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Structures, Power and Respect: The Nurse's Dilemma

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The modern nurse is caught in the throes of change. Medicine has increasingly made her into an administrative specialist, while her heritage is that of bedside care for the individual patient. From her leaders she is under pressure to become a professional while the physician and she herself are apt to doubt her qualifications as a professional. She is a woman who finds herself in a work situation where the most prestigious positions routinely go to men. She ranks low in occupational prestige and financial rewards. All this has been described and documented again and again. The conflict inherent in the nurse's situation could doubtless be elaborated even further than the existing studies have already done but more useful insight can be gathered by taking a look at how the nurse fits into the movement to apply rational knowledge in modern medicine. (Katz 1969, p. 54)

INTRODUCTION

Although a great deal has changed in the last 30 years, the difficulties described above remain. Nursing leaders' desire to professionalize the nursing role stands in opposition to the need for more basic bedside care. A deeply felt inequity between how doctors and nurses are valued persists. It is mirrored in the disparity of pay. The average nurse earns about one-third as much as the average medical specialist. The inequity is less evident but equally felt in terms of the relative value ascribed to nursing knowledge as opposed to physician knowledge. For the vast majority of nurses these tensions occur in the context of institutions, especially the acute care hospital. In hospitals, where almost 70% of nurses work, the perennial struggle between doctors and nurses over the "division of medical labour" is joined by other players including various health care workers and hospital administrators. This coupled with reduced resources results in increased tensions and greater complexity.

In this paper we will explore the structures within which these various players interact with each other and with patients, how their roles are perceived and how their work is performed. We will try to clarify some of these issues and provide some possible directions for the future.

Objectives

Our objectives are to describe the potential organizational structures and roles that could facilitate increased respect and professional autonomy associated with nurses' work. We will suggest steps that could be taken to achieve such a proposed organizational structure, and identify potential barriers to the process. We will identify how the core values of differing professional groups conflict and potentially redirect attention from the mission of health care, namely to support the needs of the patient and family, and to provide an organizational context which values communication and collaboration.

Our Research Questions

How do organizational structures interact with healthcare professionals?

Professional and organizational boundaries form obstacles and opportunities to the coordination of work, and to the collaboration among professionals. We will approach this question in relation to the work performed by the various professionals in relationship with each other and patients.

How do people understand “respect”?

The lack of clarity about what constitutes "respect" in the workplace setting is in part a function of the widely differing perspectives on the nature of health care work by the various agents in the health care system. Much of our work is in the clarification of differing views about such concepts.

What are tangible policies to change the situation?

It is clear that there are some standards and policies that are in place about workplace roles and responsibilities of all participants in the health field. A literature review would help identify those that need to be strengthened.

How do we position these issues so that you have robust ways to think about them?

It is most important to consider how correcting the issues you describe is critical to reinvigorating public confidence in Canadian medicare. Finding ways to think that allow for this connection to be transparent is a challenging question.

How can we describe them to help you with your final report(s)?

We believe that identifying and reinforcing the links between nursing and the rest of the health care systems will be an important way forward.

We recognize the relevance of the questions proposed and would add several other questions that elaborate on yours:

How much are the issues related to structures?

How much are they related to lack of respect?

How much are they related to crippling workloads?

Are there other relevant factors that lead to current nursing problems?

What are some policy interventions by nursing organizations, by government and by other professions that could change the situation?

Our Methodology

We propose four connected activities that will lead to a response to the research questions and achieve the objectives set out in your request for proposal.

1. Conceptual clarification of professional respect issues in health care

The concept of respect for others has a significant place in health care organizations. Respect is closely connected to perceptions by the various professions of each other. Professional respect is also connected to the nature of actual relationships in the workplace. We have found that clarifying differing perceptions can by itself increase understanding of roles and responsibilities and their importance to health care processes. Clarification can help to articulate policy interventions that can make a difference. We will use a framework developed with Henry Mintzberg as the base for this clarification.

2. Review literature about the issues

A preliminary literature review includes:

- The regulatory literature that defines the roles and responsibilities of health professionals, including nurses, from across Canada.
- A cross section of the nursing literature that considers the objective of nursing as a profession and describes a range of different boundaries and roles for nurses. It is our understanding that there are issues in the area that remain to be resolved.
- Some of the organizational literature that considers the structural and power relationships in the health care environment.

3. Observe change in hospital environment

It will be impossible in the short time frame for this project to do extensive observation, but we have observed staff behaviour in a ward of an acute hospital for a week as an ethnographic addition to the written material reviewed and analysed. These observations will be included in the text as illustration of points being made.

4. Develop a series of alternative scenarios and recommendations

The results of our observations will be presented in the form of alternative scenarios at the conclusion of the paper.

5. Meet with nurses, nurse leaders and other health care audiences to review results

Much of our work involves testing ideas with audiences of concerned professionals. We expect that preliminary versions of our report will be presented to a number of audiences of nurses and other professionals to test the validity of our observations and conclusions and to gain their help in considering possible solutions to the problems currently being faced by nursing.

Part I: THE FRAMEWORK

Henry Mintzberg and I spent quite a lot of time studying health care organizations and systems. We made a series of short visits to hospitals and other health care organizations where we observed doctors, nurses and managers in their daily activities, interviewed these health care professionals and later had long discussions about our findings. We prepared many drafts of the articles that were eventually published.

Our results provided a simple framework for thinking about the management of hospitals and health care systems that differentiates at least four different groups involved in their management: Doctors, nurses, managers and board members. We categorized these groups into four somewhat generic quadrants of our framework: Those most concerned with cure, care, control and community. Furthermore, we found that those categories could still be useful when considered at the system level. Along the way we came to a series of intermediate conclusions that seem to have stood the test of time. We believe that many of the problems facing hospitals in particular and health care systems in general, cluster quite readily into questions of co-ordination and collaboration inside organizations and at the system level. Figure 1 illustrates the framework.

The framework suggests that the major issues of allocation of resources, responsibilities and roles require collaboration across all four groups. We argue that much of the complexity surrounding health care does not come from the work itself but from the nature and quality of the interactions among the different cultures that participate in it.

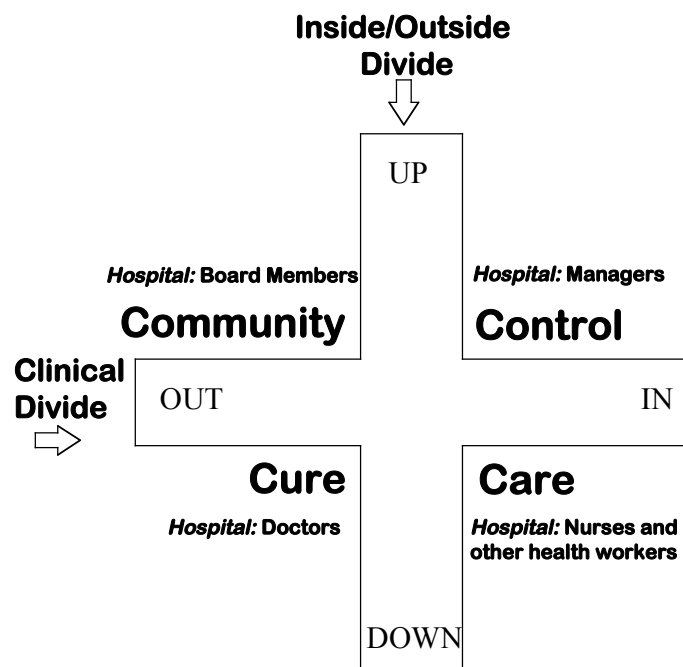
Most health care organizations contain the groups in Figure 1. Doctors' main role is to direct the cure of patients while nurses and other health care professionals are primarily dedicated to their care. Both groups work and manage clinically - close to patients. They are at the clinical edge of the organization. The horizontal line in the figure separates this clinical area, below both lines, from the non-clinical above it. Managers who control the allocation of resources and board members who represent the community are above the dividing line. These two groups manage and work away from direct patient contact. The

vertical line separates nurses and managers) who work and manage in the hospital, from doctors and board members who are usually not hospital employees, and who, though loyal to the hospital, have other and more fundamental attachments outside it.

In dysfunctional health care organizations there are powerful divisions among the four groups. Each forms a fiercely independent enclave that does not understand, cooperate or even talk to the others. This complicates the operation of hospitals and other health care organizations, and contributes to crises in health care delivery. Much of the difficulty in working relationships hinges on how these four interact. I will begin with a brief characterization of the four faces in hospitals.

We will use a series of thumbnail sketches as an overview of the four to identify some of the differences between these groups and to organize information about the issues at

**Figure 1:
A Framework for Hospitals**



hand. These groups work in different organizational structures, have very different views of what constitutes power and distinct ideas about how to receive and give respect. This initial organization will thus attempt to clarify some of the differences before we proceed any further.

CURE Represents Hospital Doctors

Doctors are in the clinical and outside quadrant of the framework. Hospital doctors tend to have a highly specific interest in a specialized (or even sub-specialized) area of Cure, usually defined by body parts, organs or diseases. They try to know as much as they can about this area, to find patients for whom they can apply this knowledge with increasing proficiency and from whom they can learn even more. National and international colleagues in their area form a kind of "chimney" of specialization that they climb to gain clinical, academic and research recognition (Freddi and Bjorkman 1989). If they do relate to a career type, it is that of independent professional practice. They tend to remain in the same job for their entire work lives. Their efforts are directed toward expanding their practice, which usually includes clinical work. Their status is thus dependent on their place in their area of specialization.

Hospital doctors measure their status and power in a variety of ways. One is by the nature of their specialty. Inside medicine there is a hierarchy of specialties, which places surgery above dermatology for instance, and hospital doctors above family practitioners. Their status is also a function of how high up they are in their own international chimney. How do colleagues around the world rate their expertise? How are their papers received? Where are they asked to present their results? The international reputation of a hospital doctor is what garners the most respect from board members and other doctors. More local measures include teaching roles and university rank. The resources dedicated to their particular area of expertise in the organization where they work indicate their power. These resources can include specialized equipment, research laboratories, clinical facilities and staff in training with them.

Perhaps because of their professional autonomy and the demands of their life style, they tend to see the hospital as a location in which they do their work, not as an organization that they work for. They often behave like independent entrepreneurs and have been compared to shopkeepers who work in a town, not for it. Though loyal citizens of the town, their interests are not always identical with those of other residents in it. (Shopkeepers might prefer a larger shopper's parking lot to a swimming pool, for example.)

Although they are below the horizontal divide in our table and on the outside of our vertical divide, doctors are hardly down-and-out. According to OECD studies, doctors tend to earn within a narrow band of net income (Sandier 1990). In most western countries their average income is a multiple of the national average wage, and their income rises with the per capita GDP of the country they work in. The net earnings of hospital specialists in Canada in 1998 averaged \$92,000 per year. This is almost three times that of registered nurses, whose average was \$35,000. The method of remuneration does not seem to have much impact on their net income. This may be because doctors live an upper middle class life style in almost all western countries.

CONTROL and Hospital Managers

Control is very difficult for non-clinical health care managers. Because they are far from patients and do not have clinical expertise they tend to manage away from the clinical activities. Managers are above the clinical divide and away from patients in several ways. They manage operational activities that do not directly involve patient care. Middle managers often spend 85% of their time on such services as food preparation, housekeeping and parking, though these items consume only 15% of hospital budgets.

Very senior managers manage relationships with external agencies to assure the funding of their hospital and to improve its ties to academic and research institutions. They feel their role is to manage strategically, not operationally, and they stay far from patients and the actual wards.

Health care managers often prefer to see their institutions as corporations and themselves as corporate employees. Their view of the ideal hospital is one where corporate lines of authority are respected. Most have come to their present posts after a series of jobs, usually in different hospitals. Their career paths are spirals in which they move laterally and upward between five and seven jobs, each with a more prestigious title, a bigger budget, or a larger work force, until they become CEOs.

When they join an institution as employees they feel an obligation to their organization and at times do not understand why doctors do not behave more corporately. A major objective of hospital managers is to have a well-managed, forward-looking corporation. This is hard to do because they have little authority over clinical activities. They open or close beds and allocate or withdraw resources, often in crude and ineffective ways.

The status and power of hospital managers is often expressed in terms of their place in the corporation – as director, vice president or at the highest level, president and CEO. Their power is a function of the size of their domain, expressed in terms of budget and staffing size. Thus hospital CEOs will often introduce themselves to each other by declaring their title, and mentioning (often with a slight exaggeration) the size of their budget and the number of people who work for them. Respected managers are those who have successfully fulfilled their roles of controlling the allocation of resources.

COMMUNITY and Governance

The community is represented by boards and their members. Boards are the final authority of hospitals and their members have special responsibility to oversee its activities. In health care organizations, boards are farthest from the day to day activity of the hospital. As non-professionals, they do not understand much about the clinical activities, and because of their distance they cannot appreciate many operational problems.

Traditionally, boards contained prominent members of the community who donated their time and money to hospitals as social institutions. The social importance of the institution reflected on them. They considered "their" hospitals to be the "best" because of an area of excellence, a historical bit of pioneering medicine, and the presence of doctors with international reputations.

Board members continue to have a strong obligation to maintain the reputation of their institution as "the best" and if there were a universal motto for board members it very well might be "Access to the Best." In the past board members went to great lengths to follow this motto and put their money where their mottoes were. Today the costs of health care and the introduction of government and insurance funding leave them able to contribute only at the margins. They might build a building or buy a piece of expensive equipment, but they cannot support the operational costs of hospitals.

Financial constraint has led boards to focus on a second goal: keeping to the budget. The demands of fiscal responsibility put boards in a dilemma: they are caught between excellence of doctors and CONTROL of expenditure. In many health care organizations the new motto (with dismay) is "Access to the best that is affordable."

The meeting is the venue of board members. Their organizational structure is the committee, of which there are many in most hospitals. Their career path (or perhaps, fate) is to move from committee to committee and some serve on many councils, boards, trusts, and task forces during their careers.

Status of board members has several dimensions. For the most part they derive their status and power from their job in the "real world" outside the hospital. Individual wealth and corporate role are critical criteria. The social position of their particular hospital and their role in it contributes a philanthropic aspect to their status.

CARE and Nursing

Although the caring face of health care includes nurses and other allied health workers, we will concentrate on nursing at this stage. Nurses' main responsibility is direct and continuous patient care. They are closest to the patients and organize and manage the workflow around them.

Historically, nurses were the first to run hospitals. When nurses were in charge, they had responsibility for all patient care and summoned doctors only when medical interventions were necessary. Managers are comparative parvenus to health care organizations although they now carry considerable authority.

From the time of Florence Nightingale, nursing had a military organization - it was a pyramidal hierarchy with a split between the non-commissioned troops and the commissioned officers. Nurses above a certain level were officers. Student nurses, staff nurses, and most ward head nurses were the non-commissioned troops. In the early days senior nurses, like military officers, had upper class backgrounds. Later academic credentials became the path to senior rank. The distinction continues and has begun to take different forms. Some nurses argue that only the senior nurses are professionals because they are the only ones with appropriate academic credentials and enough professional authority (White 1985). Nonetheless, most nurses express a strong loyalty to their profession.

This division was recommended almost 100 years ago:

There can be two classes of nurses, one made up of young women of education, culture, and refinement, whose mental equipment and preliminary education will make it possible for them to learn the needful things of their calling; and the other class, made up of well-disposed young women of excellent intention and limited education, whose curriculum can be limited within their mental possibilities, and

that will enable them to give a certain amount of very primitive care to the sick.
(Hornsby and Schmidt 1913, p. 305)

In hierarchical organizations the career path is up or out. Thus nurses' career moves tend to be up the hierarchy or out of nursing. For younger nurses the tendency has been to move out of nursing, and then in and out as economic and family demands change (Audit Commission 1991).

The nursing literature describes the struggle between doctors and nurses, sometimes calling it "the Doctor-Nurse Game." In the early 1990s the diary of a medical resident in the 1880s prompted a study in which a current medical resident kept a journal for a year. The journals of the two medical residents "written more than 100 years apart...revealed more similarities than differences in nurse-doctor relationships" (Pillitteri and Ackerman 1993).

A summary of the situation quoted below uses a military metaphor which describes the combative nature of nursing politics:

For the last Hundred years the general hospital has been the key battleground for the various forces arrayed in the division of labour in health care. There seems no reason this should change now. (Dingwall, et al. 1988)

This military language describes the doctor-nurse struggle as a war of the sexes about careers, organizations, professional status and income, authority over patients, and even models of patient care (Clifford 1989). There are many attempts in nursing to justify the special nature of caring (see Exhibit 1) and to clarify philosophically the distinct role of the nurse (See Exhibit 2).

For nurses there are a series of status and power identifiers. In the early 20th Century status was directly connected to one's place in the nursing hierarchy. The most senior nurse, in the role of Matron, was the partner of the most senior doctor, the medical superintendent of the hospital. They assumed strongly paternalistic (and maternalistic)

roles in a rigid hierarchical structure. Today nursing status is connected to a variety of factors. Some markers or indicators of status mimic medical status. Degree of independence of practice is a second typical mark. Other marks have to do with rank in what is left of the nursing hierarchy. Still others relate to educational attainment. Nurse managers more and more often gain postgraduate PhDs and declare themselves to be doctors, perhaps in competition for the status and respect bestowed upon physicians.

Figure 2 summarizes the characteristics of the four faces of health care. Each works with a different organizational type, has different interests and a different career path. There are even differences in the language they use. Managers adopt the most recent terms from the Harvard Business Review, while nurses speak of care plans, tasks and standards of practice. Doctors use Latin words for common organs and diseases, and board members insist on plain talk but seem never to get it.

Figure 2: Characteristics of Four Faces of Health Care

	Doctors	Nurses	Managers	Boards
Career Path	Steady state	Linear	Spiral	Transitory
Career Movement	None (Growth)	Up and/or out	Lateral & Upward	Lateral/up
Jobs in Career	1	2	5	Many
Status Symbols	Labs, academic rank Beds	Place in hierarchy, span of control	Title, budget span of control	Role in real world
Organizing Structure	Prof. practice	Peace time army	Corporation	Committee
Value Base	Proficiency	Professional	Efficiency	Access to the Best
Currency	Time	Staff and Hours	Money	Money Quality
Job Security	Tenure	Job Market	Contractual	Time Limited

Fragmentation

The divisions among the four groups are exacerbated by further fragmentation in the within each of them. Although this simplified framework contains four quadrants, there are, in fact, many more divisions. For the sake of convenience all the allied health professionals and technologists are included with nurses. As nursing functions have become more specialized, physiotherapists, occupational therapists, social workers, and a range of specialized technicians like phlebotomists and respiratory technicians have distinguished themselves from nurses. They have their own practice standards and some have established their own professional bodies. Similarly, non-clinical support staff are included with managers although there are differences between them.

More **medical** knowledge in narrower areas has spawned four times as many certified specialties and sub-specialties as forty years ago (Swanson 1993). The Toronto General Hospital lists more than 100 outpatient clinics each devoted to a particular area of specialization. There have been great benefits from the knowledge base of medical science as new and more effective interventions appear, but there has also been a widely acknowledged cost of fragmentation. Specialists tend to work in their own chimneys and crossover between them can be very difficult. Rivalry among the specialties can become intense and even dangerous. There are many examples of this. One good example is the case of the death of a Boston Celtics basketball player. Reggie Lewis was a star player for the Boston Celtics. After he collapsed during a playoff game, he was examined by two sets of doctors in two different Harvard teaching hospitals. One group diagnosed his problem as a serious heart condition and another said he had a slight neurological problem but an athlete's heart ("Celtic Star Hid Heart Murmur" 1993). These conflicting diagnoses led him to continue his athletic activity. He collapsed again and died several months later in a flurry of controversy that made the rivalry between medical specialties far more explicit.

The British Audit Commission revealed dramatic consequences of **management** fragmentation. They found that it takes six people and seventeen different operations to

change a light bulb in a National Health Service (NHS) hospital. This bureaucratization of procedures has led to a fragmentation of functional roles and tasks. There are many forms to fill out, a lot of delay, and poor communications between departments even though everyone may be trying very hard. The manager of the electricians in a hospital worked hard to improve the light bulb changing and reduced it to a week in non-urgent cases (Hamilton 1993).

Fragmentation extends into **governance**. Boards have numerous committees with separate and often redundant mandates. They create even more sub-committees and task forces to deal with specific issues or undertake new projects. One hospital had a committee of committees simply to keep track of other committees.

In **nursing**, many specialties follow medical disciplines. Operating room nurses distinguish themselves from those in intensive care areas; emergency room nurses consider themselves superior to staff nurses in the medical wards. The head nurse of dialysis in one hospital distinguished between haemodialysis nurses and peritoneal dialysis nurses by saying that each job required a different personality, background and training. The reduction of nursing work into fragmented tasks had serious consequences to continuity of care and to improved relationships with patients. Workload measurement connected to information systems was said to redefine patient care as the sum of services provided (Hart 1991). This created a serious dilemma for nursing. As nursing work became redescribed as tasks, technicians or other professionals such as blood drawers and psychological counsellors undertook much of the technical care. Aides and other non-professionals dressed or fed patients and did the more hands-on tasks. There was little direct patient care exclusive to professional nurses, and for some it was hard to see what remained essential to the nursing profession (Hugman 1991, Jolley and Brykczynska 1993, White 1985).

The fragmentation of care was connected to a harsh separation between academic training and the reality of the work they faced in the wards. This made for a difficult transition for new nurses. Most were not ready for what faced them and many left nursing because they

couldn't reconcile the academic nursing theory with practice. The demands of academic nursing for careful assessment and planning of care were distant from the painful and difficult work of caring for patients (Hingley, et al. 1986).

The farther away a program gets from an apprenticeship system, and the more an educational program attempts to prepare nurses who can deal effectively with the knowledge and technological explosions now and in the future, the greater will be the likelihood of producing school-work conflict and reality shock (Kramer 1974).

Summary

The fragmentation of health care makes it harder to manage workflow. It also results in redundant or contradictory diagnoses by medical specialists, nurses, physiotherapists and social workers. They all have their models of care, their standards of practice and their own professions to defend.

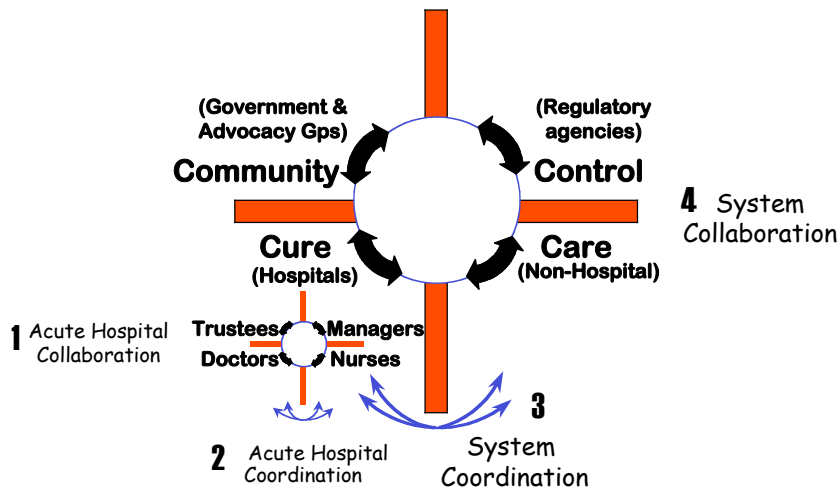
The multiplicity of fragmented roles results in a grid with hundreds of job categories, each with many levels. Many cells contain only one incumbent. The division of tasks means that in a three-day stay a patient will have face to face contact with between 50 and 80 people. Handovers from shift to shift, from professional to professional, and from professional to support worker are invariably difficult. They require large amounts of paper work, carry with them well understood inefficiencies of handover and increase the risk of error. For a chronic patient with multiple episodes of care, or a person dealing with different agencies and organisations, this navigation and information problem is enormous.

Nurses especially suffer in this environment. It is difficult to coordinate extremely complex processes with so many authorities, ideas and demands. Nurses are caught between the mountains of recording and the needs of patients. When we observed a ward we found many examples of this kind of difficulty, which taxed nurses. On a daily basis

the early morning rounds were followed by a period of clarification of the orders by the nurses. They had to be sure that they understood the orders correctly. This invariably required several telephone calls to ordering physicians to clarify, correct or append the order. Once the clarification occurred, the orders were carried out. After this they were noted in the patient chart. This process was repeated with waves of clarification, action and charting. In the midst of this activity particular patient needs had to be met. Providing pain medication, assuring that food was delivered, preparing patients for off ward procedures or to go home all occurred throughout this period.

This fragmentation quickly identifies two major issues that manifest themselves inside hospitals. The first and more general one is how to increase collaboration among the various groups in the hospital. As long as the four groups we have identified (as well as the other interests in the hospital) find it difficult to understand each other it will be difficult to set a shared agenda and allocate resources. The second and even more critical problem that results from excessive fragmentation is the difficulty in the co-ordination of patient care across the various boundaries of specialization, professional interest and idiosyncrasy. These two problems occur not only at the hospital level but also in the health care systems as a whole. The coordination of care across the system, especially between the acute hospital and other agencies and providers mirrors the problems of coordination inside the hospital. There are finally problems associated with collaboration among all the components of the broader health care system. These issues are portrayed graphically in Figure 3.

Figure 3:Major Issues



Part 2:

Some Attempts To Change the Structures and Power Relationships in Health Care

There seems to be something radically wrong with the trained nurse of to-day – the medical profession says there is something wrong; the thinking women at the head of training-schools say there is something wrong; and the lay public finds something radically wrong. Not all of these elements agree as to just what the trouble is, in fact, they all seem to differ.

The doctors say the nurses who are being graduated from the training-schools are not efficient, and a great many thinking members of the medical profession say that the nurses are being trained to too fine a point, but not in the right direction. The heads of training-schools think the nurses are not being sufficiently trained. The public does not seem to care to analyze situation, but merely finds fault with the nurse as an individual. (Hornsby and Schmidt 1913, p. 304)

This passage is almost ninety years old, and there have been many attempts to solve the issues raised. Most have involved identifying and implementing structural and procedural changes to health care organizations and systems. Most recognize the splits between care, cure, control and community. Some try to force them to conform to external standards, others demand that they merge their personalities. We will not review these attempts in detail. They have had mixed results, as the examples below suggest. We consider that the examples we describe are sufficient to indicate that structures by themselves will not solve the relationship and power problems associated with health care. We choose three examples, care planning, clinical directorates and program management as typical examples of restructuring that attempt to integrate the work of health care and allocate a more equitable balance of power in the health care organization.

Care Planning

The introduction of care planning in various forms has largely been driven by nurses. In some hospitals it has helped them coordinate workflow while in others it has increased

paperwork at the expense of direct care for patients. One of the successes of care planning includes the development of more transparent care processes. Very often the process of developing a care plan builds relationships across the boundaries of discipline and profession. Everyone involved has a better idea of their role, and patients can know what the process will be for many procedures in advance. The problems associated with care planning include the large amount of time needed for development, the difficulty in getting doctors engaged in the planning process, the problems associated with keeping formal care plans up to date, and the large number of exceptions to the plans that often render them irrelevant. Doctors' reluctance to engage in the process it has exacerbated bad feelings between them and nurses. We will discuss below the idea that this approach seeks to standardize the work pattern without considering the fact that in health care a great deal of adjustment among various providers is also needed.

During our observations an irate patient was released from hospital two days earlier than the care plan asserted. He had prepared himself on the basis of the handout description of his procedure and because he was in his mid-eighties and somewhat physically frail, he had arranged for his niece to bring him to the hospital from some distance and to pick him up in three days. His early release caused great difficulties in logistics for his niece, who had brought her car in for servicing while he remained in hospital.

Clinical Directorates

Clinical directorates were meant to bring doctors into management roles. Although it is often declared that any health professional can become a clinical director, for the most part this management experiment has been applied to physicians. At its best it integrates clinical responsibility with the management and allocation of resources. Clinical directors create a work team made up of the professionals who work in a particular area. They learn to work together for the benefit of patients within the resource envelope allocated to them. Because any member of the team can, in theory, assume the mantle of clinical director this structure is respectful of all professionals as equals.

There was often a reluctance among clinical professionals to assume management responsibility, and a lack of preparedness for doing so. Many clinical directors were poor managers and were induced to assume the role by promises of special privileges or extra help. They were rarely given a free hand at managing their areas, but were placed into a corporate hierarchy as middle managers. For many it was a painful experience that merely proved their incompetence at management and the unwillingness of managers to give up control. For others there was the dilemma of identifying themselves with management or with clinicians. There was a fine line that divided those who became traitors to their profession, having been lured into the management camp, from those who remained true to their fellow doctors and merely represented the medical point of view to their increasingly disenchanted management colleagues.

In hospitals with clinical directorates, the few nurses who became clinical directors often had little success in managing the medical staff. Most often they were not clinical directors, but served as nurse auxiliary to the medical director in a relationship that mimicked the older tradition of medical superintendent and matron. The role did not, by itself increase respect for nurses who assumed it.

Program Management

Program management was meant to create structures that followed patient needs rather than medical disciplines or institutional demands. Programs cut across traditional silos and attempted to create integrated programs of care. In some versions they engaged nurses to follow patients throughout their hospital experience. In others it trained multi-skilled workers and professionals to perform a variety of care related tasks. Multi-skilling would decrease the fragmentation of the patient experience by allowing more continuous contact with the people who cared for them. Nurses were often given primary responsibility for particular patients and could follow those patients throughout their hospital experience.

At its best, program management improved the patient experience in hospitals and resulted in increasing stability of patient care teams. Many of the multi-skilled workers assumed new and more interesting responsibilities and were given more possibility for career advancement. Nurses had more contact with individual patients and could develop more complete relationships with them. Reporting relationships were inside the program teams rather than in a discipline. Just as clinical directorates gave lead responsibility to doctors for their area, program management gave special responsibility to nurses as program leaders. The physiotherapists and other allied health professionals would report to the nurse who most often became the program leader.

The greatest difficulties with program management have to do with the creation of new boundaries to replace the old ones. If the metaphor for the old boundaries between disciplines was that they functioned like vertical silos, the new boundaries began to function horizontally, much like sewer pipes. Cross-program co-ordination became more difficult as the programs consolidated their structures. Older patients with multiple conditions created difficulties for programs dedicated only to one. Structures, by their very nature, create new barriers by reducing older ones.

This also created new difficulties for professionals. The horizontal orientation of program groups disrupted the vertical structures inside the various disciplines. It made for more difficult professional ties and collegiality and reduced the voice of many professionals in the management of the institution. The head nurse of a program-managed hospital had only professional responsibility, but no line authority. This meant that nursing as a profession had less power overall but more power locally. The consequence was that there was a reduced capacity of disciplines to protect their job security. In one hospital the psychologists were fired en masse once program management was instituted because their lead no longer could sit at the management table to defend his area.

Summary

Although these attempts are not comprehensive, we would suggest that they are sufficient to indicate that structural change by itself is not sufficient to realize the objectives of increasing respect for nursing and for increasing collaboration among health providers. A good account of some of the perils of restructuring without considering other factors appears in *Beyond Restructuring* (Glouberman 1996).

PART 3: SOME DIRECTIONS FOR NURSING

We will consider three possible directions for health care and their implications for nursing professionals:

1. that present trends continue,
2. that there is a massive shift toward community and primary care,
3. that there is a dramatic rethinking of how health care work is done.

We will describe these three possibilities and consider the implications to different health care interest groups in order to examine the consequences to nursing.

Present Trends Continue

If present trends continue, most new health policy will not succeed in changing the current patterns of control and authority in health care delivery. But the funding for health care will be a continuing and increasing problem. New technological innovations will demand more resources. There will be even more political pressure on health care. Further attempts to "fix" the hospital will not succeed because the competing professional groups and institutions will continue to maintain their boundaries. Health care costs will continue to spiral out of control and outcomes will become even more mixed than they are now.

The **governance** of health care organizations will continuously change as governments increase the pace of restructuring. There will be no strong realization that rapid structural

changes destabilize the loyalty of citizens to their institutions. Members of boards will increasingly become government appointees on the grounds that “he who pays the piper calls the tune.” Many of these are political appointees in line for more lucrative assignments if they do their masters bidding.

The **management** of health care organizations is already in frequent crisis. If present trends continue, these crises will increase in frequency and severity. The constant response to crisis is reorganization. Health care managers have become more expert at changing organizations than running them. There is some suggestion that the differences between financially distressed hospitals and ones that are financially sound has little to do with manageable variables. Indeed some managers feel they are pulling levers unconnected to anything at all.

Doctors are most under attack. Dissatisfied patients sue them; financially strapped governments and insurance companies squeeze their income; media identify them as villains of the health care crisis along with drug companies. Some doctors are leaving their practices because of the high cost of insurance; others are sensitive to growing patient mistrust. The traditional response of the profession has been to fortify its enclave, strengthen the boundaries and fight off all attacks. This retrenchment will continue in this future.

As **nurses** increase their professional status in hospitals, and lift the level of academic credentials, their services become more expensive. Financial pressures on hospitals force them to hire fewer nurses. The incipient split between the various levels of nursing becomes more overt. Practical nurses, technicians and nursing aides (sometimes called "nurse extenders") assume more responsibility for patient contact and they separate from a small core of highly educated professional nurses who become brokers for caring services and managers of nurse extenders who do the hands on care of patients.

Some nursing careers will become more professional but will be farther from the direct caring role. Some nurses see this as an appropriate future for nursing, while others argue

that this would merely formalize the split between the troops and the officers that has been the tradition of nursing. The "real" nurses are and always have been "Pink collar" workers who are not really professionals at all. According to them the nurse extender role would be the true future of nursing,

If pressures of professionalism drive some highly credentialed nurses into a brokerage role, it will cause others to become "doctor extenders." The smaller number of junior doctors in most hospitals will not be supplemented by attending staff. Instead professional nurses will increasingly perform these duties. This forces them to do less direct caring and more technical clinical intervention with patients as the price for greater professional status.

In this scenario there are three possible roles for nurses: as pink-collar workers, as doctor extenders and as managers and brokers of services. A minority of nurses would assume an increased professional role with greater authority and power, but the vast majority of nurses would continue to work as subordinates to others, whether doctors or other nurses.

More Community and Primary Care

There have been many attempts to shift resources from acute and long-term care institutions to primary and preventive care and care in the community. There are three strands to these movements, two of which create new possibilities for nursing.

The first and most effective was the effort to close the large ex-urban psychiatric asylums and bring long term care for mental patients back to the community. The effects of this change have already been felt throughout health care. Improved medication and the rising cost of care contributed to this trend as did those professionals who considered the large hospitals to be inhumane. They argued for the release of mental patients into the community and for treatment closer to home. Long term care reforms which began in psychiatric hospitals have been extended to other long term care areas such as physical and mental disability and to care of the elderly. There has been far less success in shifting

the resources from long term care facilities into well functioning community based services.

The second is the organization of healthy cities and communities. In many countries the healthy communities movement recognizes that health care is only a small contributor to the health of the population compared to jobs, housing and education. Proponents urge that policies to promote the health of the population must be "demedicalized" and that control over health related activities must be taken away from the "health care" establishment. They argue for a much broader citizen and community involvement in health related issues and for the development of policies and initiatives that will lead to healthier communities. Many European cities have adopted a "healthy cities" approach and a strong effort in America is being fostered by the Health Care Forum in California. This movement is related to the third strand described below.

This third is a move to increase and improve primary and community care services for the entire population. The lack of adequate primary care results in an inappropriate use of specialist doctors and acute hospitals in large cities. More primary care based HMOs and HSOs in North America, the creation of Primary Care Trusts in the UK and more primary care clinics in many other countries increases the demand for primary care practitioners. Policies to enable this include the restructuring and down-sizing of acute hospitals in major cities such as London and Toronto; the increased control by primary care practitioners over the funds spent on acute care for their patients, the increased clinical authority given by law to primary care nurses and other allied health workers in the community.

These movements affect all the interest groups in health care. Making organizations more local means strengthening the **governance** role of the community in health care organizations. Boards will represent a wide range of interests in local communities. In this scenario the opportunities for meaningful board involvement can increase because organizations are smaller and more accessible and systems are simpler. The board can

have more understanding of health-related issues and the services provided by its organization.

In local health related organizations **managers** function as CEOs of multi-services centres such as the CLSCs of Quebec or Primary Care Trusts in the UK. Many of these organizations provide health and social services: everything from local health education to legal advice. Others include alternative primary care practitioners such as chiropractors and acupuncture masseurs. The coordination of services and resources in such settings is more manageable especially with stronger local support. The opportunity to change the relationships among the healthcare groups may well depend more on the particular circumstance of the community. Managers have a clearer mandate for resource allocation from stronger boards. They can set priorities with a more intimate knowledge of community needs and wants. Many hospital managers are already increasing community contact. Others are decentralizing services to the community.

The shift to increased primary care and care in the community is happening slowly in medicine. Medical education is moving out of the hospital and into the community. **Doctors** have begun to explore the use of alternative therapies in their own practices. Others have begun to join forces with other primary care practitioners in full service primary care clinics. Payment to doctors has begun to emphasize their role in keeping the populations they serve healthier. The expectation is that as general practitioners in the UK gain capacity to run their primary care trusts they will use the funds they do not spend on acute care to develop their primary care services.

The **nursing** profession has long embraced aspects of a community-based idea of health. The Ontario Nurses Association as early as 1993 (Ontario Nurses' Association 1993) described a community oriented future for nursing which gives nurses two different new roles. Some will engage in a general nursing practice as autonomous primary care professionals in the community. They will be independent practitioners who will develop practices much as medical general practitioners do now. The promise is that because of their nursing education they can do more than traditional general practitioners because

they can provide a broader range of services during clinic and home visits. Their career path is to develop a practice in a community.

A second role is as consultants to communities. Their training will allow them to assume many functions in primary and community care and they can become members of various health related work groups. Examples include developing community training programs for pregnant women, consulting to organize healthy communities, planning new community health services and joining multi-disciplinary community health care delivery teams. Nurses have the career paths of independent consultants who move laterally from project to project.

Rethinking Health Care Roles and Relationships

One way to respond to the dysfunctional splits in health care and the excessive fragmentation of health care work is to try to understand more about how the work is actually done and to find ways to integrate it. There are many indications that this is beginning to happen. A good example is the establishment of the Yale Program for the Study of Health Care Relationships. This program considers the relationships among the various professionals and between professionals and patients with a view to better integration of care.

An important first step is increased recognition of the importance of direct care as a component of **nursing**. This involves healing the long-standing split between the “ladies” who lead nursing and the “troops” who provide direct care to patients. As nursing begins to show more respect for its role in the provision of direct care, others may well follow. Critically, if the nursing profession does not develop a greater respect for much of the work it does, it is difficult to see how it can gain respect from others. When nursing leaders distance themselves from direct care and are not trained or prepared to provide it, there is little chance that others will respect the role. An attempt to recognize this is by the creation of clinical ladders in the UK that allow nurses to gain increases in pay and rank while remaining at the bedside. This particular structural change is one that fosters

increased stability of the work force and provides incentives and rewards for remaining in a clinical role.

Managers have begun to recognize the importance of a stable environment as a basis for developing respectful relationships (see Exhibit 3). In our observation week we found that the current situation does not provide much stability to nursing staff for the development of ongoing relationships among themselves or with other professionals. In fact, some of the nurses did not know each other even though they had to work together. The part-time and agency nurses, though skillful, related to other nurses in a somewhat distant mode and did not interact with the doctors at all. A major destabilization of nursing occurred when job security began to be threatened. In fact, recent graduates in nursing are not remaining in the country or are leaving nursing entirely because there are no full time jobs or there is no job security (see Exhibit 4). People without secure jobs are not in a good position to develop relationships with co-workers or other professionals, let alone with patients. Unstable work environments make everyone more jittery and less respectful of each other. There are many calls for increasing job security for bedside nurses and increasing the number of fulltime jobs. We would argue that this is perhaps a most critical contribution to increasing respect.

There are other correctable factors that militate against the development of ongoing work relationships among nurses and with other workers. The structure of the nursing workweek with its 12-hour days allows for only sporadic opportunities to interact with other professionals. Similarly, other opportunities for face to face contact and information sharing have become more limited for a variety of reasons – including the expanded use of computers, the reduction in hand-over time and the elimination of many multi-professional rounds for the sake of efficiency. Our experience in observing a ward was that there was almost no verbal face to face contact between nurses and doctors. Virtually all communication was done using patient notes and the telephone and computer. Increased opportunities for contact with other professionals in a more stable work environment provide a necessary condition for better relationships and improved communication.

Inefficiency results from fragmentation of work. In our study of health care organizations and systems we describe six ways to integrate and coordinate work

Mutual adjustment is the most direct form of coordination: two or more people adapt to each other as their work progresses, usually by informal communication. This mechanism tends to be relied upon in the simplest of situations (two people canoeing through rapids) as well as in the most complex (teams designing a new aircraft).

Direct supervision focuses responsibility for coordinating the work on someone who does not actually do it; a “supervisor,” “boss,” or “manager” is named (and a hierarchy of authority thus created) to issue directives to people doing the work.

Coordination can also be achieved by four forms of *standardization*:

When *work* itself is standardized, procedures are specified, usually by work-study analysts (as in assembly work in an automobile factory); coordination thus takes place in the design of the work.

When *outputs* are standardized, the results or consequences of the work are standardized, thus focusing coordination at the interface of different activities (e.g. a worker is instructed to produce so many products in a day; a manager is held responsible for a certain level of financial performance).

When *skills and knowledge* are standardized, different people are trained to know what to expect of each other; they can, therefore, coordinate in almost automatic fashion (as generally happens between a surgeon and an anesthetist in an operating room).

When *norms* are standardized, socialization is used to establish common values and beliefs so that people work toward common expectations.
(Glouberman and Mintzberg 2001)

The organization of work in health care is coordinated in all the ways described above. Indeed nursing work includes all six forms of coordination. We would argue that what needs to be further developed in the hospital setting is an increase in mutual adjustment, and more widely shared and understood norms. In the health care environment there is a widespread sense of altruism and a desire to do what is best for patients. It is peculiar that, while everyone enters the field with altruistic motives, once they are acculturated into their particular discipline they begin to believe that they alone have retained this altruism while all others have not. Developing a sense of respect for other groups' contributions to patient care becomes a critical contribution to creating a respectful environment. Similarly, mutual adjustment is best achieved through practice and repetition. Trusting relationships are an excellent basis for increasing coordination through mutual adjustment.

Governing bodies are beginning to include many more patients and family members who can contribute to the redesign of work by the care teams. Members of the board are much closer to the work of the organization and might, for example, relate to specific groups of patients or care teams in an ongoing way. The closer connection of governing bodies to the actual populations served by the institution is an opportunity to create and build on the relationships that develop with nurses.

Many boards in health care and in other areas have begun the process of reconfiguring themselves from the more traditional functional committees to ones that relate to particular operating area of their corporations. In health care the patient care committees are still minor and it remains to be seen how the community responds in detail to these shifts.

Although the division of labour in the development of medical knowledge has introduced many new sub-specialties into **medicine**, it has also resulted in the greater need for collaboration. The organ transplant surgeon needs the help of a specially trained anaesthetist, a good immunologist, a physician who specializes in the organ to be transplanted and a specialist nurse who help to harvest the organs, do the transplant, and follow the patient for any signs of rejection. Other professionals such as nutritionists and social workers are also members of transplant teams.

Many medical schools have responded to the overcrowded and fragmented medical curriculum by switching to problem oriented learning. They have begun to emphasize the natural history of disease and to follow patient care processes more completely (Morris and Sirica 1993). This change in orientation bodes well for a broader rethinking of patient care beyond medical intervention and includes greater recognition and respect for the nursing function.

Medical leaders, like those in nursing, have begun to recognize the current problems and have identified the need to improve relations with nurses and respect their contribution to health care (see Exhibit 5).

In this scenario **nurses** build on the existing positive relationships they have with other professionals and with each other. The work environment, however it is organized, will achieve greater stability. Those entering the nursing profession will be assured of smaller, decentralized and more integrated teams responsible for all patient care. Their work patterns will evolve into a stable environment. There will be a shared recognition that everyone on the team makes critical contributions. Nurses and other health care professionals will be associated with one or several of these clinical teams and play a clinical role throughout their careers. In this way their practice will be significantly more professional. They will gain a clinical knowledge and as their understanding and skills improve their pay will follow. A leader of such a clinical team will be expected to assume a leadership role and also to remain clinically active.

Because the work will be rethought and shared, the boundaries between disciplines will be reduced. All members of a care team will be able to assume the hands on chores related to patient care, and those who have special technical skills will maintain and improve them in a clinical setting.

Since the clinical teams will be the basic units in which work is done, and will have a high degree of professional autonomy, they will assume the responsibility for auditing their work with a view to improving patient care. Independent review will concentrate on outcomes rather than work processes and rewards to team members will be related to outcomes.

CONCLUSION

It is easy to identify and elaborate the role of nursing professionals in each scenario once the other roles in health care are described. Figure 4 contains a summary of these nursing careers and the range of possibilities. It may be of use to those nurses who are considering the future of their profession.

Figure 4: Summary of Nursing Futures

	<i>Present Trends Continue</i>			<i>Community Based Health Care</i>		<i>Rethinking Roles and Relationships</i>
<i>Work Activity</i>	Assessment Care Plan Preparation	Junior doctor functions	Supervised Direct Care	Nursing Practice	Health Care Projects	Patient Care as member of team
<i>Profession Types</i>	Broker	Doctor extender	Pink Collar	General Practice	Consulting	Specialty group practice
<i>Authority</i>	Nurse hierarchy	Medical	Nurse hierarchy	Professional Organization	Independent	Shared Governance

<i>Control</i>	Fiscal	Fiscal	Fiscal	Community	Community	Patient
<i>Quality Measures</i>	Nursing Standards	Medical Standards	Nursing Standards	Outcome	Community Demands	Clinical Audit
<i>Career Path</i>	Up or Out	Up or Out	Limited	None	Lateral	Clinical Ladder
<i>Organizing Structure</i>	Officers only	Professional Chimney	Troops	Practice	None	Team
<i>Value Base</i>	Professional Boundaries	Professional Boundaries	Vocation	Health gain	Healthy Community	Outcome
<i>Job Security</i>	Market	Tenure?	High	Self employed	Little	Team

The traditional nurse was a member of a hierarchical career structure. Current possibilities for nursing seem to suggest a variety of potential roles. It is probable that in the future no one of these will be exclusively true, but that some mixture will occur. It is up to the nursing profession to consider each of these possibilities and decide on the direction of nursing education and practice. There is clearly a lot to do.

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EXHIBIT 1

Overview of caring and caring behaviors on the continuum of caring

Adapted from Stockdale (2000); Pierson (1999); Sanford (2000); Smith (1999); Widdershoven (1999); Bent (1999).

Benner (1991)	Care is skillful comportment <ul style="list-style-type: none"> • Emphasis on skill 	Emphasis on caregiver (nurse), on subjective vs. objective behavior, opposed to scientific reason, uses nurses narratives, process of knowing patient to provide care
Parker (1990)	Care a joint construction of meaning <ul style="list-style-type: none"> • Emphasis on interaction 	Relational. Co-construction of meaning. Negotiated understanding. Mutual engagement
Tronto (1993)	Care as a structured process of rational activity: <ol style="list-style-type: none"> 1. caring about 2. taking care of 3. care-giving 4. care-receiving <ul style="list-style-type: none"> • Mutual responsiveness 	Four moral elements of care: <ol style="list-style-type: none"> 1. attentiveness 2. responsibility 3. competence 4. responsiveness
Noddings (1994)	An ethic of care	Caregiver has engrossment and motivational displacement. Caregiver is guided not by the ethical principals but by the ideal of caring itself.
Gadow (1985)		
Leninger (1988)	Caring acts can be culturally identified through the beliefs, values and practices of cultural groups.	Caring is the factor that assisted humans to grow and survive through cultural evolution.
Gilligan 1988		
Curzer (1993)	HCP should not care for patients. Need professional detachment. Caring is a vice not a virtue.	Personal involvement conflicts with objectivity. If patient does not respond, is care denied?
Van Hooft (1987)	Caring should not be superior ideal for health care	Nurse should care for ideal of health. More doing than caring
Warelow (1996)	Caring from the patient's perspective	Context dependant and relational to economics, workloads, technology
Mayeroff (1971)	The cared for as becoming a completion of own being and partly constitutes personal identity	The other (e.g. patient) is so important that she is an extension of the carer's self. Empathize and understand the world of the cared-for.
Shiber & Larson (1991)	Caring as a process and not an end in itself. The end is not to cure disease but to enable the nurse to offer support	Before caring behavior, must be a combination of personal values, ideas, and beliefs to which the carer is committed, as well as technical competencies
Watson (1988)	Calls for intense personal relationship	Unattainable goal but nurses should strive towards it. Essence of nursing.

EXHIBIT 2

CONTEMPORARY NURSING THEORISTS

(from Deloughery's "Issues and Trends in Nursing")

1970 **ROGERS' SCIENCE OF UNITARY HUMAN BEINGS**

Nursing: A science and art to facilitate and promote symphonic interaction between human beings and their environment

Client: Any human being or individual and personal environment

Health: An expression of the life process characterized by behaviors emerging from mutual simultaneous interaction between human beings and their environment; a continuum based on value judgments

Environment: A four-dimensional negentropic energy field identified by pattern and organization, and encompassing all that is outside any given human field; any setting worldwide where nurse and client meet

1971

OREM'S SELF-CARE MODEL

Nursing: A service of deliberately selected and performed actions to assist individuals or groups to maintain self-care, including structural integrity, functioning, and development

Client: An individual who is unable to continuously maintain self-care in sustaining life and health, in recovering from disease or injury, or in coping with their effects

Health: An individual's ability to meet self-care demands that contributes to the maintenance and promotion of structural integrity, functioning, and development

Environment: Any setting in which a client has unmet self-care needs and a nurse is present

1971

KING'S MODEL – A THEORY OF GOAL ATTAINMENT

Nursing: An interaction process between client and nurse in which transactions occur and goals are achieved as a result of perceiving a need, setting goals, and acting on them

Client: An individual (personal system) or group (interpersonal system) who is unable to cope with an event or a health problem while interacting with the environment

Health: An ability to perform the activities of daily living in one's usual social roles. A dynamic life experience of continuous adjustment to environmental stressors through optimum use of resources

Environment: Any social system in society; social systems are dynamic forces that influence social interaction, perception, and health, and include hospitals, clinics, community agencies, schools, and industry

1974

ROY'S ADAPTATION MODEL

Nursing: Uses the nursing process to promote client adaptation in the four modes to enhance health

Client: A person, family, group, or community with unusual stresses or ineffective coping mechanisms

Health: A state and process of being and becoming an integrated and whole person

Environment: All conditions, circumstances, and influences surrounding and affecting the development and behavior of persons or groups: any health-related situation is implied as the setting

1976

PATERSON AND ZDERAD'S HUMANISTIC NURSING

Nursing: An existential experience of being and doing with another person to respond to their fundamental needs

Client: A unique individual who is struggling to know about self and others

Health: A state in which basic needs are addressed by another to assist growth of awareness and make responsible choices

Environment: Any situation whereby nurse and client seek awareness of the experience by responding to the client's needs

1978

LEININGER'S TRANSCULTURAL NURSING MODEL

Nursing: A humanistic and scientific mode of helping a client, through specific cultural caring processes (cultural values, beliefs, and practices), to improve or maintain a health condition for life or death

Client: An individual, family, group, society, or community with possible physical, psychological, or social needs within the context of their culture

Health: Defined by the specific culture; technology-dependent cultures view health and health care differently than non-technology-dependent societies do

Environment: Any culture or society in which ethnocaring is practiced by nurses assisting clients

1981

PARSE'S MAN-LIVING-HEALTH MODEL

Nursing: Guiding of individuals and families to share and uncover personal meaning of their living health situation

Client: Person or family concerned with their quality of life situation; man is viewed as an open, whole being, influenced by past and present lived experiences, who interchanges with the environment through choices and responsibility for those choices

Health: A process of unfolding, continuously changing, lived experiences, including a synthesis of values and a way of living

Environment: Setting is undefined but implied to be any health-related setting

1980

D.E. JOHNSON'S BEHAVIORAL SYSTEM MODEL

Nursing: Regulates external forces to stabilize client's behavioral system and restore, maintain, or attain balance

Client: A behavioral system (person) threatened or potentially threatened by illness (imbalance) and/or hospitalization

Health: An efficient and effectively functioning behavioral system (person) that is in balance/stable as a result of adapting/adjusting to outside forces

Environment: No specific setting is identified

1980

NEUMAN'S HEALTH-CARE SYSTEMS MODEL

Nursing: Assists clients to reduce stress factors and adverse conditions that affect optimal functioning

Client: Individual, family, or group with an identified or suspected stressor that may disrupt harmony and balance

Health: A level of wellness in which all needs are met and more energy is built and stored than is expended

Environment: Includes internal and external forces surrounding the client; nurse-client settings are not described

1985 **WATSON'S MODEL OF HUMAN CARING**

Nursing: A transpersonal process of caring that enables the client to find meaning in wellness, gain self-knowledge and control, and restore inner harmony for self-healing

Client: Any individual who enters into a transpersonal caring process with a nurse

Health: Unity and harmony within the mind, body, and soul, which is associated with the degree of congruence between the self as perceived and the self as experienced

Environment: The setting is undefined but is implied to be any situation in which the nurse interacts with a client

EXHIBIT 3

Respect for nurses drives success at St. Elizabeth: Good pay and chance for input result in low turnover

Sunday, March 25, 2001 Cincinnati Enquirer

Most Tristate hospitals have been struggling to hire nurses.

The problem is so severe that hospitals have diverted record numbers of life squads elsewhere five of the past six months.

One exception is the St. Elizabeth Medical Center group in Northern Kentucky.

Unlike their big competitors north of the Ohio River, St. Elizabeth's three hospitals in Covington, Edgewood and Williamstown are not desperate for nurses. They are not facing financial crises. And they are not sending life squads someplace else every other day.

St. Elizabeth has been adding beds and services while other hospital groups have endured closings and deep cutbacks. Along the way, St. Elizabeth is quietly developing a reputation for low cost and high quality, especially in cardiac services.

“The key to all this has been the nurses,” said Joe Gross, St. Elizabeth president and chief executive. “Our product is patient care, and the biggest raw material in that product is our nursing employees.”

No hospital, not even at St. Elizabeth, is having a rosy time. But its confrontation with economic troubles offers insight into issues facing hospitals today.

Among the signs of success at St. Elizabeth:

- With a \$5.6 million profit on operations, St. Elizabeth was the only big hospital group in the Tristate that made money in 2000. It earned enough to give nurses a 6.5 percent raise this year and all employees a bonus averaging \$500. Cincinnati's biggest hospital groups — the Health Alliance of Greater Cincinnati, TriHealth and Mercy Health Partners — have reported losses and closings in recent years. Mercy Hospital in Hamilton is the latest, expected to close by June 1.
- St. Elizabeth has about half the nurse vacancies other Tristate hospitals face. The average nurse has worked there more than 10 years.
- The hospital group hasn't gone on diversion at all in 2001. Hospitals go on diversion when they are swamped, directing life squads to take all but the most unstable patients someplace else. Through February, Jewish Hospital declared 41 diversions; Christ Hospital, 26; Good Samaritan and Bethesda North, 15 each; and University Hospital, 13.

- St. Elizabeth has collected several industry awards since 1999, including a ranking among the nation's 100 lowest-cost hospitals and among the nation's top 100 hospitals for cardiac care.
- St. Elizabeth has been adding services, including a new cancer wing in 2000 and a women's health unit this year in Edgewood. It also recently tripled the size of its emergency department in Williamstown.

St. Elizabeth has spent years building a culture of respect for nurses, Mr. Gross said. “At its best, nursing is no cakewalk,” he said. “It's a demanding profession, emotionally and physically. We try to let nurses do what they like to do: care for the patient and work with their families.”

Other nurses in the Tristate notice.

“Nurses are staying there,” said Cheryl Townsend, a nurse at University Hospital. “They seem to have a family atmosphere. They seem to have a close connection between the administration and the nurses that do the work.”

St. Elizabeth's treatment of nurses is uncommon, said Dr. Linda Aiken, an expert at the Center for Health Outcomes and Policy Research at the University of Pennsylvania.

Hospitals nationwide are failing to retain nurses, she said, because they no longer offer the pay, the involvement and the institutional support nurses expect. Hospitals are less able to compete for nurses with home-care services and doctors' offices.

“There are plenty of nurses in the United States at the moment,” Dr. Aiken said. “But they don't feel good or safe about the work they're doing in hospitals.

“There are some hospitals out there, like St. Elizabeth, that are developing those conditions. But most hospitals are way, way, way behind in terms of modern approaches to managing their workplaces.”

St. Elizabeth can afford to offer the highest average hourly pay for nurses in the region — \$20.89 per hour. And the hospital group involves nurses in many decisions, such as what supplies to buy and how to staff the units.

Perhaps most important, St. Elizabeth avoided two morale-bursting policies common among Cincinnati hospitals: It does not pay large signing bonuses to new employees. And it does not hire temporary-agency nurses.

At some hospitals, as many as half the nurses in hard-to-fill shifts are temporary staff, Mr. Gross said. “Nurses don't like working with (agency) nurses that get higher pay than they do but don't know the hospital as well,” Mr. Gross said. “They don't like seeing new co-workers getting bonuses they don't get.”

St. Elizabeth's willingness to close medical units rather than overburden nurses also breeds loyalty, said Jane Swaim, who left University Hospital five years ago to become vice president of nursing at St. Elizabeth.

"The administration truly supports nursing. I've had (nursing staff) increases every year I've been here," she said.

Melanie Ingram, 43, has been a nurse at St. Elizabeth since 1993. She came to the hospital because it offered much higher pay than the hospital near her home in Milan, Ind. She stayed because she feels involved in how the hospital runs.

"I have a vested interest in seeing that things go well," Ms. Ingram said.

At other hospitals, temporary nurses often don't get involved in planning or solving problems, Ms. Ingram said.

St. Elizabeth's location also has contributed to its growth during difficult times for health care.

St. Elizabeth is 140 years old, and is Northern Kentucky's third-largest employer. The area's continuing influx of residents and businesses provides its hospitals with employees, volunteers and financial support.

The sense of pride at St. Elizabeth can be measured in hard dollars: More than 75 percent of employees give part of their pay to the hospital group's "Vision" program, contributing \$1.5 million for various hospital projects.

St. Elizabeth moved its main hospital from a limited-growth location, Covington, to a fast-growing suburb, Edgewood.

The greater demand has given the hospital greater leverage with health insurers.

In contrast, many of Cincinnati's biggest hospitals remain concentrated in older neighborhoods with shrinking populations. Until the mid-1990s, the state blocked them from moving into growing suburbs.

St. Elizabeth also avoided the waves of hospital consolidations, which led to downsizings, closings and management reorganizations at Health Alliance, TriHealth and Mercy Health.

St. Elizabeth is not immune to the industry's ills. It still copes with tight reimbursement from insurers and a shrinking pool of nurses. The hospital group has vacant nursing jobs. "Lots of days, I think I can't walk one more mile," Ms. Ingram said. "But the reasons I went into nursing are still there. I always wanted to fix things for other people."

EXHIBIT 4

FOR IMMEDIATE RELEASE: Press release from the Registered Nurses Association of Ontario, February 23, 2001

Full-time jobs, support for relocation, better wages/benefits could bring RNs back home: Expatriate RNs willing to come back to Ontario -- but we must earn their return

TORONTO -- If Ontario wants to win back the thousands of registered nurses it lost to other countries during the past decade of downsizing, it will have to earn their return, according to the instructive results of a survey of expatriate nurses released today by the Registered Nurses Association of Ontario (RNAO).

The good news, said RNAO President Shirlee Sharkey, is that the survey results show an overwhelming willingness on the part of expatriate nurses to consider returning to nursing in Ontario: 78.3 % of all respondents stated they would consider returning to Ontario. Sharkey said the very strong response to the survey – a 32.9% response rate from across the world and 36.6% from the United States – is also indicative of registered nurses' wide-spread interest in nursing employment in Ontario. These statistics are but two telling results contained in a report, *Earning their Return: When & Why Ontario RNs Left Canada, and What Will Bring Them Back*, released today by the Registered Nurses Association of Ontario during a news conference at Queen's Park.

As part of the RNAO's comprehensive campaign to retain and recruit nurses, the association mailed out survey forms in late 2000 to all reachable RNs – 3,272 – living outside Canada who remain registered with the College of Nurses of Ontario (CNO). These nurses live in 73 countries, but the great majority – 2,621 (80.1%) – are in the United States, concentrated in Texas, Florida, North Carolina, California, Michigan, and New York. The association wanted to find out when and why these registered nurses left Ontario, where they settled, whether they are willing to return, and what conditions would help bring them back home.

Among the key findings of the survey:

- 65.5% would be encouraged to return by the availability of full-time work; 66.3% mention relocation expenses; 32.1% listed wages/bonuses; 13.9% cite availability of specific positions or locations; 11.4% refer to job security; 9.2 % want education/training support; only 1.7% cited taxes
- 62.8 % of those surveyed left Ontario because of downsizing and lack of full-time employment (this includes many who left in 1999 and 11 of the 23 who left in 2000)
- 28% of those surveyed left because of family, personal reasons; 13.2% left because of pay/benefits
- 52.2 % left between 1996-2000; 30.7% left between 1991 and 1995

- In the past decade, there has been a sharp upsurge in the importance of job availability and a decline in other key factors such as family/personal considerations and travel/weather factors. For example, job opportunities were cited as a key factor for leaving Ontario by only 21.42% of those who left between 1961-1970; 50% of that same group cited travel or weather as the determining factor in their departure. In comparison, only 5.53% identified travel or weather as the key factor among those who left Ontario between 1991 and 2000.

Comments from nurses (see attached) who filled out the survey reveal a range of emotions and experiences – from disappointment and anger at the nursing lay-offs in the 1990s, to frustration at the lack of full-time work, to a powerful pull to return to a publicly funded health-care system, to a desire to raise their children in Canada. “There remains a well of good will and commitment to nursing in Ontario among expatriate RNs, but we must earn their return,” said Sharkey. “Having once been burned by stop-go funding for nurses, they want to see some assurances before uprooting themselves and their families to come back home.

When we can provide enabling, healthy work environments and a consistent commitment to stabilizing and improving career choices for nurses, RNs will respond,” she said. Said RNAO Executive Director Doris Grinspun: “It is the steadfast desire of respondents to attain fulltime, stable employment. Without it, RNs tell us they will not return. Fixing critical issues for nurses will not only encourage the return of those who have left, it will also serve to help us keep RNs still in Ontario.”

The RNAO report includes key recommendations for employers, government and the association to help address those critical issues. They include:

- Employers must commit to a minimum target of 70 % full-time employment for nurses (Latest CNO figures, released February 20, 2001, indicate that 51.87% of Ontario nurses work full time, as compared to 49.6% in the previous year. Although this is welcome news, we have a long way to go to achieve the 70% target.) Government funding methods must encourage this objective and discourage casual employment.
- The government, to meet its target of securing 12,000 new, permanent nursing positions for Ontario, must continue to flow earmarked funds, with clear accountability mechanisms, until the RN/population ratio is comparable to the rest of Canada. (In July 2000, Ontario had the lowest number of RNs per capita compared to all other provinces and territories. In 1999, there were 67.7 RNs employed in nursing per 10,000 population – a decline from 74.7 in 1994.)
- Employers must support adequate nurse-patient ratios appropriate in all sector settings.

- Nurses want, and must continue to receive, educational support from government, employers, and the RNAO. The overwhelming response to the survey augurs well for RNAO's job fair next Monday, February 26, 2001 in Houston, Texas where 35 Ontario employers will try to bring some of Ontario's registered nurses back home to help alleviate the system-wide nursing shortage. Furthermore, the survey reveals that 73.2% of respondents said they would attend a job fair in their area.

To obtain a copy of the report, visit the RNAO's Web site at www.rnao.org.

For more information, please contact:

Sine MacKinnon, Director of Communications

Registered Nurses Association of Ontario

416-599-1925 / 1-800-268-7199, ext 209

IN THEIR OWN WORDS:

Views & Voices of expatriate Ontario RNs who filled out survey

- I want to return, my life, family, friends and future hopes are back home. *(Departed August 1996)*
- It is my desire to return to Ontario providing I can obtain full-time work to support myself. *(Departed April 1996)*
- If I can get a good RN position in hospital – a med-surg unit – with good salary, benefits and a fulltime position. *(Departed 1995)*
- I never wanted to leave my home but I had no choice. *(Departed December 1994)*
- The complete disregard and lack of respect for professional RNs and their need to earn a decent full-time income, with reasonable hours, at one place of employment. *(Departed 1965)*
- We left Canada for more positive work environment, to be treated better by our employers and for better job security. We decided we had had enough... *(Departed 1994)*
- There were no full-time positions available in Ontario. Only part-time or casual work. Hospitals and long-term care facilities all offered poor staffing, increased workload and nurse-patient ratios. *(Departed January 2000)*
- Lack of consistent schedule, poor working conditions (at times unsafe), lack of funding for further education or career growth... *(Departed May 2000)*
- Treat RNs with the respect they deserve and they will return. *(Departed July 1997)*
- I remain worried about job security in Ontario. Many nurses were laid off in the early 1990s with restructuring [seeking assurances]. *(Departed June 1994)*
- I want to ... [but] Just because Ontario needs nurses now – what will happen in five years? *(Departed 1994)*
- Only [return] if jobs are full time and in an area where I am interested. *(Departed 1984)*
- Why? To face another nursing lay-off in a few years. *(Departed May 1996)*

- I would gladly return to Ontario if I was guaranteed a job with security. What happens when the money the government has allocated to health care runs out? *(Departed 1994)*
- I was forced to leave Ontario if I was going to work in my field. *(Departed August 1999)*
- Only if I can get a job in my same field and receive a comparable salary to the one I am receiving now. *(Departed 1994)*
- Ontario should value its nurses right from graduation. *(Departed August 1999)*
- Fear of hospital closing, no future for full time work with benefits. *(Departed 1998)*
- I was laid off at ___ Hospital. My only chance at a job, being a new grad (with one and a half years' experience) was agency work. I hadn't even finished paying off my student loan.
- No nursing jobs, too many lay-offs and I needed to support my family.

EXHIBIT 5

Hailing one of health care's priceless resources -- nurses

Commentary. By Michael Greenberg, MD, *AMNews* contributor. Jan. 28, 2002.

The U.S. Dept. of the Interior spends millions of dollars to protect our nation's endangered species. It writes long lists of plants and animals whose populations are dangerously low and hires scientists to figure out ways to increase their numbers

Too bad they haven't turned their attention to nurses.

In the fragile ecosystem of medical care, nurses are the ones who create the protective environment essential to the well-being of both doctors and patients. We cannot function without them. Their job is to provide knowledge, comfort, care and compassion.

But, lest nurses be offended by my comparing them to the plant and animal life that are on the endangered species list, the metaphor stops here. My point is that it seems society expends greater resources and energy on the protection of birds and flowers than on protecting the viability of the nursing profession.

Throughout my training, it was as many nurses as doctors who turned me from a green medical student into a full-fledged physician. At times, nurses were my primary source of learning. Because the housestaff was overwhelmed, an operating room nurse took the time to teach me the fine points of suturing. When she saw I had mastered the technique, she put the needle holder into my hand during a procedure. "The student is ready to close," she informed the surgeon.

My initial assignment during my first post-graduate year as a pediatric resident was the newborn nursery. Not yet a father, and uncomfortable in my awareness of how little I really knew despite the magical initials that had been recently appended to my name, I admitted my fears to the head nurse.

Her smile put me at ease. "We're going to teach this young doctor how *not* to drop babies," she announced to the other nurses in her unit. And by the end of the first week, I was a pro.

Even more frightening to me were the high-risk nursery and pediatric intensive care units. But by admitting my ignorance and asking for help from the nurses in each area through which I rotated, I felt myself respected and supported. And I believe the patients were better cared for because of the partnership I created with the nursing staff. At least they prevented me from killing anybody. During my dermatology residency, nurses I met while moonlighting in attendings' private offices taught me medical techniques and also provided me with an education in business and practice promotion.

A significant part of the success of my more than 20 years in practice is directly attributable to the wonderful nurses who have worked with me. Along with my office

staff, they maintain the "sacred space" in which patients and I interact. Nurses are full-fledged partners in the health care equation, offering not only their compassionate perspective but also their eyes, ears and hearts. I am indebted to them for the many times they have prevented me from doing or saying something foolish, or worse, harming a patient.

Hospitals and office practices have difficulty filling vacancies as nurses discover they can earn higher salaries in other professions. But beyond the money, nurses are disappearing because as much misery as managed care has brought to doctors, they have been affected more than we have. Nurses traditionally have been the human interface between the hospital and patient. While our time with patients was measured in minutes, nurses spent hours with patients. They were the ones who knew how patients were *really* doing and informed us at the first signs of trouble.

With the advent of managed care, many nurses have been relegated to shuffling papers and recording information. And as much as we didn't become doctors to argue with insurance companies, nurses didn't earn their degrees to push pencils.

Unfortunately, I don't have a solution for the problem. Raising awareness of the crisis is a good start. Nurses are a priceless health care resource that is not being renewed or protected. And if we as doctors don't do something to reverse the situation, both our patients and our own profession will suffer. Let's not wait until nurses become extinct.

Dr. Greenberg is a dermatologist in Elk Grove Village, Ill. and author of the novel *A Man of Sorrows* (<http://www.anovelvision.com/>). You can contact him by e-mail (offped@aol.com).

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APPENDIX: ANNOTATED BIBLIOGRAPHY

Aiken, Linda H., and Patricia A. Patrician. "Measuring Organizational Traits of Hospitals." *Nursing Research* 49, no. 3 (2000): 146-53.

Background: The organizational context in which nurses practice is important in explaining variation in patient outcomes, but research has been hampered by the absence of instruments to measure organizational attributes empirically.

Objectives: To report on the development and utility of the Revised Nursing Work Index (NWI-R) in measuring characteristics of professional nursing practice environments.

Methods: The NWI-R was used in a national acquired immunodeficiency syndrome (AIDS) care study. The sample consisted of 40 units in 20 hospitals. Of these 20 hospitals, 10 provided AIDS care in both dedicated AIDS units and general medical units, thus introducing to the design an element of internal control. The remaining 10 hospitals were selected through a matching procedure. Three of the matched control hospitals were magnet hospitals. Nurses were recruited into the study if they worked at least 16 hours per week on the study unit. The nurses completed the NWI-R in addition to other measures.

Results: A response rate of 86% was attained. Response rates per unit ranged from 73% to 100%. Cronbach's alpha was 0.96 for the entire NWI-R, with aggregated subscale alphas of 0.84 to 0.91. Validity of the NWI-R was demonstrated by the origin of the instrument, its ability to differentiate nurses who worked within a professional practice environment from those who did not, and its ability to explain differences in nurse burnout.

Conclusion: The NWI-R has been found to capture organizational attributes that characterize professional nursing practice environments.

Aiken, Linda H., Donna S. Havens, and Douglas M. Sloane. "The Magnet Nursing Services Recognition Program: A Comparison of Two Groups of Magnet Hospitals." *American Journal of Nursing* 100, no. 3 (2000): 26-36.

In the 1980s, the American Academy of Nursing reported on hospitals that were able to recruit and retain highly qualified nurses in a competitive market. Subsequent research showed that 'magnet hospitals' have better outcomes than

nonmagnet hospitals. This study compares the original magnet hospitals with ones that met criteria for accreditation as magnet hospitals by the American Nurses Credentialing Center. It provides the evidence nurses need to convince their hospitals to seek this accreditation.

Baumann, A., R. Deber, and et al. "Who Cares? Who Cures? The Ongoing Debate in the Provision of Health Care." *Journal of Advanced Nursing* 28, no. 5 (1998): 1040-45.

The authors suggest that the models of care and cure are not in opposition, but are instead end-points on a continuum which ideally should be used by all health providers, rather than being characteristic of different clinical professionals. This conceptualization places less concern on what should be done by doctors as opposed to nurses, and more on the needs of the particular situation. The resulting convergence among roles should not imply that nursing and the allied health professions will adopt the medical model, but that medicine, nursing and others will work together with patients for all members' mutual benefit. In this expanded continuum, the focus for decision making becomes the patient and family in partnership and collaboration with health professionals.

Brannon, R. "The Reorganization of the Nursing Labor Process: From Team to Primary Nursing." *International Journal of Health Services* 20, no. 3 (1990): 511-24.

Post WWII, nursing was organized to include stratified nurses (registered and auxiliary) in a labor process called "team nursing." This method adapted Taylorist principles to demarcate tasks between the two types of nurses. In the 1970's and 80's, team nursing was replaced by "primary nursing" with a majority of RN's. Auxiliaries were displaced in the process. The transition to primary nursing is explained through the convergence of managerial interests with the professionalizing interests of nursing's elite. However, primary nursing was not simply imposed from the top down. Team nursing produced divisiveness between RNs and auxiliaries at the same time that it forced these workers to violate the official differentiation of tasks and held RNs responsible for work performed by auxiliaries. Primary nursing eliminates the problems of team nursing as RNs perform reunified tasks in an unmediated RN-patient relationship. However, primary nursing has produced a new set of contradictions, including an intensified labor process.

Brannon, R. "Restructuring Hospital Nursing: Reversing the Trend toward a Professional Work Force." *International Journal of Health Services* 26, no. 4 (1996): 643-54.

RNs are currently threatened by a new managerial strategy to restructure work on hospital wards through the implementation of "Continuous Quality Improvement" and the "downsizing" of the professional work force. The strategy reintroduces nonprofessional and unlicensed nursing personnel in such a manner that may displace large numbers of registered nurses and affect patient care adversely. Ironically this change is introduced to reduce hospital costs rather than to improve quality and it reverses the cost-containment strategy of the 1980s when hospitals displaced nonprofessional nursing workers and moved toward a professional work force. The article discusses the prior shift from team nursing to primary nursing and explains how this trend contributed to the present effort to reverse the process. The author then discusses current work redesign methods that have been adapted from traditional industrial applications to destroy work jurisdictions and further rationalize hospital production through the downsizing of the professional work force and the creation of cross-trained workers in a new team-based management approach. The article concludes by discussing nursing's response to corporate-imposed work restructuring and the significance of these changes.

Clarke, J. "The Diminishing Role of Hands-on Care." *Nursing Times* 95, no. 27 (1999): 48-49.

Conflict between the desire for nurses to increase professional profile which many believe entails a move away from attending a patient's bodily functions. In reality, nurses are willing to give this role to others while claiming for themselves duties that take them from the patient's bedside. Nurses seldom admit to a desire to be apart from patients. Pegram (1992) found that nurses expressed regret about this erosion of their role. Who will care for the physical needs of patients if first nurses and then HCA's expunge this from their role? Implications are enormous when one considers how much communication and assessment takes place during these acts of care. Do patients feel "cared for" by their nurse? The increasing academic and professional standing of nurses is driving us further from the roots that contributed so much to our uniqueness (p. 49)

Clifford, Colette. "An Experience of Transition from a Medical Model to a Nursing Model in Nurse Education." *Nurse Education Today* 9 (1989): 413-18.

Corser, W.D. "The Contemporary Nurse-Physician Relationship: Insights from Scholars Outside the Two Professions." *Nursing Outlook* 48 (2000): 263-8.

This article analyzes the contemporary nurse-physician work relationship as it has been studied through the perspectives of non-clinical scholars during the later 1980s and 1990s. Five categories of published works by non-clinicians are evaluated. A more consistent review of these types of works by non-clinicians may enable nurses and physicians to more capably study the longstanding organizational and professional variables that may still be affecting this facet of their individual practices. N.B. that the author discusses McMahan (1994) who contends that role conflicts are embedded in the "care" and "cure" ideologies. Interpersonal friction may arise from the routine physical isolation maintained by nurses and physicians in most practice settings. Also reviews the literature on power asymmetry. Communication patterns contribute to a negotiated order between nurses and doctors. Author notes that very few of these studies done by non-clinical people are ever cited in nursing publications and few works are generated by teams composed of either nurses with physicians or clinicians with non-clinicians.

Davies, Celia. *Gender and the Professional Predicament in Nursing*. U.K.: Open University Press, 1995.

Examines the way in which our understanding of nursing is gendered, and how our notion of nursing is connected to our idea of what it is to be a woman. It explores the implications this connection has for the status of nursing as a profession, and re-examines some of the fundamental questions that the nursing profession has tried to address, such as:

- What is nursing care?
- Who should do it?
- Why is it so difficult to manage the provision of nursing care?

Davies demonstrates that once nurses try to define and shape the nature of their work they are marginalized or silenced. Frequent descriptions of them as 'sentimental', 'divided' or 'incompetent' highlight the need to understand nurses' exclusion from policy debates, and why their voices are so seldom heard.

She contends that in a society divided by gender, defining nursing as women's work is deeply contradictory. We value nurses but we devalue nursing. She suggests that alongside the debates about managerial efficiency in the NHS we need another kind of debate about how we

organize health and social care, about what we mean by professionalism and about the worth of caring work.
(quoted from back cover)

Deloughery, G., ed. *Issues and Trends in Nursing*. New York: CV Mosby, 1995.

Various chapters cover subjects like history, economics, social policy, legal, ethics, education, rural and urban nursing, image of nursing, political awareness.

CHAPTER 2: THE EVOLUTION OF NURSING SCIENCE AND PRACTICE

Deloughery describes nursing as a field that changes, grows, and advances continually in response to perceived social needs. She characterizes it as a "reflection of social reality" (p. 58), more than a simple technique or a skilled trade, it is an abstract dynamic process with concrete results.

Issues around nursing theory and practice have been debated for decades and are still debated today. Early discussions focused on the question of whether nursing should be viewed as a basic or an applied science. The main motivation behind the development of a theoretical basis for nursing practice was probably a desire for professional status. In the beginning, efforts were directed at collecting empirical knowledge through observation and rational thought. In 1929, Isabel Stewart pointed out the weaknesses in using only these methods. She said that general observation with the goal of collecting a fund of scientific data was not enough. Rather, observation must be "direct, exact, rational, and selective" (p. 61).

In 1978 Carper described four basic patterns of knowledge that are found in nursing and in other fields. Each one is equally important. They are empirical knowledge, which is based on objective evidence; ethical knowledge, which seeks credibility through logical justification; esthetics, which looks at the creative process and byproduct; and personal knowledge, which integrates and analyzes the current interpersonal situation with past experience (p. 61).

One major debate in nursing has always been the split between theory and practice. Deloughery writes that ideally, nursing theory, research, and practice are interrelated, but in the past nursing was seen as a job requiring skill of hand and technical efficiency, whereas the need for knowledge, intellect, judgment, and social insight was overlooked.

Nowadays, the link between theory and practice is closer and people are aware of the fact that nursing science, practice, theory, and research are interwoven and inseparable. However, Deloughery points out that "Sometimes the importance of applying theory to practice is overemphasized, while the value and usefulness of developing theory from practice is underestimated" (p. 65).

Deloughery categorizes nursing models on three levels:

1. Underlying theoretic base

Peplau, Orlando and King were early "interactional" theorists who used ideas from psychiatry, communications theory, and systems theory to build a model that focused on the interpersonal nurse-client relationship. Later, organizational behaviour theory influenced King, Johnson and Neuman to view the client as a system interacting with other systems, such as their family, community and environment. Stress-adaptation theory built on those models, claiming that the client experiences stress, which leads to disequilibrium, and the nurse's job is to restore a state of equilibrium and independence. Most recently, Martha Rogers initiated the move from a traditional world view of science to a humanistic transactional view of health and nursing, which looks past the body and mind to include spiritual and higher levels of consciousness.

2. Level of theory development

Stevens first classified nursing theory as either descriptive, in which major concepts are identified and described but no relationship between them is addressed; explanatory, in which concepts are linked; or predictive, in which the logical and empirical adequacy of the relationships is clarified and tested, and in which future outcomes are described.

3. Level of abstraction

Walker and Avant categorized nursing theory according to four levels of abstraction. The first and highest is meta-theory, focusing on broad philosophical issues. The second is what they called "grand nursing theories", which provide global conceptual frameworks for practice and education. At the third level are middle-range theories, provide direction for nursing. Finally, the fourth level is practice theory, which specifies the goal and the actions necessary to achieve the goal. Deloughery believes that nursing theory is moving in the direction of the fourth level of abstraction, which provides testable conclusions.

In Box 2.1, pages 84-85, Deloughery summarizes various contemporary nursing theorists and their major ideas about nurses, clients, and health. Beginning with Rogers in 1970 and ending with Watson in 1985, she

shows a clear shift away from the biological and purely empirical models towards the humanistic health experience models. By the 1980s, while various scholars were debating how theory is constructed and what criteria nursing theories should live up to, most graduate nursing programs had added classes in theory development to their list of core courses. So, while there is still a split between nursing theory and practice, Deloughery ends the chapter by stating that we are on our way to "stronger collaboration between practitioners, scholar, theorists, and researchers" (p. 99).

DiMaggio, P.J., and W.W. Powell. "The New International in Organizational Analysis." In *The New Institutionalism in Organizational Analysis*, edited by P.J. DiMaggio and W.W. Powell, 63-82. Chicago: University of Chicago Press, 1991.

Bureaucratization and other forms of organizational change occur as the result of processes that make organizations more similar without necessarily making them more efficient (p. 64). Bureaucratization and other forms of homogenization emerge out of the structuration of organizational fields. The authors question why there is such a homogeneity of organizational forms and practices. The process of institutional definition or structuration consists of: 1) increase in extent of interaction among organizations in the field 2) emergence of sharply defined inter organizational structures of domination and patterns of coalition 3) increase in the information load with which organizations in a field must contend 4) development of mutual awareness among participants that they are involved in a common enterprise. Once disparate organizations are structured into an actual field, powerful forces make them similar to one another. Isomorphism is the process of homogenization and it is a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions. Coercive isomorphism results from pressures exerted on organizations by other organizations upon which they are dependant and by cultural expectations in the society within which organizations function. Mimetic processes (modeling) is a response to uncertainty and a way to copy another organization. Organizations tend to copy other successful organizations in their field. A third source of isomorphic organizational change is normative and stems from professionalizations, which is the struggle of members to define the conditions and methods of their work and to establish a cognitive base and legitimation for their occupational autonomy. Two aspects of professionalization are important sources of

isomorphism: formal education in cognitive base and growth of professional organizations that span across organizations. They argue that organizations become more similar through this process of institutional isomorphism, which then explains why there is a lack of innovation. They argue that there are two views of power: 1) the power to set premises, define norms and standards 2) point of critical intervention at which elites can define appropriate models of organization which then go unquestioned for years.

Dingwall, Robert, Anne Marie Rafferty, and Charles Webster. *An Introduction to the Social History of Nursing*. London: Routledge, 1988.

This historical overview of nursing begins by looking at the type of nursing care available in 1800 and traces the "interdependent growth of general nursing and the modern hospital and examines the separate origins and eventual integration of mental nursing, district nursing, health visiting and midwifery." (back cover)

Edwards, Steven D., ed. *Philosophical Issues in Nursing*. U.K.: MacMillan, 1998.

Philosophical questions considered in this book and central to nursing include the following:

- What is nursing?
- If nursing is a practice-based discipline, what is the point of classroom-based teaching?
- How should nurses conceive the relation between mind and body?
- How does philosophical inquiry relate to nursing?
- How is specialisation compatible with the emphasis on holistic nursing?
- Which research method is best suited to nursing?
- What relevance do philosophical accounts of the self have to nursing?

(back cover)

Freddi, Giorgio, and James Warner Bjorkman, eds. *Controlling Medical Professionals: The Comparative Politics of Health Governance*. Vol. 21, Sage Modern Politics Series. London: Sage Publications, 1989.

Glouberman, Sholom, and Henry Mintzberg. "Managing the Care of Health and the Cure of Disease - Part I: Differentiation." *Health Care Management Review* 26[Glouberman, 2001 #2], no. 1 (2001): 56-69.

The clinical methods used in health care and disease cure are easily understood. Yet when combined into institutions and broadened into social systems, the management of them becomes surprisingly convoluted. Part I of this article presents a framework to help understand how this happens. (p. 56)

Glouberman, Sholom., and Henry Mintzberg. "Managing the Care of Health and the Cure of Disease - Part II: Integration." *Health Care Management Review* 26, no. 1 (2001): 70-84.

The development of appropriate levels of integration in the system of health care and disease cure will require stronger collective cultures and enhanced communication among the key actors. Part II of this paper uses this line of argument to reframe four major issues in this system: coordination of acute care and of community care, and collaboration in institutions and in the system at large. (p. 70)

Hugman, Richard. *Power in Caring Professions*. Basingstoke, England: Macmillan, 1991.

Hugman discusses the concept of 'social closure', defined as 'a process by which social collectivities seek to maximise rewards by restricting access to resources and opportunities to a limited circle of eligibles'. He uses the notion of social closure as a basis to discuss professionalisation and to examine the caring professions in particular.

Jamal, M., and V. Baba. "Job Stress and Burnout among Canadian Managers and Nurses: An Empirical Examination." *Canadian Journal of Public Health* 91, no. 6 (2000): 454-58.

This study examined the relationship of job stress with burnout and its three dimensions (emotional exhaustion, lack of accomplishment, and depersonalization), job satisfaction, organizational commitment and psychosomatic health problems. Data was collected by means of questionnaires from managers and nurses. Job stress was significantly correlated with overall burnout and its three dimensions and job satisfaction in both samples. In the nursing sample, job stress was also significantly correlated with psychosomatic health problems and organizational commitment. Moderated multiple regression only marginally supported the role of gender as a moderator of stress-burnout relationship.

Jolley, Moya, and Gosia Brykczynska, eds. *Nursing: Its Hidden Agendas*. London, England: Edward Arnold, 1993.

CHAPTER 3 - A SOCIOLOGIST'S VIEW: THE HANDMAIDEN'S THEORY

"This chapter seeks to uncover nurses' social/institutional roles in health care. The key to understanding why nurses carry out caring as they do, lies not in professed organisational intentions but within the depths of the hidden social structure." (p. 43)

Katz, Fred E. "Nurses." In *The Semi-Professions and Their Organization: Teachers, Nurses, Social Workers*, edited by Amitai Etzioni. New York: The Free Press, 1969.

Katz examines how hospital nurses fare in a context "in which knowledge is systematically harnessed for solving problems but is also a weapon for giving or depriving people of distinctive social statuses." (p. 55)

Kelly, Lucie Young, and Lucille A. Joel. *The Nursing Experience: Trends, Challenges, and Transitions*. 3rd Edition ed. U.S.A.: McGraw Hill, 1996.

Kramer, Marlene. *Reality Shock: Why Nurses Leave Nursing*. St. Louis: CV Mosby Company, 1974.

Reality shock is a term to describe new workers who have prepared for a profession only to find themselves unprepared for the work situation. Discrepancy in culture between schooling and work. Professional-bureaucratic shock develops in work situations in response to the way work is organized. Work can be organized by whole-task or part-task methods. Nurses are socialized to view work as whole task and are not taught to think critically about how to organize work and how to delegate (16). Professionals tend to resist bureaucratic rules, standards, supervision, and loyalty (17). Conflict: 1. Nurses are required to perform 4 types of duties: technical, administrative, organizational, and educative--this creates a discontinuity between the job the nurse expects to perform and the actualities of her work. 2. Second major conflict is nurse-doctor. Nurses are relationship oriented and base studies in behavioral science whereas doctors are trained in biological sciences. 3. Conflict inter nurse-supervisor. The latter personifies the organization. Supervisors have little access to rewards for nurses or even awareness of what rewards they would like. Thus, severity of prof-bureaucratic conflict is related to type of educational prep, role configuration, disparity in reward systems, and to structural features of the organization. With increased professionalism, there is increased conflict. However, org conflict can be a source of innovation. Nurses are unable to convert prof-bureauc work organizational

conflict into growth-producing initiatives for self, nursing community or h/c system.

Kuhse, H. *Caring: Nurses, Women and Ethics*. Oxford: Blackwell, 1997.

She rejects feminine ethics of care as a distinguishing feature between medicine and nursing. There is no reason to assume that care has priority over cure--illustrated by a study of the ICU (p. 48).

Laschinger, H. K. S., and J. Shamian . "Staff Nurses' and Nurse Managers' Perceptions of Job-Related Empowerment and Managerial Self-Efficacy." *Journal of Nursing Administration* 24, no. 10 (1994): 38-47.

The article explores Kanter's theory of structural power in organizations that has potential to create empowering work environments for staff nurses and managers in health care settings. Power is defined as ability to get things done and access to power is formal and informal (through alliances). Kanter claims that employees prefer to work with managers they perceive to have power both "upward and outward" in the organization. The results of the study add credibility to the link between organization structures and personal levels of confidence for executing the managerial roles. Staff nurses perceived themselves to have less power than managers did. Kanter says that sharing information builds trust. Managers must share power with staff to gain power.

Mastorovich, M.J., and K. Drenkard. "Nursing Future Search: Building a Community of Nurses in an Integrated Healthcare System." *Journal of Nursing Administration* 30, no. 4 (2000): 173-79.

This article describes a large group intervention that is used to managed change and plan for the future. A case study of this method, called "Future Search" is included. Traditional externally driven approaches to change result in decision making from the top down, with a small group assuming responsibility for the whole. An alternative, as presented here, is to obtain a view of the whole by creating an environment wherein all stakeholders are welcome and all views of the current reality are accepted. True system integration can occur when the voice of the whole system in engaged in the dialog.

Menzies, I.E.P. "A Case Study in the Functioning of Social Systems as a Defence against Anxiety: A Report on a Study of the Nursing Service of a General Hospital." *Human Relations* 13 (1963): 95-121.

The classic study of fragmentation in nursing care.

O'Neil, Edward H., and Diane M. Hare, eds. *Perspectives on the Health Professions*. Durham, North Carolina: Pew Health Professions Programs, 1990.

Pillitteri, Adele, and Michael Ackerman. "The 'Doctor-Nurse Game': A Comparison of 100 Years - 1888-1990." *Nurse Outlook* 41 (1993): 113-16.

This is a qualitative study of the interactions between doctors and nurses. It compares a physician's journal from 1888 with a doctor's tape-recorded journal from 1990. Pillitteri and Ackerman conclude that not much has changed in 100 years.

Powell, D. "Nurses-Sacrificial Lambs of Healthcare." *RN* 64, no. 1 (2001): 51-52.

One nurse's opinion of why conditions in nursing do not change.
Domination of women in the profession equals acceptance of conditions.
Need to organize and express with one united voice.

Sandier, Simone. "Health Service Utilization and Physician Income Trends." In *Health Care Systems in Transition: The Search for Efficiency*, edited by Organization for Economic Co-operation and Development, 41-56. Paris, 1990.

This is a study of physician income in OECD countries.

Shorr, A. "Has Nursing Lost Its Professional Focus?" *Nursing Administration Quarterly* 25, no. 1 (2000): 89-94.

The author believes that the nurses of the 1970 and 80s were valued and professional members of the clinical team. He feels that nurses now act mechanically. He discusses four situations where nursing practice has become mechanical: understanding and applying community standards of care to nursing practice; timely and accurate documentation of all relevant activities; communicating with physicians in a timely, professional manner; patient advocacy. Today nurses discharge discrete tasks rather than act as part of a team.

Snow, J.L. "Looking Beyond Nursing for Clues to Effective Leadership." *Journal of Nursing Administration* 31, no. 9 (2001): 440-43.

Effective leadership is one of the most elusive keys to organizational success yet it is a key ingredient to making any organization work. Leadership is also changing in nature. Our current faster, more flexible, flatter organizations face intense competition and require dynamic

leadership. This article synthesizes research conducted during the past 5 years that quantifies what separates superior leaders from average leaders

Tillman, H.J., J. Salyer, and et al. "Environmental Turbulence Staff Nurse Perspectives." *Journal of Nursing Administration* 27, no. 11 (1997): 15-22.

This qualitative study explored staff nurses' perceptions of how turbulence in the internal environment affected their ability to provide patient care. Organizational and performance theorists have developed models describing the potential effects of the internal environment on job performance; however, attempts to characterize the internal environment and to operation the concept have been limited (p. 15). There are two conceptions of the environment: the simple-complex and the stable-dynamic. Simple-complex refers to both the number and the comprehensibility of the environmental factors taken into consideration when making decisions and the stable-dynamic refers to the frequency and predictability with which env't factors change. In healthcare, the env't factors can change quickly, as in changes in third party payers. Little research exists on the effect of env't turbulence on staff nurses and their work performance. Env't change can also include number of admissions and discharges in a 24 hr period. The study used phenomenologic inquiry and interviewed staff nurses in acute care. Nurses expressed a lack of control of nursing practice; relationships with other HCP were compromised because supplies were not available; reduction of other services has negative effect on staff; forces outside hospital can create added work or increase the intensity of the work of the nurse. The main findings were: inadequate buffering of disruptive forces in the environment; supervisors must examine cost cutting plans that affect nursing; nursing performance of non-nursing functions can have negative effect; decreasing control of the work of nursing; changing role of the patient in the system-means that systems must be in place to support the active role of patients but also to make the decision making process more manageable.

Wade, G.H. "Professional Nurse Autonomy: Concept Analysis and Application to Nursing Education." *Journal of Advanced Nursing* 30, no. 2 (1999): 310-18.

Professional nurse autonomy is an essential attribute of a discipline striving for full professional status and it is often confused with personal autonomy, work autonomy, or aggregate professional autonomy.

Professional nurse autonomy is defined as belief in the centrality of the client when making responsible discretionary decisions, both independently and interdependently, that reflect advocacy for the client. Critical attributes include caring, affiliative relationships with clients, responsible discretionary decision making, collegial interdependence, and proactive advocacy for clients. Antecedents include educational and personal qualities that promote professional nurse autonomy. Accountability is the primary consequence of professional nurse autonomy. Associated feelings of empowerment link work autonomy and professional autonomy and lead to job satisfaction, commitment to the profession, and the professionalizations of nursing

White, Rosemary. *The Effects of the National Health Service on the Nursing Profession 1948-1961*. London: King Edward's Hospital Fund for London, 1985.