the family and the hierarchical sexual division of labour and society (Eisenstein,1979).

The separation of work and family as it has occurred in industrial, capitalist societies is a major focus of socialist feminism. In pre-capitalist societies the family was the economic unit. Workers produced agricultural goods and crafts which they exchanged to meet their subsistence needs. The production of

such goods was within familial settings. Industrial capitalism moved work from the familial to the public sphere. Labour became the exchange value and workers became alienated from the products of their labour. Women became isolated in the home and their existence became that of a non-waged domestic labourer, reproducing children as a potential labour force and caring for husband and family. The home became the haven for men away from the competitive world of work.

Feminists take as their central concern the reality of women's lives and this reality for socialist feminists encompasses relations of class, sex and race. The relations between the private (personal) and the public (political) are a focus of socialist feminism and are irrevocably tied to the concept of ideology. Eisenstein (1979:42) states "thus the dialectic will be self-consciously extended to relations between consciousness, ideology and social reality".

Socialist feminists believe that class analysis is necessary but not, in itself, sufficient to understand women's oppression. Marxist method can be used to examine the patriarchal struggle. This theoretical stance differs from radical feminism in the issue of universalism. Radical feminists contend that patriarchy, as control, has existed throughout

history and within all societies (Firestone, 1970). Socialist feminists dispute this issue arguing that patriarchy, as male domination over the lives of women is specific to different societies and within specific periods of history. Within capitalism, patriarchy came to be determined as the source of cultural and social stability. Monogamous marriage provided men with identifiable heirs who would inherit their wealth and name. It provided men with the legal ownership of women. Eisenstein writes:

None of the processes in which a woman engages can be understood separate from the relations of the society, which she embodies and which are reflected in the ideology of society.

Eisenstein, 1978:47

In marriage the act of childbirth defines a woman as a mother; outside of marriage she is termed a solo mother. If a woman works in the home of another woman, or for a man, she is paid a wage. If she works in the home for her husband it is a labour of love. Ideology thus defines, protects and maintains the power relationships within society. The social relationships of capitalist patriarchy are maintained through the ideologies of male supremacy and racism.

The family is a social, economic, political and cultural unit of society. It is historical in its

formation. The family as a social institution, reflects particular relations in society. The situation of women in the family is indicative of these relations. Socialist feminists recognise that female work encompasses the activities of production (within the wage-labour force), reproduction and consumption. The reality of women's work in the family is as reproducers of children; as socialising agents to children for their roles in work and society; and as labourers to feed, clothe and care for children and husband. In this latter instance the women's role is that of domestic labourer. Chodorow (1979:102) argues that the separation of the public and private spheres increases sex inequality. She suggests "women's mothering has continued to be basic to women's lives and the organisation of the family and fundamental to the genesis of ideology about women".

The sphere of reproduction highlights women's oppression (Chodorow, 1979; Gordon, 1979). It reflects quite clearly both patriarchal and capitalist control of women's fertility. Though feminists have sought control over women's fertility through the right to abortion, the power lies with the alliance of capitalism and patriarchy. Recent technology in the field of contraception and abortion has not given women the freedom Firestone (1970) had hoped. Development and sale of contraceptive medication and

devices are at the discretion of the pharmaceutical companies. The medical profession controls access to abortion and to some forms of contraception. The state, through legislation controls the availability of abortion (McIntosh,1978).

Hartman (1979) argues that job segregation by sex is the primary mechanism in capitalist society that maintains the superiority of men over women. It enforces lower wages for women in the labour market. Low wages keep women dependent on men and encourage women to work. Married women perform domestic chores for their husbands. Therefore men benefit from wages and the domestic division of labour. The domestic division of labour acts to weaken women's position in the labour market. They either work part-time or do two jobs. Thus Hartman (1979:208) suggests "the hierarchical domestic division of labour is perpetuated by the labour market and vice versa". Women are seen as a surplus labour force to be used in times of plenty, but first off the payroll in times of need.

Sociological approaches to women's work have tended to use taken for granted assumptions that women's primary role is in relation to the family and therefore work is a tension between the roles of women as workers and women as homemakers. They have failed to provide an analysis of the distribution of

female labour among particular occupations and industries (Beechey,1978).

Women tend to be concentrated in the lower-skilled lower status jobs. Davies (1979) describes the feminization of the clerical labour force. She found a sexual division of labour in the office where the managerial positions are mainly held by men while women hold most of the low-level clerical jobs. This division of labour she argues is strengthened by the positions men and women hold outside the office. Professions that are women dominated are immutably mirrors of the women's role in the family. Notable among these are nurses, kindergarten, pre-kindergarten and elementary school teachers (Grimm,1978).

The oppression of women in both the private and public realms, in the spheres of production and reproduction is seen to be the result of two interlocking systems capitalism and patriarchy. Thus socialist feminists analyze the situation of women as it is influenced by the economic relations of class and through the practice and ideology of male supremacy.

A major difficulty within feminism is that each perspective is believed to be **the** analysis of the oppression of women in society. Feminists therefore

tend to take their own perspective as the true one and to criticize other views. Marxist feminists criticize radical and social feminists for being insufficiently materialist and therefore oblivious to class struggle. Radical feminists criticize marxists and socialists for ignoring the importance of patriarchy. Socialist feminists criticize marxists for being overly economic, and radical feminists for being subjective and ahistorical (Sargent,1981). Black feminists argue that racism is insufficiently analysed (Joseph,1981) and lesbian feminists argue that little consideration has been given to the liberation and sexual determination of all people (Riddough,1981).

Hartman (1981) writes:

Recent attempts to integrate marxism and feminism are unsatisfactory to us as feminists because they subsume the feminist struggle into the "larger" struggle against capital.

Hartman, 1981:2

Many marxists she argues, see women's issues as less important than class struggle and potentially divisive to the movement. Marxism she asserts is "sex-blind". Therefore what is required is a much stronger union that recognises that even within classes women are oppressed. Harding (1981) believes that the gender division of labour is primary and

therefore any form of societal relations will superimpose on this division. A class system which in reality does not include the complex situation of women within its analysis will not provide the the necessary freedoms for women. Patriarchy as a system of control has existed in many societies prior to capitalism and it is in the male interest to continue this form of control.

Barrett (1980) in her criticism of marxist feminist analysis claims that an alliance between socialists and feminists would provide a more effective solution to women's oppression. Although she believes that socialist males have shown more support of the women's movement than their male counterparts, she argues that it is women themselves who are the only ones who will be able to change the system of male dominance. Women's oppression must be understood within the sociopolitical systems within which it occurs. Feminism, Barrett(1980:258) asserts, seeks to change the relations between men and women and although the basis for this will come from "an autonomous women's liberation movement the strategy must involve political engagement with men". She comments:

**Just as we cannot conceive of
women's liberation under capitalism
so we cannot conceive of a
socialism whose principles of**

equality, freedom and dignity
are vitiated by the familiar
iniquities of gender.

Barrett, 1980:258

It was mentioned in the introduction to this chapter that socialist feminism as theory is still being formulated. The efforts of feminists to synthesize traditional marxism and radical feminism both as theory and method have been problematic. The tendency, as seen in the literature, has been to focus either on capitalism or patriarchy. Eisenstein (1979) conceptualizes a feminist class analysis which would take into account the many facets of women's lives. She uses as class distinctions women who work outside the home, houseworkers who work only in the home, and those who work both in the home and in the labour force, welfare women, unemployed women and wealthy women who do not work at all. These class distinctions she would further define in terms of race and marital status. She advocates the need to study how women in each of these categories share experiences with other women in activities of reproduction, childrearing, consumption and maintenance of the home. The multigrid pattern resulting from this analysis "mirrors the complexity of sex and class differentials in the realities of women's life and experience" (Eisenstein, 1979:33).

The sexual division of labour in the field of health care can be seen clearly in the occupation of nursing. Social relations in hospitals can be seen to mirror the women's role in the home. Nurses became the doctor's hospital and office wife (Lovell, 1981:30). Gamarnikow (1978:121) notes:

Nursing is a unique non-industrial female occupation. It was established and designed for women and located within a labour process - health care - already dominated by doctors all of whom were men. Success depended on both creating paid jobs for women who needed them and situating and defining these jobs in a way which would pose no threat to medical authority. The particular form of the sexual division of labour which resulted from this conjecture is vivid and precise. It represents the patriarchal division of labour in relatively pristine form, especially in that in many ways it cuts across class boundaries.

Ashley (1976) allies the role of nurses to that of the housewife. Nurses cared for the 'hospital family':

Their purpose was to provide efficient economical production in the form of patient care ... Through service and self-sacrifice they were to work continuously to keep the "family" happy ...

Ashley, 1976:17

The next chapter investigates nursing in relation to the feminist movement. It demonstrates that nurses as women enforce their own oppression by ignoring the strategies that feminism can offer.

CHAPTER THREE NURSING AND FEMINISM

Nursing as a profession has been notably absent from the women's movement and with few exceptions nursing literature has not incorporated feminist thinking and feminist theory (Chinn & Wheeler, 1985). These writers, in support of feminism, suggest:

In nursing, a feminist perspective requires an uncompromising questioning of the forces that divide us from one another, the ethics of our actions, and our co-optation into the unhealthy environment of the current health care system.

Chinn & Wheeler, 1985:77

Nursing until recently has been somewhat antagonistic to feminism. Nurses have felt that there was no need for them to become involved in the women's movement because within their own profession, they feel they control what they do. What nurses have failed to realize is that this is not so. Cleland (1971:1542) states "there is no doubt in my mind that our most fundamental problem in nursing is that we are members of a women's occupation in a male dominated culture".

In this chapter the practice of nursing is recounted from a feminist perspective. Some nursing authors in recent years have acknowledged that nursing has been

limited in the advances it can make by the socio-political system within which it is structured:

The sexual division of labour involves not only the allocation of tasks but a continuous sexual interaction which is as important in constituting gender as the interactions of private life. In no other work place are power relations as highly sexualised as they are in hospitals. Bureaucratic domination is directly reinforced by sexual power structures.

Game & Pringle, 1983:94

The history of modern nursing had as its origin the Victorian view of what constituted a "good woman" and nursing work "became identifiable with domestic labour" (Gamarnikow, 1978:98). Ashley (1976) notes:

Nursing, perhaps more than any other profession, has been influenced by social conceptions regarding the nature of women. Modern nursing originated at a time when Victorian ideas dictated that the role of women was to serve men's needs and convenience. Nursing's development continued to be greatly influenced by the attitudes that women were less independent, less capable of initiative, and less creative than men, and thus needed masculine guidance.

Ashley, 1976:75-6

These preconceptions continue as can be seen by the work of Kalisch & Kalisch (1982a; 1982b; 1982c).

Images of nursing, as portrayed in the visual and

print media, have been a source of study by these writers. In content analyses of nurse and physician characters in novels, motion pictures and television, some six hundred and seventy nurse and four hundred and sixty-six physician characters from 1920 to 1980 were examined.

In a comparative analysis of the findings of these studies Kalisch & Kalisch (1986) found that media nurses are predominantly female, caucasian, under thirty-five years of age, single and childless. Media physicians were older, parents, enjoyed a higher socioeconomic status and were predominantly male. Physician characters were presented as more central to the plot whilst nurse characters were relegated to more supporting roles. They state:

Nurse characters are shown to be significantly less intelligent and rational, to exhibit less individualism, and to value scholarliness and achievement less than physician characters across all types of entertainment media.

... nurses score consistently higher than physicians in all three media on only one attribute - submissiveness.

Kalisch & Kalisch, 1986:184

These nurse stereotypes, Kalisch & Kalisch argue, promote negative social perceptions of nearly one half of all health care providers. They influence

consumers perceptions of nurses and can affect nurses views of themselves.

Davis (1971) in a study of one hundred nursing and social work students with respect to self-concept, occupational role expectations and occupational choice found quite a disparity between the two occupational groups. The social work students' self-concepts were of "independent, spontaneous and assertive" individuals. In contrast the nursing students' self-concept was of "dependable, methodical, capable and conscientious" individuals with "some tendency to be submissive and sustain subordinate roles" (Davis,1971:371).

White (1971) in a study of female identity and career choice noted incongruency between nurses' views of nursing and the views of other female college students. Those who rejected nursing as a career, did so because they "believe that nurses are overbossed, have little chance for advancement and have most of their thinking done for them" (White, 1971:280). He also found that nursing as an occupation is viewed as one:

**... which calls for hard work,
sacrifice and even drudgery,
and the nurse is seen as being
very much subordinated to her
supervisors and to physicians.**

White,1971:281

Quite often the nurse's self-image conflicts with the public's role expectations for a nurse. On the whole nurses hold a lower self-image than that held by the public (Murray, 1983).

The movement of nursing into hospitals in the period of Nightingale reforms brought nursing firmly under the control of the medical profession and hospital administrators. One extremely effective method used by the medical profession to gain control over nursing was in the field of nursing education. Ashley (1976:77) notes "the 'born nurse' theory was a popular argument supporting the contention that nurses were better off with little education". The 'born nurse' theory reinforced the belief that nursing was women's work and therefore required little intellect. Anderson (1973) finds that these attitudes remain. She records comments made by doctors in response to a question of nursing education:

Schools of nursing should recruit students who have common sense rather than intelligence. She should be willing to help the doctor and have a kind personality. ... practical aptitude rather than any striking intellectual achievement ...

The best type of training for nurses is entirely oriented around the ward; that is, entirely practical with tutorials on the ward for academics, and perhaps ward rounds to explain conditions.

I doubt if it is very good to
have classroom lectures.

Anderson, 1973:81-82

Any reforms made by nurses in relation to their own education has been met by considerable opposition from both the medical profession and hospital administrators (Ashley, 1976). The transition of nursing education in New Zealand from hospital schools to the general education system has only been achieved in the last decade and a half (Kinross, 1984). Opposition to the transition of nursing education is illustrated in a comment by Robb (1947:73) "it ... diverts the attention of the nurse-in-training from her true work of nursing, and tends to turn her into an 'amateur medical student'".

Ashley (1975) notes that nurses historically have been conservative. Nightingale as one of the early leaders did not support the suffrage movement and was adamantly opposed to the registration of nurses (Baly, 1986a). With rare exception nurses were non-feminists. One notable exception was Lavinia Dock (a leading American nurse) who warned her colleagues about the threat of male dominance in 1903 (Ashley, 1975). Nurses did not become involved with the women's movement. Instead their attention focussed on problems related to their own education and professional development. Nurses who sought to

make changes in nursing have done so within a masculine framework which has also guided their work.

The administration of nursing has traditionally been the responsibility of the matron. She, in turn, was accountable to the medical superintendent and the hospital administrator. Because nurses were heads of their own department, some nurses saw this as an advantage. However it has become obvious that this was not a powerful position for nursing. The control remained in the hands of the medical profession and administrators. Cleland (1971) notes that nurse administrators did not control their own budgets and she suggests the acquiescing behaviour of nursing directors toward the male hospital administrators was like housewives asking for the grocery money. The leadership in nursing has only had power in direct relation to other nurses.

Nursing leaders sometimes demonstrate male characteristics as leaders. They have developed a rigid hierarchy and become firmly entrenched in their positions. This 'Queen Bee' syndrome describes anti-feminist behaviour in women who have careers in leadership positions (Donnelly, Mengel & Sutterly, 1980) At work this leader aligns herself with men and seeks their approval while expecting those women who report to her to perform in traditional female roles. This leader has a negative influence on her subordinates.

She doesn't train her subordinates or share her expertise and in some cases will actively work to retain the status quo. In nursing this denies young nurses effective role models and can work against the changes that nurses want to make. This leader feels threatened by assertive nurses.

Nurses have, Ashley (1975) argues, sought approval from men not liberation. The power battles in nursing have been between nurses rather than against male oppression. Nurses in their divisiveness have helped maintain their own oppression. Clay (1987) argues that nursing has its own brand of discrimination against women. He suggests it is not surprising that men in nursing quickly move into management positions because although the profession is dominated by women the road to advancement is through a model in which men who work full-time get an advantage, so also do single nurses.

There is disparity between nursing leaders perception of nursing and the actual practice (Stromberg,1976; Dachelet,1978). Where nursing leaders see nurses as independent practitioners working in a multidisciplinary team, the actual practice does not support this view.

McIntosh & Dingwall (1978) in a two year study of interactions within a multidisciplinary health team

found that "teamwork" for nurses consisted of the performance of tasks. The doctors were seen to be delegating work and the nurses sought permission from the doctors before initiating any actions. This study indicated that the doctors still saw themselves as the head of any health care team. Simmons & Rosenthal (1981) in their study of nurse practitioners found that nurses had a good relationship with the doctors if the nurses stayed within their own practice and within limitations defined by the doctors. The nurses in the study felt they could expand their roles but were waiting for the doctors to change their views of nursing, before seeking greater independence. The nursing participants in both these studies felt that they were independent practitioners, however their actual practice showed this was not the case.

More contemporary nurses are married with families or are sole income earners with dependents. Hospital employment does not take cognisance of the dual roles many nurses have. Cleland, Bellinger, Shea & McLain, (1970) in a survey of factors influencing the decisions of married nurses to reactivate their careers found that those who remained inactive did so because of "frustrations associated with nursing (16.3 per cent), poor employment conditions (37.2 per cent) and time conflicts between employment and home (41.2 per cent) (Cleland et al 1970:450). These

authors note that hospital employment fits the male model of career pattern. Males are expected to work even if they are widowed or divorced and have custody of their children, Cleland et al argue that "this model of employment is both unrealistic and ineffective in the employment of female nurses" (Cleland et al, 1970:451).

A feminist perspective of nursing shows that regardless of the reforms nurses wish to make, unless they realise the oppressive effects of the medical profession and hospital administration, they will succeed only in so far as they are allowed. Ashley (1973:638) writes "nurses have permitted themselves to be used simply as a labour force: a means of production, to be controlled and utilized to keep the system and its various parts functioning".

The effects of the women's movement for nursing can be summarised thus:

... when feminists discussed women's position in terms of powerlessness, dependency and discrimination they were describing the position of the nurse within the health care system as well

Simmons & Rosenthal, 1981:371

Feminism has much to offer nurses as many nurse authors suggest. Heide (1973:826) proposes:

... benefits that would result from the liberation of nurses and nursing: adequate nursing care budgets controlled by nurses; ... the end of sexist advertising for nurses; the end of relegation of nurses to a derivative and "handmaiden" role and denial of intellect to nurses which have hampered nursing's development as an independent academic discipline; recognition that nursing as an art and science is complementary, not subordinate, to medicine with both the nurse and medical practice acts reflecting that complementarity.

The concept of multidisciplinary health teams with implied collegiality has been shown not to have been totally successful for nurses. The doctor retains control and the nurse continues in a dependent role (McIntosh & Dingwall, 1978). Roberts & Group (1973) suggest that nurses should become more involved in community based health care while Simmons & Rosenthal (1981) argue that any expansion of the nursing role requires the collective efforts of the nursing profession. Nurses must be careful however that an expanded practice does not mean that nursing takes on more tasks the medical profession no longer find "challenging, interesting or prestigious enough (Lovell, 1981:38).

Nurses need to become more aware of the oppression they so silently accept and reinforce (Lovell,1981). Consciousness raising and cohesive behaviour (Heide, 1973) and a conscious decision to assume power (Cleland,1971; Bowman & Culpepper, 1974) will assist nurses to develop the strategies they require to gain control over their own practice. Roberts & Group (1973:320) state:

As long as women stay within or accept the institutional bureaucracy of the hospital, they will never be free from the control, authority, and power of male physicians.

In the next chapter feminist research is briefly outlined. The methodology used in this study is described.

CHAPTER FOUR

METHODOLOGY

The previous three chapters have outlined three themes, the impact of the history of nursing on contemporary practice; the siting of nursing within a bureaucratic, patriarchal structure, the hospital; and the effect of capitalist patriarchy as ideology and practice on the situation of women in general and nursing in particular. The explicit framework within this study is feminist research. The study focusses on the experiences of female registered nurses and their practice within the context of their work in public hospitals. Conway (1983:204) in a review of the literature on socialization and roles in nursing comments:

Primary sources of role stress for professional nurses that have been documented repeatedly include ambiguity, lack of autonomy and limitations imposed on the development of the nurses' professional role by the competing demands of the work setting and other professionals notably physicians.

In this study I have taken the comments of the participants as the central means of expressing the the degree of control these nurses feel they have in relation to their work. An analysis follows in chapter six.

Feminist research developed as a counter to the androcentric focus of sociology (Oakley, 1974a), although it has not remained the prerogative of feminist sociologists and in recent years can be seen to cross many disciplines (Callaway, 1981; Patai, 1984). Feminist research denotes a paradigm shift in that it challenges the dominant traditional research methodology and has as its central focus the subjective experiences of women in society. Feminists argue that the objectivity so rigorously sought in traditional research methods is exploitative; the respondents are simply sources of data production (Oakley, 1981). Roberts (1981:15) notes:

Feminism is in the first place an attempt to insist upon the experience and very existence of women. To this extent it is most importantly a feature of an ideological conflict and does not of itself attempt an unbiased or 'value-free' methodology.

In response to criticism from her male colleagues of a lack of objectivity in the work of feminist researchers, Roberts (1981:16) counters:

Feminists, in stressing the need for a reflexive Sociology in which the sociologist takes her own experiences seriously and incorporates them into her work, expose themselves to challenges of lack of objectivity from those

of their male colleagues whose sociological insight does not enable them to see that their own work is affected in a similar way by their experiences and their view of the world as men.

Feminist research offers potential for social change by making the position of women visible, by challenging the status quo and by making information from research projects available. This latter claim is demonstrated by Oakley (1974;1979) in the publications of her studies of housework and motherhood, and by Roberts (1985) in her publication of women and their doctors. Both women show their commitment to providing information from their studies both for their academic colleagues and for women in general.

In this study the implications of using feminist research are demonstrated in the processes and underlying ideology I will now describe. As a nurse and feminist my commitment is to defining the actual work experiences of female nurses as the participants expressed them and in chapter five the responses of these nurses are recorded.

Sample

The sample of nurses in this study is determinedly small. It is not representative of registered nurses

in New Zealand nor was any attempt made to achieve this. Time limitations imposed on a study of this type precluded a representative sample. Therefore no attempt can be made to generalise any findings resulting from this study. However it is possible to draw some conclusions and make comment on the implications of the findings (see chapter six).

The most important facet of this particular study is that it has given the participants the opportunity to share their experiences and to define for themselves and others the satisfactions and dissatisfactions they experience in their work environment.

Four female registered nurses agreed to participate in this study following an approach by the researcher and having received a written explanation of the study (see Appendix One). The criteria chosen for inclusion in this study were that the participants be female registered nurses working full-time in general wards of public hospitals. They were to have had at least one years experience as registered nurses. The participants met the criteria. Whilst there is some homogeneity about the participants some aspects should be noted as they will become obvious with the participants' responses to some questions. The length of experience of the participants as registered nurses varied from almost two years to twenty plus years. Two of the participants are charge nurses, the other two are staff nurses and

these positions do affect the views participants have of their own practice and the ability each has to alter it.

Interviews

Dyadic interviews provided the process of information sharing in this study, however there are some distinct differences between the interview as used in traditional research and in feminist research. Oakley (1981) argues that the traditional method of interviewing as outlined in the texts illustrates a masculine paradigm. The interviewer is present purely to obtain information and techniques used are aimed specifically towards this primary objective. The interviewer is discouraged from being too involved, too friendly, sharing values and opinions, giving information and reminded constantly that the essence of the interview is to elicit information from the respondents. This type of interview situation does not fit happily into feminist ideology where the essence is of shared concern. As Oakley (1981:41) notes:

... in most cases the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship.

Feminist researchers have developed their own interviewing techniques which overturn all aspects of the masculine paradigm. The participants are treated as people of value whose very existence is vital and whose experiences are valid for them and not merely a statistic to be debated and made to fit a theoretical construction. Recent feminist studies demonstrate the departure from traditional interviewing techniques and highlight the development of feminist research methodology. Oakley's work on the transition to motherhood (1980) forced her to redefine her research methods. She summarizes three reasons for her change in interviewing. Firstly she "did not regard it as reasonable to adopt a purely exploitative attitude to interviewees as sources of data". Secondly she "regarded sociological research as an essential way of giving the subjective situation of women greater visibility not only in sociology, but, more importantly, in society than it has traditionally had". Thirdly "an attitude of refusing to answer questions or offer any kind of personal feedback was not helpful in terms of the traditional goal of promoting 'rapport' " (Oakley, 1981:48-9).

Finch (1984) utilized a similar technique in her study of clergymen's wives, and her study of women who were running and using preschool playgroups. Finch (1984:71) found that her participants were

happy to talk to a female researcher. She notes "the extreme ease with which, in my experience, a woman researcher can elicit material from other women". Both of these researchers found that their participants were relaxed and divulged quite explicit information about their experiences. Finch offers some possible reasons for the easy flow of information. Firstly, she suggests women are used to accepting intrusions into their lives. Through their experience of motherhood they are subjected to questioning by doctors, midwives and health visitors. As housewives they have frequent 'door to door' salesmen, for example, insurance salesmen. Secondly, with the setting being the individual's own home, the interview was conducted in an informal manner and "can easily take on the character of an intimate conversation" (Finch,1984:74). The third reason she offers is that because women were predominantly homemakers they welcomed the opportunity to talk to a sympathetic listener.

In this study two focussed, semi-structured interviews, not more than two weeks apart, were undertaken with each participant. The purpose of two interviews was to overcome the participants' natural self-censorship and to develop a rapport so that both the interviewer and the participants had time to feel at ease with each other. The time between the first and second interview gave the

researcher time to listen to tapes from the initial interview and therefore to determine the subject matter of the second. It provided the opportunity to further question or clarify points raised by the participants. It also allowed them the chance to clarify, add to or discuss with me points they had raised previously or to share concerns that the interviews had highlighted about their work and their feelings about their experiences.

The setting for the interviews was the decision of the participants and the researcher agreed to any place they felt at ease. Three of the four interviews were at the participants' own homes and the fourth in a borrowed room. I had made clear in my initial approach that I would like to record the interviews on audiotape. I assured the participants that I would transcribe these tapes and that I would send them their transcripts. They could, on receipt of these, delete any part of the interview they did not wish included in this study. The tape-recorder did not appear to interfere with any of the interviews and in fact the participants became quite helpful in positioning themselves and the recorder to maximise the reception. I feel that offering the transcripts to the participants gave them the control as to how much of what they said would be used in the study. All participants were offered their transcripts. One participant did not wish to see

hers following the interviews. The others have left the transcripts unaltered.

Four questions provided the framework for the interviews and the dialogue guided further questioning. The four questions asked related to the organisation of nursing care in the participants' wards; to their satisfaction with this organisation; to the decision making of participants in regard to their own practice; and to the influence of other members of the health team on that practice. The content of the participants' responses to these questions and to further probing (see chapter five), could have lead to identification of the participants. The anonymity of the participants has been preserved by using generalised terms in place of specific potentially identifying data used by the participants. This has in no way altered the essence of what the participants have said but does serve to protect their identities. New Zealand has a small population with a limited number of general hospitals and some specifying data could lead to identification of participants. To clarify this comment I will use as an example the situation of a nurse working in a cardiac surgical ward. She, in her interview, may refer to the Cardiac Surgeon either as a general term or by name or to a patient who has recently received cardiac bypass surgery. There are a limited number of such units in this country and therefore

I could put that nurse's anonymity at risk. I made a commitment at the initial interview that anonymity would be preserved and that no identifying information would be included. The participants in agreeing to participate in this study accepted my guarantee (see Appendix Two). None of the participants in this study worked in a cardiac surgical ward.

Analysis of the Data

Small scale research provides an opportunity for the researcher to view both the totality of the situation as described by the participants and to examine the components for any connections. The rationale for studying the practice of nurses was to gain some insight into individual experiences. The literature to date (see chapters one to three) considers nursing as a collectivity. A common source of study of nursing has been in relation to roles and role expectation (Davis, 1971; White, 1971; Anderson, 1973; Conway, 1983). A feminist view of nursing has included historical perspectives (Ashley, 1975; Ashley, 1976; Gamarnikow, 1978) and concepts of power (Ashley, 1973; Roberts & Group, 1973; Lovell, 1981; Simmons & Rosenthal, 1981; Clay, 1987). Few feminist studies of nursing have attempted to investigate the subjective experiences of nurses, notable exceptions are Game & Pringle (1983); and Keddy, Gillis, Jacobs,

Burton & Rogers (1986) who focussed on relations between doctors and nurses.

The value of small scale research is that it focusses on the experiences of individuals. It is non-hierarchical. The values individuals place on their experiences are not contaminated by interpretation by the researcher. In accepting the validity of the participants' existences, the researcher can analyse responses in terms of the emphases the participants placed on them. The rationale for studying the practices of female registered nurses was to gain insight into their experiences as 'lived' by them. Asking about the organisation of their nursing practice in the wards established current practices. The question regarding their satisfaction with this organisation gave some idea of the problems as seen by these nurses. In questioning participants about their decision-making practices their views of nursing care in relation to both themselves and their patients were identified. The final question relating to the influences of other members of the health team on their work examines the autonomy of professional nurses and their work within multidisciplinary teams. Oakley (1980:109) in support of small scale research suggests:

Since the researcher is in constant contact with the data at every stage of its collection and processing,

he or she can be more sensitive not only to the experience but also to the explanations that are cited by the interviewee, and is more likely to be able to integrate such explanations into the data analysis.

In the next chapter the responses of the participants to questions regarding their practice are recorded. Feminism is concerned with the reality of women's experience. These four female nurses shared their experiences in relation to their nursing practice in the hospital setting. The varied lengths of experience of these nurses precluded questions regarding the changes that have happened in the practice of nurses over time. What has been described by these nurses is their nursing practice and the influences on it at the present time.

CHAPTER FIVE

THE RESEARCH

In this chapter the responses of the participants to questions asked during their interviews are recorded. Although participants were asked the four core questions in much the same phrasing, the impetus for further probing depended on the answers they gave.

The four core questions were -

1. Can you tell me how the nursing care of patients is organised in your ward ?
2. Are you satisfied with this kind of organisation ?
3. Do you make decisions regarding the nursing of patients in your care ?
4. Does anyone else in the health team influence your nursing practice ?

The responses participants gave have been recorded under three sub-headings of organisation, decision-making and influence on practice. As can be seen, these areas are not discrete, for example, the influence of other members of the health team, notably doctors and other nurses, is seen to occur in all areas of the participants' practice.

ORGANISATION OF NURSING CARE

Participants were asked how nursing care was organised in their wards and whether they were satisfied with that organisation. From their responses which follow, it appears that there is a considerable variation in the way that nursing practice is organised. Each participant gives a rationale for their declared satisfaction, or in two cases, dissatisfaction.

(Can you tell me how the nursing care of patients is organised in your ward?)

Patient allocation. The nurses are allocated rooms that's the easiest way to stop them running from one end of the ward to the other. They are given rooms and that's according to their skills, skills and knowledge base.

Ann

(So it doesn't matter what training they have or skills in relation to training?)

No their training gives you their skill level.

Ann

(Are you satisfied with that organisation of care?)

Yes I am because it gives people a choice. They can choose to continue to look after somebody. If they wish to follow a patient through from admission to discharge they just ask to carry on looking after that patient. Because of the layout of the ward its easier to do it that way because patients who are sicker are in single rooms and as they

recover they move into multi-bed rooms, so they are moving around the ward.

Ann

Ann was satisfied with the organisation of nursing care in her ward although other nurses might be somewhat confused with her definition of patient allocation when in effect what she was describing was room allocation. Carol's ward was organised on a different basis.

(Can you tell me how the nursing care of patients is organised in your ward?)

It's organised on a team basis with team responsibilities for groups of patients. It is not primary nursing in its purest sense but the practice of the nurses is the nursing process so it's scientific problem-solving approach ...

Carol

(When you say team is that one team for the ward with a team leader or ...?)

No the ward quite clearly geographically divides into three areas one is specialist and two are general. The teams comprise registered nurses and enrolled nurses. They rotate through teams and they rotate geographical areas in the ward to give a larger experience as practitioners. There's a nominal team leader that's responsible to me for the management of those patients.

Carol

(Are you satisfied with this kind of organisation?)

No. Well it's an intermediate process. I have an end vision of

what I want it to be. I'm working toward the stage where my staff say this no longer meets our needs. Then when they do I'll move into the next phase of change but we were very task-oriented when I went to the area ... all you can do is teach people to be responsible for their own actions and so I've been selective in the groupings I've put together.

Carol

(What is your ultimate aim?)
The ultimate aim would be to eliminate the second level [nurse] out of the ward entirely and to have nurses autonomous with their own care. ... I envisage the changing nature of my area would lessen the need to have second level nurses.

Carol

Fay works in a ward where primary nursing is the organisation. She relates her experience of this form of nursing care.

(Can you tell me how the nursing care of patients is organised in your ward?)
When a patient first comes into the ward and it's acute we have a system where it's primary nursing in that ... the patient has a primary nurse where she sort of organises the patient's care. Patient problems [are identified], objectives are set each duty or day or month, and it's really specified, Mr X's shortness of breath will be relieved in twenty minutes if, [for example] he had chest pain and that's all documented. The intervention would say you would administer oxygen or anginine or whatever. You get a patient history, how the patient perceives

his health status ... You actually do a quick assessment when they first come in, in twenty-four hours or as soon as the patient comes in a quick assessment is done and then it's updated, for example, if the patient has any breathing problems we put shortness of breath, oxygen required, that sort of thing.

Fay

(You have primary nursing so one nurse determines the patient care, writes up the plan?)
Yes, writes the nursing care plan but you also have other nurses. On your days off other nurses look after that patient and it's documented so they know what's happening. That doesn't mean if it's a long term patient that you need to have this patient as a primary throughout his hospital stay. ... when we have a meeting well you can say would someone like to take over for a while. Especially patients who've been long term, like four months in a ward, if you feel you've put your best in it and you want a rest ... then you just say and usually someone else will pick up from where you are. If you've got problems relating to what the patient may have you can say to your colleagues, what should we do about this? We discuss things like dressings ...

Fay

I asked Fay about the structure of the nursing workforce in her ward and how this affected primary nursing.

(What nursing staff do you have?)
 A charge nurse, registered nurses,
 enrolled nurses and technical
 institute nursing students.
 Enrolled students but they're
 under the supervision of
 registered nurses when they come
 to the ward. Technical institute
 students have a tutor but usually
 we supervise. They are allocated
 one or two patients.

Fay

(What happens with the organisation
 of the ward, are the registered
 nurses the only primary nurses?)
 No the enrolled nurses are primary
 nurses as well.

Fay

(What type of patients would an
 enrolled nurse have?)
 C.V.A.s, social admissions,
 people who come in with leg
 ulcers. They wouldn't have any
 patients that came in acute.
 Well they do have a say sometimes
 they say I would like this
 patient to be my primary
 otherwise the charge nurse
 determines it, but you can have
 a say, I would prefer to have
 this patient as a primary.

Fay

(When the patients come in, you
 don't have a problem of a person
 being the primary nurse for too
 many patients?)
 No the full-time registered nurse
 gets allocated about three or
 four primaries - up to three or
 four, you don't necessarily all
 the time have three or four.

Fay

(Are 'part-timers' primary nurses?)
 Ones that do 0.8 like four duties
 a week. I think occasionally 0.6's
 [three days a week] but not often.

Fay

(Are you satisfied with this organisation of care?)

This is the first hospital I've seen primary nursing in action, but the other hospital I came from it didn't work too well, it was just getting into it when I left. It seems to work all right. When you come on for five duties and you have that patient you can continue on the care, and you can go on the doctors' round if you prefer to. The charge nurse has a book and she writes down what's been said on the patients' round but it's up to the primary nurse if she wants to go on the doctors' she can rightly do so but sometimes that depends on time as well.

Fay

(The charge nurse always goes on the round?)

Yes if there is no charge nurse the nurse in charge does it, [for example] the senior staff nurse.

Fay

(What would her job be?)

Coordinating care, running of the ward, see that doctors' orders are being carried out and that the staff know where they are with each patient.

It may not be the primary nurse that's looking after the patient for that day. She would know that Mr C is going for a scan, that it's documented. She would know if a social worker's referral is needed, she would see it's done and she delegates really.

There is a multidisciplinary team on this ward, occupational therapists, physiotherapists, social workers, medical team.

They have a team meeting once a week so that everybody knows what's going on. Lasts the whole morning.

Fay

(Who from the nursing staff attends?)

The charge nurse and she encourages the nurses who are primary nurses to go.

Fay

Whilst Fay appears satisfied with the organisation of the ward in which she works Tina is not happy about the situation in which she works.

(Can you tell me how the nursing care of patients is organised in your ward?)

Sure. The ward that I'm working on at the moment ... when people get there in the morning you get allocated a room. You don't have a lot of say in what room you are going to be allocated and you accept that and do everything for those six people in that room for that duty. So primary nursing as far as that goes except we do have several enrolled nurses who of course you have to do the drugs for and I.V.s and special diagnostic tests and all sorts of things - help with procedures.

Tina

(Who allocates the patients?)
Usually it's the charge nurse

Tina

(So she starts early?)

No she'll do it the night before or the day before. I think probably, well it hasn't really been tested but, if you were strongly against whatever room you were in and kicked up a fuss you could probably get the one you wanted. But it doesn't happen that way.

Tina

(Are you satisfied with this organisation of care?)

No I'm not satisfied.

The reason I'm not satisfied is that I still think that what happens is you tend to revolve around tasks by necessity. If you've got people that you are doing things for like the enrolled nurses you tend to go into their rooms that they're responsible for and do things for their patients. That I'm not happy about. I don't think it's a good situation to have somebody coming in, a registered nurse, and doing things for another nurse's patients. ... It feels like you're taking responsibility without knowing the patient terribly well and the patient doesn't know who this other person is and goodness knows they see enough staff in a hospital on a day to day basis anyway without being confused by more people. Most patients don't understand the difference between an enrolled nurse and a registered nurse. I don't know how to solve that problem. It's a difficult problem to solve. I think enrolled nurses are really good, they're really worth their salt in lots of situations but you get down to the situation that the practicality of them not being able to do a lot of the things that registered nurses can or not being allowed to do them anyway. So suddenly you'll have your day planned for your patients and then suddenly what will happen is an enrolled nurse will say the I.V.s run out or somebody was supposed to have medication three hours ago and it's just not a very good situation really.

Tina

The structure of the nursing workforce in New Zealand contains two levels of practitioner. There is a

three year programme in technical institutes for students of nursing leading to registration. In hospital-based schools of nursing there is a one year apprenticeship type training for students of nursing leading to enrolment.

The difficulties inherent in two discrete levels of nursing education and thus practice causes Tina some concern. She relates her experience of working with enrolled nurses and how this has a considerable effect on her own practice. She demonstrates some ambiguous feelings about the role of the enrolled nurse in her ward, but offers some solutions based on another experience she has had.

(What is the structure of the nursing workforce in your ward?)
Predominantly registered nurses with one or two enrolled nurses.

Tina

(Maybe the solution lies in that it's not an appropriate place for enrolled nurses?)
But then you're regulating the enrolled nurses to places without I.V.s and without drugs - I mean just basic nursing cares really. I don't know if that's fair. You see in another ward where we're doing recordings enrolled nurses are used. Nurses are much more human recorders if you like. You're doing half hourly recordings on people and it's really good to have the person doing those like an enrolled nurse does them.

Tina

(Do they understand what they're doing and why they're doing them?)
Yes because you're working in a much closer area, not spread out. You're working in a unit and as a registered nurse I'm much happier about keeping an eye on what's happening to the patients and it doesn't really matter if an enrolled nurse is working there as well. I keep coming back to that because I'm very aware that registered nurses are responsible for those patients and I don't think it's fair having to be responsible for them and take responsibility for everything that happens without quite a lot of control over it.

Tina

(You said last time that you felt it was unfair because you had the responsibility of other patients, for example, the enrolled nurses' with their special diagnostic tests and I.V. therapy, without the control. What did you mean?)
As a registered nurse you are responsible for those patients but the control was that because it is more than your normal workload those people [patients] aren't in your room, sometimes they're not even in the next room, they're right down the other end of the ward and it can make it quite difficult by virtue of the distance and your 'busyness' you lose that much control over what's happening.

Tina

(Is there any way you can change that or deal with that?)
I suppose the ideal is at least get a registered nurse in the room that's next to the enrolled nurse that would be a sensible thing to do.
I think it comes under a lot of things that could be improved but there seems to be a general inability or unwillingness to do both on the part of everybody

really. It seems to me that ... people with a desire to change things get frustrated and so they don't want to stay there anymore and go to another ward. So those who aren't keen to change stay and things don't get changed.

Tina

Nursing has a tradition of oral communication and recently there has been an emphasis on documentation through the use of nursing care plans.

(When you come on in the morning you are allocated a room. How do you find out what's happening to those patients? Do you have nursing care plans?)

Yes, the first half to three quarters of an hour is devoted to sitting down and reading through the Kardex. Prior to that the night staff will give a verbal report. ... if you've been in that room before you'll probably know the patients quite well and you don't have to refer to the nursing care plan but if it's the first day in that room I always go and look at the care plans, it's very useful just to try and organise what's going to happen.

The care plan has problem, objectives, assessment and evaluation and they're done to varying degrees of competence. Sometimes they're just dreadful but sometimes they're really good. The thing that's really good on our ward is that we have a set number of operations for which we have a printed care plan so virtually all you have to do is go over to the filing cabinet, pick out the care plan for that person and put your personalised things on it. I think it's very effective because it has a very clear objective and assessment

and problems that can go wrong and why you're doing things and for a lot of people that's really helpful. I don't think it's so much for the people who work there but for the people [nurses] who are 'pooled' there, people who are new it's a very good teaching method.

Tina

DECISION-MAKING

The third question participants were asked related to decision-making. They were asked whether they made decisions regarding their nursing care and when they answered in the affirmative, which they all did, they were asked to give examples. Their answers were interesting in terms of what it was that they thought constituted nursing care.

(Do you make decisions regarding the nursing of patients in your care?)
Yes.

Ann

(Can you give me some examples?)
It is usually at the level like what records the person's going to have because the staff nurses either don't think about it or can't decide or won't decide. An enrolled nurse has to have direction, has to have the registered nurse directing care. I decide when to mobilize people and those sorts of things, total nursing care.

Ann

(Do you do that as a registered nurse or as the nurse in charge?)
As the nurse in charge usually.
Well it's both because I'm both.

Ann

(So your registered nurses wouldn't actually plan the care of their patients?)

Yes they write the nursing care plans and they decide how to nurse that patient, up to a point really, the cut off point is their knowledge or skill level and that's where I would make the decision when they either haven't the knowledge base or the skills or the optimum inside information as it were. Because I do the doctors' rounds and have more association with the doctors and so therefore more knowledge of what direction we're going.

Ann

(You are the only one who does the doctors' rounds?)

If they've got time from actual 'hands-on' contact they [the nurses] can go on the doctors' rounds. If they wish to join the round that's fine I don't stop them from doing it.

Ann

(That's for patients in their care?)

Senior staff nurses come on the round anyway. We have a paper round first.

Ann

(What does that mean?)

We sit in the office and discuss the patients with their charts.

Ann

(Like a case conference?)

Yes. The senior staff nurses tend to come. They try to come into that but everybody will try

to pick up as we go into the rooms to see the patients. They try to be there then.

Ann

(Do you do any 'hands-on' work?)
Yes when I've got time. You want to know what sorts of things?

Ann

(Yes. Do you take a patient load?)

No. I just never have time to take a patient load. I'm always interrupted by management things and organisational things, doctors. So it's not fair on the patients. I do 'hands-on' care. Often it may be skill things like C.V. line dressings, those sorts of things. I give opinions on things it's almost like a consultative role. I make beds and I take records and I give out meals and I get patients up to the toilet and I take them for walks ... as time allows.

Ann

(Does that help you in your planning care?)

I don't change patient care without going and looking, talking to the patient and getting all the information. I've seen the patient and seen their condition and usually talk to them. I'm usually the one who talks to the relatives.

Ann

Like Ann, Carol is a charge nurse and her opinions of decision-making relate to that role. She doesn't feel her decision-making relates directly to patient care.

(Do you make decisions regarding the nursing of your patients?)
I would see my role more as a consultancy situation in that I expect my staff [to be] doing this and why they're doing it.

Carol

(Can you give some specific examples?)
I don't expect a nurse to come and ask me if it's appropriate to move somebody on a cardiac mobilisation programme on to the next phase on that programme. I expect them to come to me and say I've moved Mr So and So from stage two to stage three because yesterday he did this, this, this and this. I don't actually expect her to say that I expect her to say why she hasn't. So that my interest is not in the normal outgoing things that should occur as part of the nursing process but I want to know the changes and the unusual things that don't happen and the reasons why the norm doesn't ensue.

Carol

Fay and Tina are staff nurses and their concepts of nursing practice are shown in their responses to the question. Fay highlights the difficulties that occur in communication between doctors and nurses. Stein (1978) describes the doctor-nurse game where nurses must not be seen to be giving direct advice to doctors. Fay shows how this happens in practice.

(Do you make decisions regarding the nursing of patients in your care?)

Yes

Fay

(Can you give me some examples?)
Something like dressings we usually have a say of what we should put on it and then if it's not very successful we ask what else we can put on it and it would be referred on to someone else. Sometimes registered nurses can question I.V. fluids if they're not happy. Well I would , I would go up and say that's too much fluid for that old person to be having or we could say Mr X is nauseated could some Maxalon be charted.

Fay

(What kinds of responses do you get to your suggestions about I.V. fluids or changing drugs etc.?)

I'm not sure that all house surgeons like you going up to them and saying "what do you think?" I think the majority hear you out and say "well oh yes or no I think that's what we wanted her to have."

Fay

(Is there any easy way of getting things changed for your patients if you wanted I.V. fluids changed or something like that? How do you approach the doctors?)

I would say So and So's having fluids eight hourly is that too much? You can sort of go round in quite a few ways but I usually use the direct approach really and say -

Fay

(Is it too much, still questioning?)
Yes, still questioning and yes most of them are pretty good on the whole.

Fay

(How do you feel about having to do that? If you came to me as a nurse you would say that Mr So and So's having too much fluid because this, this and this. How does it feel instead to go to the house surgeon and question?)
Well sometimes I talk with another registered nurse and see how she feels, another one on the ward and ask for a second opinion and I think ...

Fay

(What I'm trying to get at is that communication between nurses is a direct communication but when you said you'd see the doctor you weren't as direct in what you would say)
Well I'd take the fluid balance chart what he's written on it and just approach him really. ... Mr So and So's fluid output's really low and he's short of breath should we slow the fluids down or do you mind coming to see him.

Fay

Tina's response to the question regarding decision-making was to describe a recent example where she felt she had considerable impact on the placement of one of her patients.

(Do you make decisions regarding the nursing of patients in your care?)
Yes.

Tina

(Could you give some examples?)
Yes. We have a lot of acute trauma. I think a lot depends on the nurse's initiative. I think you can have a lot of

control or you can just not take that control and I think a lot of people don't but I think that's not to say it isn't there. One of the examples I can give is the other day we had a head injury who a lot of people thought, it was generally thought that he wasn't going to do very well and that he was more or less going to be a vegetable and we were just going to be doing nursing cares. We had had a referral to a geriatrician to assess him to go into a private hospital or rest home. The geriatrician came up and I happened to be looking after this patient. The Geriatrician assessed him and then came and spoke to me and he said "what would you like done with this patient, how do you feel about his future care should be planned?" I felt strongly that he should not go into a private hospital or rest home, that he should stay on the ward. It was the best place, he was going to get the most physio, the most care, his mother knew all of us and we got on very well with her. She was very good with her son did a lot of care for him and it would be sad to see him carted off somewhere else new where she was going to have to get to know everybody else again and that perhaps he would get physio or perhaps he wouldn't, perhaps he would get occupational therapy or perhaps he wouldn't. You know those sorts of things. I said no that's what we're here for that's our job I think we shouldn't just cart everybody out when they're no longer in medical danger. I think we should keep him here and he was amazed and he said "well that's very good and I think that's the case too. If I don't feel any pressure from the nursing staff then I'm happy to leave him here too" and so that's what happened and he's doing really well. I feel quite responsible for that.

If he had spoken to one of the other nurses who said no we want him out we want the bed, he's a pain or he's hard nursing or whatever, then he would have gone. So that's a case of having quite a lot of control. Also I've been in the ward quite a time and I'm now one of the senior staff nurses and I think that gives quite a lot of control plus I'm willing to take it.

Tina

(If you had a patient going home and you wanted some follow-up from the domiciliary nursing services how is that organised?) It would just be a matter of filling out a referral form and ringing them up on the telephone that's the procedure.

Tina

I asked Tina whether as part of her nursing practice she accompanied the doctors when they were seeing her patients. Tina describes some of the frustrations inherent in communication patterns between doctors and nurses. Her solutions, however, are quite intriguing.

(What about when there's a consultants' round do you go with the consultants?) Well the charge nurse does that, the charge nurse or the person who is doing charge that day. They have a book which they write in while they're doing a round and then they come to each individual staff nurse or enrolled nurse and tell them the plan. However, I always try and get in on it too because I find the communication is really

bad and I think it's very important to know what's happening with my patients and I don't like leaving it to chance whether I'm being told or I'm not being told. It's extremely frustrating to be told by a patient that they're going to do this or going to do that and you have no knowledge of it, and I therefore take quite a lot of initiative and go along and sort of hang on the corners sometimes. By now I've got to know the doctors and consultants really well. They don't mind. There's much more to and fro communication so it's good. Consultants don't have a specific time that they're there so it's very lacksadaisical really in lots of ways. They come when they feel like it. Some consultants are better than others, they make an effort to make the nurses aware that they're there. Other ones will barely go in the door, sort of walk down the corridor so you have to be fast there's no doubt about it. Even the Charge Nurse has to be fast to realize that they're there. I'm quite assertive at finding out from the doctors, I'm not backwards in coming forwards. I'll say I'm looking after these people what's happening have you made up your mind or what are you doing?

Tina

(You don't have any trouble?)
 No I don't have any trouble relating to them. They're not great communicators some of them. I think given that foundation I don't have any trouble.

Tina

(What do you mean they're not great communicators?)
 They sort of mumble and say maybe this and maybe that and they'll go away. You'll ask them a question and they won't answer

it directly. They won't initiate information. They'll tell you if you ask.

Tina

(Do you notice in their interaction with registrars and house surgeons that that exists?)
Yes I don't think it's anything to do with nurses it's more a function of the consultants ability to communicate.

Tina

Within the hierarchical structure of the hospital organisation there are often seen, by the participants, to be comparable levels. Stein (1978) makes the point that it behoves junior doctors to 'get on' with the nursing staff.

(What about communication with house surgeons?)
Theirs is good. There are many factors that affect that. One is they're more likely to be my age or around my age and that helps because you have a common background. Two, they're likely to be around more often and by virtue of them being around even if they're bad communicators you can get more from them because they're there. And because they're not so high in the hierarchy makes them more willing to please, more willing to get on, more willing to work as a team with the nursing staff and also because in certain areas nurses know an awful lot more than house surgeons. So it behoves them to get on well with us.
We've just changed house surgeons and you can see they're quite worried about the whole thing and in the past I've made a point of sitting down with them and

telling them the preferred fluids that we give, the preferred drugs, doses, the preferred pain relief, all that sort of thing that understandably they don't know coming from another ward. I think they appreciate that.

Tina

INFLUENCE ON PRACTICE

The fourth question asked participants about the influences of other members of the health team on their practice. The health team in this instance refers to the multidisciplinary group of health care professionals who work in a hospital. These professionals include nurses, doctors, social workers, physiotherapists and occupational therapists.

(Is there anyone else in the health team that influences your practice?)

If someone comes up with a better idea on how to do something or some change has to be made, or they perceive has to be made in the ward or in the management of patient care, anything really, if they can convince me that that's good and I like their idea then I'll do it their way.

Ann

(Who would those people be?)
Other nurses, they can be at any level as in enrolled nurses, staff nurses or nursing tutors.

Ann

(You look at a health team as more than just nurses.)
I see what you mean, occupational therapists, physiotherapists ... Doctors don't actually have much influence on my nursing care apart from a procedural change that usually has input from nurses anyway.

Ann

(What do you mean by procedural change?)
Well if you're going to change a procedure like underwater seal drain then usually it's the nurses who make the final change in practice if not in theory. The doctors think they make decisions but they don't. We have a practice manual. Nurses have a committee that sets up, modifies and updates and changes the practice manual. The doctors are asked for their opinion and then the nurses write it out and change things and they send it to them [the doctors] for them to proof read and they say "yes, O.K." but the person who originally wrote it is their charge nurse.

Ann

(How do you feel about the fact that it's sent to the doctors for their approval if it's a nursing procedure?)
Well it's not necessarily a nursing procedure. Doctors don't have practice manuals.

Ann

(What sorts of things would be in a practice manual?)
Care of underwater seals. When we set up the practice manual we wrote a procedure [and] got the doctors to look at it. They said yes that's fine with us. This is how we do it we suture the thing in and so forth and then another consultant said no we don't do it that way, we don't suture it in and we're going to

teach the registrars to do it my way. So we brought in the Infectious Disease Nurse, the charge nurses from the Intensive Therapy Unit, the medical wards and they said we don't like this for various reasons and we went back to the consultant and said you've really got to suture these in because for these reasons - infection control etc. So they went along with us.

Ann

(So it's basically a consultative group of nurses and doctors?)
 Yes. No the nurses have the final say because they write it because it's a nurses' manual and there are new doctors coming in and they have to find out what to do so they look up the nurses' manual. I'm not joking they do to see how to do their procedures.

Ann

I have often heard complaints informally from nurses that patients had been discharged by the doctors before they (the nurses) thought they should be. I asked Ann about this. Her comments show the informal control that she as a charge nurse has over the movement of patients in the ward.

(Who decides if a patient can be discharged?)
 If a patient is in for a medical condition and that's all they're there for, there's no other problems, then the doctors decide when they can go home in consultation with the nurses and physiotherapists etc. If it's a disorder, for example, they can be ready for discharge and the nurses say well they've

been to the education class which is run by a nurse, or the physio wants to teach them something else then they are kept in for another day for that. Or if there are some social problems then the consultants say I'm finished with them and as far as their medical care is concerned when you are ready to discharge them, discharge them. And then it becomes my decision as to when they're discharged. When I'm satisfied with their social situation and so forth then I say they can go home.

Ann

(What would happen if a situation arose that a consultant wanted that bed and said that the patient was to go home?)

We don't send them home because they've got to have transport home and they've got to have this and that organised and we don't manage to get it organised and they go home when it suits us. It doesn't happen often because I've worked with my consultants for so long they act on my opinion now.

Ann

Ann has been in her position for some years and she explains how this has helped her in her interactions with the consultants on her ward.

(You say that things have changed, that you feel you have quite a bit of control over what you do. What have been the changes and how have they come about?)

Nursing care of people. It used to be that the doctors decided when someone could get up or what records should be taken, this sort of thing. I believe that nurses have the ability

and the knowledge base to be able to decide those things and so in my ward that's what usually happens.

Ann

(And how did you manage to achieve that?)

I've been with the same consultants for some years and they trust my judgement. Over the years I've proved that what I do is effective. I've managed to get the turnover pretty rapid so they let me make a lot of decisions that perhaps if it was a different charge nurse they wouldn't.

Ann

(What was the situation when you took over X years ago?)

The doctors had pretty much control over what happened to patients like mobilisation etc. but that's rare for that to happen today. My ward is aimed at rehabilitation and 'rehab' starts on admission and the emphasis is on that. That means early mobilisation is important. I refer to the physio, O.T. and medical social workers.

Ann

(You refer to your other colleagues like district nurses, specialist nurses?)

Yes. District nursing forms - I fill them in. I refuse to put the consultant's signature I put my own. The form's got 'referred by' and it's meant to be a consultant but I refuse to do that because it's usually my decision that they're referred to the district nurse. [It's] traditional because district nurses work with general practitioners and G.P.s won't accept nurse referrals. It seems to be historical but we don't

get them back. The consultants don't know they've been referred or very rarely.

Ann

(What about house surgeons when they come to the wards and don't know about procedures etc. How do you find house surgeons cope with nurses making decisions?) Most of them are happy to leave it to the nurses to decide on things. I've had patients who've had leg ulcers and need dressings. Well I decide or the nurses decide usually the senior nurses. Usually the consultants say you leave that dressing and the nurses will decide what to do. You get the individual doctors who don't like it, they tend to be more chauvinist in their outlook. Less problem with the female house surgeons. The male nurse has a worse time than the female nurses, they [house surgeons] are less likely to listen to him. That's the male house surgeons.

Ann

I wondered whether the nursing administration (Principal Nurses, Assistant Principal Nurses and Supervisors) influenced Ann's practice.

(Do you think the (nursing) hierarchy is still a tradition?) No I think it's more on a practical level now rather than tradition. Somebody has to take responsibility in the end. In the day to day running of a ward there's nobody above a charge nurse that has an influence on them. The senior staff nurses have a patient load, they do medications but they don't supervise. The enrolled nurses tend to come to the charge

nurse with their questions so the charge nurse directs their patient care more than anyone else. Nurses tend to work together even though they're allocated patients.

Ann

(Can directives from the nursing hierarchy influence what you do in your ward?)

We don't really get many directives that affect patient care. I can't think of any.

Ann

(There are policies that affect nursing care, for example, Infection Control, Intravenous Therapy etc.)

That's not from the nursing hierarchy it's from a specialist group.

Ann

(What about the general administration side, for example, the House Manager?)

Very little really. It's usually for requisitions, equipment that affects you. The effect would be when they say you can't have this because it would cost too much.

Ann

Carol talks about the influences of other members of the health team on her practice. Some she sees as helpful, those she sees as not helpful she deals with in her own way.

(Does anyone else in the health team influence your practice?)

Yes my three senior staff nurses in the ward, my fellow charge nurse colleagues and currently

at the moment the specialist registrar because he has good experience.

Carol

(How does he influence what you do?)

He has good experience from different areas to say these are the kinds of things that might be tried - he's a good resource for me.

Carol

(Remembering that we are talking about nursing practice does he still influence?)

No influence is not the word. I listen to what he says. That's one of the resources that I listen to. What I do, is a result of my internalising all the information and from the people it comes from.

Carol

(When I talk about health team I'm talking about a multidisciplinary team)

Yes I think we probably have an across the board kind of relationship. There are some patients they take a major role in the management of and leave guidelines for management for us. I'm quite happy to follow those if they happen to be the major person at that time in that person's care. I have no problem with that.

Carol

(Do you find the nursing hierarchy has any affect on what you do?)

I don't use them as a resource for my nursing practice.

Carol

(What about the consultants, do they have a say in what you do?)
Yes I think they do. I think that as I am at the moment trying to establish some sort of standards of care that the expectations that they have need to be considered when I'm setting nursing standards.

Carol

(What do you mean by expectations?)
Well our specialist area is my current phase at the moment and we are producing a room for a specialist form of treatment, so the kinds of things I'm asking them are what sort of level of air-conditioning do you expect in this room, what do you consider is appropriate for protective nursing measures. That's a give and take situation so I listen to what they have to say.

Carol

(You are quite comfortable with this nursing issue?)
Just because I discuss it doesn't mean I'm going to follow it. I think in the interests of team relationships that it is appropriate to be seen to consult with people. You don't actually have to listen. Oh I hate the petty politics I just don't enjoy it at all but there are several ways you can approach a situation and sometimes up front is not the best way. Because they perceive themselves to be the top of the tree and you see that sometimes their resistance to what we want to do is absolutely, utterly and totally because we made the decision. Whereas if you play the little game and talk about [it] and go back and say remember we discussed this and play all the little public relations games that we play then you get your right answer which is what you intended to happen.

Carol

(How do you feel about the need to play games?)

I never used to be really good at that sort of thing. I've got better over the years. I tried the up front system once and all it did was alienate me, it became difficult to work within my nursing structure. People with big mouths and forthright ideas, you're fine if you're in with the people who make the decisions but if your face doesn't fit and you're an up front person then the door closes and I did not work well in the cold so to speak. It's much easier to come in from the cold and do it with people and if you have to 'pussy-foot' around sometimes then that's what you have to do.

Carol

(What does that do for your self-esteem?)

I don't have any problems with my self-esteem, I know my qualities, and my values and my worth.

Carol

(Do you think you might try the up front approach again?)

That's very clearly part of my makeup and is highly visible most days of the week. Now I'm selective in the battles I fight. I only fight the important ones I don't waste my energies on the ones that don't matter. So the doctor wants something to happen and it doesn't make any difference to me, doesn't alter the quality of care that my patient is receiving, doesn't mean any more work for my staff, doesn't really alter much at all, I'm really happy to go with that flow because he feels like he's made a decision and that's fine. It doesn't alter anything for me. I only fight the battles I mean to win.

Carol

Carol makes quite clear distinctions between her interactions with consultants and junior doctors.

(How much influence do House Surgeons have on what you do as a nurse?)

They don't have any influence on what I do as a nurse at all. I see myself clearly up my ladder much higher than they are up theirs because they are part of the junior team that work in my ward. Quite clearly they work in my ward, they are orientated to the way we do things in my ward and I expect them to meet my standards. I expect them to give clear instructions both written and verbal to the people who are looking after their patients.

Carol

(Do you accompany the consultants on their rounds?)

If it's an arranged round. We have chart rounds - we go through the charts and the management. My idea is, I think it's rather important that some nurse has input into that. If I don't happen to be around then one of my senior staff or one of the girls from one of the teams tries to be around. I don't consider it's essential to go to the bedside with the consultants because the cases and the course of treatment is well discussed before we get there and I like the person who's looking after the patient to go. I find it difficult to tolerate three and a half hour rounds and so I opted out of those as a method of indicating to them that there was a lot of drive in and we've smartened our act somewhat considerably so that they are good learning experiences. If they want to do a round out of the time they've got scheduled

in the book then they do it on their own because we also have schedules.

Carol

(Do the doctors decide when people are going to be discharged?)
No not necessarily, in fact less and less because discharges are often the result of a lot of work. The preparation for discharge needs to go on for several days and we try to estimate a discharge date for somebody several days ahead and say when investigations will be finished and, barring this contingency, we will anticipate their discharge. So I will 'tee that up' but if they're talking discharge and I believe it's inappropriate then usually they don't go home because that's the input the nurses have.

Carol

(When it comes to referring the patients to your other colleagues like district nursing who does the referral?)
I write it and they, the doctors, sign it.

Carol

(Why do they sign it?)
Because I have inherited an historical situation in my ward where the relationships in the team were not good, so we're working on that, but the referral and the intention to refer is mine and I tell people when patients need to be referred. I feel it's not necessarily appropriate that the house surgeon signs that piece of paper.

Carol

(Why not?)
Because I am a professional person and I am able I believe to decide whether someone needs

to be referred to one of our colleagues or not.

Carol

I learnt at the second interview that Carol now signs her own referrals to her colleagues in district nursing.

(What about the O.T.'s, physios, social workers. Do you find that they influence what you do?)
I think there is no doubt that if you use the quality of term good or bad that if you have a good physio they have a strong influence in your ward and that's a very positive influence because you find at the bedsides that they teach nurses. If you however have a bad physio or O.T. likewise the patient gets a poor deal and the nurses perceive them as not being people of value who can contribute to care. I think the most integral person almost is the social worker. We have a weekly meeting that the registrar and I chair and everybody has input into that.

Carol

(What about the general administration part of the hospital, does that affect what you do?)
Increasingly it will. Yes it does in the supply of equipment to us. I think you have the classic situation where people are doing the ordering that have no experience of the kind of equipment you need. When they do the tenders they pick up the cheapest which is sometimes an absolutely inappropriate piece of equipment to replace something that you have been using and you end up having to use other connections that cost more money

and those sorts of things. I think that more and more we are going to have to work closely with these people because money is going to be the 'god' for a little while to come. The problem I have is not being supplied enough information from those that I call support people to allow me to make an informed decision. I do have concerns of a young man telling me no when I want things and that makes me angry.

Carol

(What do you do?)
I usually bypass him.

Carol

Ann and Carol perceive influences of others on their their practice primarily as it relates to nursing management. In contrast, Fay relates the influences on her practice at the level of direct patient care.

(Is there anyone else in the health team that influences your practice?)
The physios.

Fay

(And how do they influence what you do?)
Well they can. If a C.V.A. patient comes in they'll put up a chart to say how a patient should be lying, how they should sit in a chair with a sling or a pillow. They'll bring a frame and say Mr So and So's ready but he still needs the assistance of one nurse.
Dietitians also, well, we usually refer [to] them if patients come in a bit overweight. We usually send a dietary referral and then the Dietitian comes in and sees

the patient and says yes she agrees and with the patient's cooperation they can go on a reduction diet.

Fay

(What about referrals [to] or working with the medical social workers?)

They come up to the ward and discuss how do you think So and So will cope at home. They might ask you if you know anything about the home circumstances.

Fay

(Do they accept your opinion of what the abilities of the patient are?)

Yes.

Fay

(Do you have much to do with the consultants?)

No not much with the consultants. We have more to do with the registrars and house surgeons.

Fay

(Who deals with the consultants?)
The charge nurse will.

Fay

(What about the doctors' round when the consultants do a round, do you go on that round?)

Sometimes but the consultant usually directs the questions to the registrar. It's a medical session when they are going on the rounds more than the nursing side.

Fay

(They would never direct nursing care, anything that you would think is nursing care? All their comments are limited to medical?)

Yes well they know the nursing side because they've had a team meeting beforehand with the

social worker, physio and O.T. and the nurse as well. So it's just a medical round.

Fay

(What about the nursing hierarchy, does that have any influence on your practice at all?)

The Hospital policies come out and that has to be adhered to. The supervisors have a say as to the numbers of staff that you have on each duty. So they can dictate, well, you can only have four staff on for a duty because another ward's load is heavy. Sometimes you get sent away [to another ward].

Fay

(The policies ... you said they had to be adhered to. What happens if you don't like them?)

You can always speak to the charge nurse and also staff nurse meetings. You can speak to your colleagues and see how they feel because your colleagues can be really supportive in times like that.

Fay

(Can you get things changed?)

Don't know, I've never come across that one where I've disagreed on policies.

Fay

The influences of other members of the health team on Tina's practice are varied and, like Fay, relate to direct nursing care.

(Does anyone else in the health team influence your practice?)

I think that when you're working in a situation on a ward which

is a multidisciplinary team approach you do get influenced by them. I mean influenced in many little ways. If a physio says can you have this person ready by nine [o'clock] because I'd like to take them to physio then you organise around that because it's important. If the social worker says this is such and such a situation, can you be aware of this, then you are aware of it. If they feel strongly about a certain line of medical intervention or discharge plans then you take notice of it. You either pass it on or you be aware of it.

Tina

(Does anyone influence how you practice?)

Yes I can give you an example. There are a lot of patients with acute trauma, people who have been hit by a husband or a de-facto or a boyfriend or whatever. I think it's really important to have a social worker give you that information so you can be a bit more understanding of the situation. Obviously a physio would influence how you got people out of bed etc.

Tina

Tina describes the nursing hierarchy as it relates to her ward. She gives an example of the effect that nursing management outside the ward has on patient care, and in relating this example shows the powerlessness felt by some nurses when they challenge this authority. This example also shows how the intervention of the medical profession influences nursing decisions and, importantly, how Tina felt about this intervention.

(Does the nursing hierarchy influence what you do?)
Well the nursing hierarchy as it occurs on the ward really consists of the charge nurse, the registered nurse, enrolled nurse student. The charge nurse influences the day to day running of the ward and she influences your behaviour there's no doubt about that but I think a lot of it would not be a static nursing hierarchy. I think a lot of it would be the personalities involved in a group of people no matter what level they were.

Tina

(What about policies?)
The other ward I worked on, the individuals took a lot of responsibility for changing things, being aware of what's happening and taking initiative. And one example of that would be we have always previously done recordings on the odd hour and also the drugs are due at that time so one person said why don't we do them on the even hours and the drugs on the odd and that works so much better. Those sorts of things are constantly happening, constant improvements, reappraisals of things that are happening so at that level policies get changed frequently. They don't have a lot of power over the big policies and they don't take much responsibility for that but on the other ward there's an incredible apathy. If somebody suggested we should change things or look at things there would just be a big yawn. So there are two different ways of staff operating in terms of policies on their ward.
A policy of having a certain number of staff on duty, and there's been a lot of problems with that where the registered nurses said no, this is not good enough, this is not safe, we're not happy, give us more staff or there's going

to be a big accident and we're not going to take responsibility, we've been telling you about this for months, and they've consequently gone through the nursing hierarchy and the Nurses' Association and said what's the story? It was very difficult to do, they were very brave 'cos it wasn't easy, it got branded as a personality problem, you haven't done it the right way, all those sorts of things. [The staff said] that's not what we're talking about, we want more staff, it's not a personality problem, could you stop side-tracking, this is what we want ... I think that was a good example of challenging a policy that they didn't have any control over and wanted to change it.

Tina

(How do you feel about that?)
I think it's absolutely disgraceful. I think it's amazing. If those nurses are given the responsibility to look after these patients they're good responsible nurses. In the end those nurses got not only their Association but they got letters signed by the doctors who were witnessing and were saying this is just disgraceful. It's not the responsibility of the doctors, the doctors aren't our bosses, we are not responsible to the doctors. It was nice of them to do it, and it probably packed quite a punch but that's not the point, they shouldn't have had to do it, it's got nothing to do with them, it's the registered nurses who know how busy they are, who know how dangerous it is.

Tina

Other influences on Tina's practice included time and peer pressure from her nursing colleagues.

(Do you feel that there's any constraints on your practice?)
Yes there's lots of restraints. The restraint that leaps to mind is time. That's almost self-explanatory. If you haven't got time and you're really busy then things get shortcuted and you don't do things that you want to do.

The other restraint that I've been feeling lately has been, for example, I arrived in the morning, I had been working in a room so I knew it well and I know I'm going to be busy so I've got all my plans for the day worked out so I want to get a move along. There's this dreadful inertia so that if you get up and look sort of keen and reasonably interested and want to get on with your work and everyone else is still sitting after report has finished but sitting down chatting, and there's this terrible what are you doing, why are you getting up, don't be so keen, sit down you don't have to go yet, don't be a martyr. It sort of drags you down, it's awful, any enthusiasm generated just sort of goes dead. I find that an incredible restraint. I like to think it doesn't affect me too much in the way I operate but it does affect me inside.

Tina

Communication continues to have a considerable influence on Tina's practice.

(You talked about a multi-disciplinary team that you work in. Do you have team meetings?)
We have team meetings once a week which the charge nurse or the nurse doing charge goes to. I've been one or two times. The charge nurse is supposed to write in this book and tell you about what's

happening. I don't think that always happens but for me I find the usual contact is on a day to day basis because those people are usually on the ward and you get to see them and you talk about the patients independent of the charge nurse. I find that works really well. I like the informality of it partly because I'm not included in the formal structure - communication channel.

Tina

(Would you like to be?)

Yes I would, I think a registered nurse should take as much responsibility for those patients as possible and I think the problems are evident and the time it would take to coordinate the registered nurses to go in there.

The charge nurse changes recordings on some patients, I usually do mine. She does the doctors' round etc., team meetings.

Tina

(In so far as you have your own patients, you do everything for them, you plan their day?)

Yes you do have a lot of control over their day but the only thing I'd say is that if communication is not very good, which it sometimes isn't, we'll have people coming in like orderlies who'll take patients to various procedures, and because nobody has actually told you or the communication has broken down you weren't aware that they required a CT scan at such and such a time, those sorts of things. And they do happen quite often so that you might have somebody's day planned but you haven't all the information to plan it.

Tina

(Where is that information?)
Some people tend to take it over
the telephone and not pass it on
or it's just written in the notes.
It usually is but I'm just saying
that as a thing that can throw
you off when information hasn't
been passed on. You can't work
around it obviously and I also
think people seem hesitant to
say things in case they say them
too often, and I'd much prefer
people said it to me three times
than not at all.

Tina

In the following chapter the comments made by these
participants are analysed and discussed.

CHAPTER SIX

DISCUSSION

The focus in this chapter is on nursing work in hospitals. The organisational structure of the nursing profession impacts considerably on the practice of its members. The responses of the participants in this study are analysed in terms of their current practice; the effect of the nursing hierarchy as an organisational structure; the result of this on nurses' sense of autonomy and control over their practice; and doctor/nurse relations as they currently occur in hospitals. Quotes are included to reinforce the analysis. Page numbers refer to the origin of the quote in chapter five.

Current practice

The registered nurses in this study who provide direct patient care are allocated their own patients for whom they plan and implement nursing care. These nurses also undertake specialist tasks for other nurses, for example, enrolled nurses. Enrolled nurses are in all instances in this study assigned their own patients but because of the limitations of their training they are unable to provide total nursing care. These enrolled nurses receive assistance from registered nurses for the aspects of

care they are unable to implement such as:

drugs ... I.V.s ... special diagnostic tests ... (p.59)

... the charge nurse directs their patient care more than anyone else. (p.80)

In some instances these nurses are allocated patients who do not require specialist skills:

C.V.A.s, social admissions, people who come in with leg ulcers ... (p.57)

This division of labour precludes registered nurses from focussing their energies solely on the nursing requirements of their own patients. Although nurses affirm their patients as central to their work they see the structures as limiting this and it is the tasks which become central:

... you tend to revolve around tasks by necessity. (p.60)

... nurses are much more like human recorders ... (p.61)

... what record[ing]s the person's going to have ... when to mobilize people ... (p.64)

C.V. line dressings ... make beds ... take record[ing]s ... give out meals ... (p.66)

When participants were asked about the organisation of nursing practice in their wards they spoke of primary nursing, team nursing, patient allocation and room allocation. The reality is that certain tasks supersede whatever ideological form of nursing practice is used:

you get allocated a room ... and do everything for those six people ... so primary nursing as far as that goes except we do have enrolled nurses who ... you do the drugs for and I.V.s and special tests ... help with procedures.(p.59)

In this study the current practice of the nurses in charge of various wards is viewed more in the light of the management skills they require:

co-ordinating care, running of the ward, see that doctor's orders are being carried out and that staff know where they are with each patient.(p.58)

I give opinions on things, it's almost like a consultative role.(p.66)

Impact of others on practice

Hierarchical structures within hospitals define the work of individuals both in the institution and within professional boundaries. The nurses in this study describe two distinct though integral nursing hierarchies. The central hierarchy consists of the principal nurse, her assistants and supervisors. The participants in this study see the centralised hierarchy controlling only the movement of staff within wards:

... supervisors have a say as to the numbers of staff you can have on each duty. (p.89)

they've gone through the nursing hierarchy and ... [said] we want more staff ... (p.92)

The second hierarchy, and of major import to the participants, is contained within individual wards:

In the day to day running of the ward there's nobody above a charge nurse... (p.79)

... the nursing hierarchy as it occurs on the ward really consists of the charge nurse, the registered nurse, enrolled nurse, student (p.60)

The rigid organisation of the past, as described in chapter one, appears to have changed from a vertical to a more horizontal hierarchy and nurses focus on the structures within the organisation as they directly affect their work. The central control of the matron (principal nurse) over nursing practice has been replaced by a form of patriarchal control by the charge nurse reminiscent of the 'Queen Bee' syndrome described in chapter four. It is the charge nurse who determines the organisation of nursing practice in her ward. She also allocates the patients to the nursing staff who presuppose they can challenge her decision but who in effect passively accept the patients they are assigned:

Well they do have a say. Sometimes they say I would like this patient to be my primary patient otherwise the charge nurse determines it ... the full-time registered nurse gets allocated about three or four primaries [primary patients] ... (p.57)

I think probably, well it hasn't really been tested but, if you were strongly against whatever room you were in and kicked up a fuss you could probably get the one you wanted. But it doesn't happen that way. (p.59)

Control of information is another form of subtle display of power. Nurses rely on the communication skills of the charge nurse to ensure they are informed of the changes in the treatment of their patients. The charge nurses described in this study accompany the consultants on their ward rounds and make notes of the changes in treatment determined by the consultant:

The charge nurse has a book and she writes down what's been said on the patients round ... the primary nurse can go ... (p.40)

...I do the doctors' rounds and have more association with the doctors... (p.47)

... the charge nurse does that [doctors' rounds] ... have a book they write in ... (p.52)

It can be very frustrating for nurses to learn of new treatments from the patient. The data illustrates ways by which nurses can challenge the status quo and develop their own strategies to be included in the decision-making which occurs during the ward round:

I don't like leaving it to chance whether I'm being told or I'm not being told ... I therefore take quite a lot of initiative and go along and hang on the corners sometimes ... I'm quite assertive at finding out from the doctors ... I'll say I'm looking after these people what's happening, have you made up your mind or what are you doing? (p.53)

The power relations between nurses within wards as demonstrated in this study exemplifies a masculine hierarchical model of management and impinges on the practice and behaviour of the nursing staff. The charge nurse is seen to exert a form of patriarchal

control over nursing staff by determining the organisation of nursing care; by allocating patients; through control of information and by proscribing the limits within which nurses may work. The staff in the ward though they may feel they would like more control find that the structures mediate against them:

If they've got time from actual 'hands-on' contact they [the nurses] can go on the doctors' rounds. (p.65)

If you haven't got time and you're really busy then things get shortcutted and you don't do things that you want to do. (p.93)

Pressure by peers to conform to existing patterns of behaviour can be seen to be a constraint on nursing practice is demonstrated in the following comment:

I know I'm going to be busy so I've got my plans for the day worked out so I want to get a move along. ... if you get up and look sort of keen and interested ... and everyone else is still sitting ... chatting ... there's this terrible what are you doing, why are you getting up. Don't be so keen ... you don't have to go yet, don't be a martyr (p.93)

In the analogy of the hospital family (Ashley, 1976), the consultant is clearly the father/decision-maker in respect to medical treatment. He enters the ward usually at selected times to do a round of his patients in the company of the charge nurse and other members of the medical team, registrars and house surgeons. On occasions, usually weekly, there are multidisciplinary team meetings. These are attended by the medical team, the charge nurse of the ward,

sometimes her senior staff nurse(s), physiotherapists, occupational therapists and social workers. These meetings can be of short duration or may last an entire morning. Each patient is discussed and each member of the team makes comments on patient progress as appropriate. It is the charge nurse who determines which members of her staff may attend. In some cases she is encouraging, in other cases she realises the priority of nursing care precludes all nurses from attending.

Historically the relations between nurses and doctors have been in the form of power relations with the doctor having ultimate control over patient care. Doctor/nurse interactions can be seen to take the form of game-playing (Stein, 1978) as described in chapter four (pages 67-69). In this game both participants know and understand the rules. The primary rule is that the doctor is omnipotent. The nurse may make recommendations as long as she uses the correct verbal and non-verbal cues. She must never be seen to direct a recommendation. She must do it in such a way that it appears to be the doctor's decision. Nurses in this study show they have become adept at this game. When questioning whether a patient is receiving too much intravenous fluid the nurse may say:

Mr So and so's fluid output's really low and he's short of breath. Should we slow the fluids down or do you mind coming to see him? (p.69)

In some situations, for example, in decisions doctors wish to make, the nurse may use a more subtle means of ensuring she gets what she wants or at worst that the decision does not impinge on her staff:

So the doctor wants something to happen and it doesn't make any difference to me, doesn't alter the quality of care that my patient is receiving, doesn't mean any more work for my staff, doesn't really alter much at all, I'm really happy to go with that flow because he feels like he's made a decision and that's fine. (p.83)

Or alternatively the nurse may call in her own specialist nurse colleagues in support of a dispute with a consultant:

Then another consultant said no ... we're going to teach the registrars to do it my way. So we brought in the Infectious Disease Nurse, the charge nurses from the Intensive Therapy Unit, the [charge nurses] from the medical wards ... (p.76)

The tradition of physician control can be seen to impinge on nursing referrals to their district nursing colleagues:

I write it and they [the doctors sign it. (p.85)

The form's got 'referred by' and it's meant to be a consultant but I refuse to do that ... (p.78)

Typically access to and from the hospital has been the domain of the medical profession. Nurses in this study illustrate the means by which they can ensure that a patient is not discharged prematurely:

they've got to have this and that organised and we don't manage to get it organised and they go home when it suits us. (p.77)

... but if they're talking discharge and I believe it's inappropriate ... they don't go home ... (p.85)

Nurses make distinctions about different members of the medical hierarchy. If the consultant is seen as the father in the hospital 'household', then the house surgeon is the son who is not yet ready to step into the father's shoes. The charge nurse commonly interacts with the consultants while other registered nurses work in close contact with the house surgeons. This cross hierarchy link can be seen in comments made by the participants:

... they're [house surgeons] not so high up in the hierarchy makes them more willing to please, more willing to get on, more willing to work as a team with the nursing staff ... (p.73)

Usually the consultants say [to the house surgeon] you leave that dressing and the nurses will decide what to do. (p.79)

I [charge nurse] see myself clearly up my ladder much higher than they [house surgeons] are up theirs ... they are part of the junior team that work in my ward ... they are oriented to the way we do things ... I expect them to meet my standards. (p.84)

Hierarchy, it would seem, plays an important role in hospital organisation. It structures the particular work that individuals may do and helps to structure the relationships within the institution. Nurses show in some instances that they have a degree of control over what they do. It can be seen from the experiences of the nurses in this study that it is

the nurse in charge of the ward who is able to organise the nurses in her ward. It is she who negates the traditional influences of the medical profession over nursing care.

Can nurses be said from this study to be powerless in controlling what they do? In so far as these nurses do not have power over their own practice without due regard to the structures of the organisation they can be said to exhibit a degree of powerlessness. This is especially so for registered nurses who are giving direct nursing care. The analogy of the family serves a useful purpose in that it identifies the roles and relationships of the hospital team as it relates to the nursing and medical professions. The ward symbolises the household, the charge nurse adopting the role of the mother and the consultant, the father. Staff working in the ward in this analogy are the siblings with the patients as the babies for whom certain tasks must be performed. Included as siblings are the nursing staff and the junior medical staff. Sibling rivalry occurs between nursing staff, as illustrated in page ninety-three, and between nursing staff and junior medical staff, as illustrated in page seventy-three.

It would seem from this study that nurses have adopted patriarchal means of control. The effect this form of control has had on nursing practice is

four-fold. Firstly it decreases the chances other registered nurses have of autonomy and control over their own clinical practice. Secondly it reinforces the concept of hierarchy and legitimises the masculine model of management. Thirdly it inhibits collegiality between nurses and between the medical and nursing profession. Finally it forces the patient into a recipient, dependent role. The power struggle between doctors and nurses has been shown in this study to be an incipient factor in interactions and therefore is much harder to overcome than if it were an open form of confrontation. Thus any attempts at multidisciplinary team approaches to patient care are likely to remain a tension between medicine and nursing.

Considerations for further research

The conclusions drawn in this study cannot be generalised to a larger nursing population in New Zealand therefore it would be appropriate to extend this study to a larger population representative of registered nurses in New Zealand. In so doing it would also be possible to extend this study to include some considerations of the changes that have occurred in nursing practice in New Zealand over the last two to three decades. It would also be of interest to compare the experiences of nurses in different settings, for example, examining the

analogy of the family within a community setting rather than within a hospital. Questions one would ask, is horizontal and vertical nursing hierarchy present in the community? Is rivalry expressed and in what way? Is powerlessness more or less identifiable in community nursing practice?

Critique of framework

Socialist feminist theory has been helpful in providing an explanation of the development of nursing within an historical and social milieu. The theoretical framework has also been useful in explaining the structures which have impeded reforms in nursing. Feminist research methodology has proven beneficial in identifying the subjective experiences of female registered nurses and in particular removing the traditional hierarchical interviewing structure and validating the experiences of the nurses in this study.

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APPENDIX ONE

Home Address

Hi,

My name is Robyn Goffe and I am a graduate nursing student at Massey University. I am undertaking a research study toward meeting the requirements of a Masters Degree and would appreciate your assistance.

Registered nurses are prepared in educational settings to use their knowledge and skills to plan and evaluate the care they give and to practise as colleagues of other members of the health care team. The preparation of the nurse to practise in a certain way will only be effective if the structures in which she practises facilitate it.

This study will examine clinical nursing practice in a hospital context. It examines the perceptions of registered nurses in relation to their practice; whether or not they feel they have some control over what they do and how they practise, or whether there are other influences within their work environment that affect what they do.

One of the more effective ways to identify an individual's perception is by questioning and to this

end I would like to interview registered nurses to find out their feelings about their own nursing practice.

I envisage two informal interviews in a non-threatening environment e.g. the participant's own home or place of choice. Each interview would last 30 to 60 minutes depending on how the participants feel and what information they are happy to share. I would like to record the interviews on audiotapes which I will erase at the completion of the study. No-one will be mentioned by name, nor will any identifying information (such as place of work) be included in my thesis thus participants' anonymity can be assured. Participants can withdraw from the study at any time.

If you feel you can help with this study or would like to know more about it before committing yourself could you ring me collect at _____ so that we can arrange a time and place for interview.

Thanks for your consideration,

APPENDIX TWO

I, _____, consent to participate in the study currently being undertaken by Ms Robyn Goffe, graduate nursing student at Massey University.

I have received a written explanation of the study. I understand that I will participate in two interviews, that these interviews will be recorded on audiotape and that the tapes will be erased at the completion of the study.

I acknowledge that I will receive a transcript of my responses and that I can delete any information I do not wish recorded and included in the study. I accept that I can withdraw from the study at any time and any information I have shared will be destroyed.

I accept Robyn's undertaking that my anonymity will be preserved.

Signed _____

Date _____