Nurses' voices

By

Margaret Nowak and Maureen Bickley

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Abstract

In this paper the authors analyse aspects of the qualitative data from open-ended questions included in the RN Survey 2002. The authors discuss the changes wrought by New Public Management (NPM) in the Australian and WA health sectors. They argue that the requisites of NPM and managerialism are not necessarily consistent with the historical role of professionalism in the delivery of health care and of nursing as a health profession. The nurses' qualitative responses are analysed using the framework from NPM and managerialism as a means to develop understanding of the issues and concerns expressed by nurses. The paper identifies three areas of dissonance: professional dissonance, career choice dissonance and ideological dissonance. It argues that, as a result, nurses emotionally and professionally resist what has been termed 'the instrumental motivations of managerialism'.

Introduction

Nurses in Australia, the USA, Canada, New Zealand and the UK have, since the early 1990s, gone through a period of considerable workplace change. Significant in the change experienced in this period throughout the health industry has been the introduction of New Public Management (NPM) and related trends towards market based discipline, 'managerialism' and budgetary stringency, (Cline, Reilly & Moore 2004, Ferlie, Ashburner & Fitzgerald 1995, Malin, Wilmot & Manthorpe 2002, Newman & Maylor 2002). This workplace change is identified in a number of qualitative studies of nurses' work satisfaction and workplace attitudes, as significantly changing the nursing role in practice (Bone 2002, Cline et al. 2004, McNeese-Smith 2001, Newman & Maylor 2002, Sharmian, O'Brien-Pallas, Thomson, Alksnis & Kerr 2003).

A key unifying issue for nurses in the qualitative studies cited above has been that, in the process of workplace change the relational or 'emotion work' (Bone 2002, James 1989), which nurses hold as an important part of their role, has given way to the technical aspects of their role and the administrative demands of management. The studies cited provide evidence that this results in workplace dissonance for nurses who in many cases express the feeling that these demands are in conflict with their own professional values and the sources of their workplace satisfaction. Bone argues that nurses interviewed for her study expressed feelings of loss, and remembered workplace satisfactions no longer possible under current working conditions (Bone 2002:144).

The other theme which emerges in these qualitative studies is a strong expression by nurses that 'management' fails to listen to or respond to their concerns, communicate effectively with them, offer support following events such as patient abuse, or provide feedback (Cline et al 2004, McNeese-Smith 2001, Newman & Maylor 2002, Daiski 2004). Management deficiencies are also invoked by nurses in these studies in relation to issues such as inflexibility in dealing with shifts, hours, insecurity in the workplace, high workloads and failure to deal with workplace issues such as bullying, discipline and discrimination.

Qualitative data collected as part of the RN Survey 2002 of Western Australian (WA) nurses, and detailed in this article, found evidence of similar responses to those reported in the USA, UK and Canada. The sense of anger was palpable in the responses, as was the apparent dissonance between the expressed professional

nursing values and what nurses perceived as the employer/management values expressed through resources allocation in the health system.

These responses are explored further in this article and linked to issues raised in the management of institutional and organisational change in the health industry. In Australia, the UK, New Zealand and Canada particularly, changes in the health industry are largely driven by public sector imperatives and ideologies together with the funding issues for public services.

In what follows we briefly outline the changes wrought by NPM in the Australian and WA health sectors and some of the issues raised in the critical debate of NPM. We then follow with a discussion of the historical role of professionalism (Malin et al. 2002) in the delivery of health care and of nursing as a health profession. The methodology adopted in this paper is outlined and the strategy used in analysing the data from the open-ended questions in the RN survey 2002 is discussed. We then consider the results of the RN survey qualitative data, using the framework from NPM and managerialism as a means to develop understanding of the issues and concerns expressed by nurses. The paper identifies three areas of dissonance: professional dissonance, career choice dissonance and ideological dissonance. It argues that, as a result, nurses emotionally and professionally resist what Bolton (2004:318) terms "the instrumental motivations of managerialism".

New Public Management, managerialism and health in Australia

New Public Management (Aucoin 1990, Hood 1991, 1995, Malin et al. 2002) and its alter ego 'managerialism' became the prevailing orthodoxy within public administration in the 1980s. Miller & Rose (1990) use the concept of 'technologies of government' to represent the new methods used by the state to maintain rule in an apparently non-coercive way. They argue these 'technologies' lead to the atomising of power and, as a result, implementation rather than policy becomes the focus of resistance. These technologies progressively permeated the Australian public sector, including health services, in the 1980s and 1990s and were generally introduced without health sector consultation (Germov 1995).

Hood (1995:95) characterises NPM as associated with seven dimensions of change: unbundling service units into corporatized units, greater competition in provision of service including the use of quasi-market mechanisms, stress on private sector styles of management practice, discipline in resource use (do more with less), visible and accountable hands-on top management, explicit and measurable standards and performance measures, and emphasis on results. Embedded within these seven dimensions are trends which have been differentiated as 'managerialism' (Beattie 2000, Baum 1996, Malin et al. 2002) involving generic not sector specific management, detachment of policy advice from management, disaggregation of the public sector within a regulatory framework, with tightly specified outcomes-focused contracts, focus on quantifiable outcomes as opposed to qualitative processes, and customer or client focus as opposed to 'the public'.

Hood (1991:15) argues that NPM can be understood "mainly in the direction of cutting costs and doing more with less as a result of better-quality management and different structural design." He noted that there was tentative empirical support for improvements in productivity but that final evaluation on values of fairness, trust,

reliability and adaptability required further investigation. Barnett & Barnett (2003) reflected these concerns when they concluded that in New Zealand

> "market approaches to health care have major limitations and that the ultimate goal of a health system should be the equitable, efficient and effective provision of care, not the profitable sale of commodities" (Barnett & Barnett 2003:145)

Hood (1995:96) identifies the 'erosion of self-management by professionals' (with concomitant movement away from trust in professional standards and expertise) and 'less producer friendly style' (contract employment, discipline and parsimony) as two of the operational issues resulting from NPM. Each of these issues resonates with the health services workforce generally. More specific issues raised by Baum (1996) and Beattie (2000), which are seen as the outcomes (albeit unintended), of NPM and in particular 'managerialism', include: the focus on readily measurable outcomes to the detriment of those less amenable to quantification; increased volume of paperwork at the expense of service provision; rule bound rather than providing for flexibility and responsiveness; responsive to the logic of cost *rather than* care; increase in the amount of management/hierarchy rather than reduction; elevation of processes and reorganisations rather than outcomes.

Professionalism and the delivery of health care:

Professionalism stresses the importance of the intervention of expert judgment in what are otherwise seen to be 'indeterminate' social needs and issues (Malin et al. 2002). The community acceptance of a profession's autonomy in exercising this expert judgment is underpinned by this professionalism being based on the "standardisation of skills through externally controlled training and qualification" (Malin et al. 2002: 84). Professionals are assumed to require a level of autonomy in practice, where their professional judgment can be trusted and for which they are accountable. Health sector work has been largely based on the practice of such professionals including nurses, doctors and 'Allied Health Professionals' (occupational, speech and physio therapists). These professions have historically exercised considerable autonomy in establishing their own education and training standards and standards of professional practice. The introduction of the significant investment in university qualifications in the 1980s was taken as evidence of an enhanced status for the nursing profession.

Malin et al. (2002) contrast the standardisation of skills of the professional with the standardisation of work processes and the delineated roles which is bureaucracy's operating strategy. As they have pointed out, in the evolution of the public sector's involvement in the health industry, the activities of the 'welfare professions', doctors, nurses, and social workers have increasingly been defined by the state. Fish and Coles (2000:292) argue that this has resulted in the development of tension between the technical/rational approach to professional practice and the professional artistry approach. The former, where 'delivery' of service to clients follows predetermined routines and behaviours, is consistent with the needs of both bureaucratic and NPM or managerial approaches to public sector organisations, while the latter, involving a mix of 'professional judgment, intuition and common sense' (Fish & Coles 2000:293), is the way these professions view their practice and professionalism.

The introduction of Total Quality Management (Morgan & Murgatroyd 1994) with its emphasis on patients as 'consumers' (du Guy & Salaman 1996) together with the case-mix funding process, funder/purchaser/provider approach and accreditation (e.g. Australian Council of Health Standards 'Equip' accreditation for hospitals and the Australian Government RCS accreditation standards for nursing homes) have encouraged the notion of standardisation. Whilst this is seen as strength by Morgan and Murgatroyd the very concept of standardisation and commoditisation may constitute what Keenan (1999) sees as an attack on nurses 'occupational autonomy'. The system of quality audits has served managers' and bureaucrats' needs whilst labelling many of the results of professional autonomy as 'deviations'. In the USA the notion of standardisation has manifested itself as 'managed care' and in the introduction of nursing case management (NCM) which sought to have nurses manage the balance between the conflicting values of 'quality of care' and 'costs of care'. With case-mix funding, case decisions are based on patient types or 'product lines' and risk categorisation (Padgett, 1998).

Nurses are not the only professionals affected by NPM. Germov (1995:60) argues that attempts to make the medical profession more accountable through a market-oriented policy curtails clinical autonomy and erodes the position of the medical profession. The resistance to the introduction of USA-style managed care in Australia was evident in the debate preceding the 2005 federal budget (Sydney Morning Herald 2005) on in-vitro fertilisation funding. The debate highlighted the potential for the use of financial means to control health provision and curtail professional autonomy, and the resistance to its implementation at this atomistic level. Re-conceptualisation of 'deprofessionalisation' in the discourse about managerialism and the professions is needed.

Qualitative data collection and analysis:

In addition to the quantitative survey questions in the RN Survey 2002 of WA nurses, the survey instrument also sought to provide the opportunity for qualitative responses through which greater understanding of the experiences, motivations, issue and concerns of nurses could be gained. This paper considers aspects of the qualitative data which were collected in two open-ended questions. In the first open-ended question, nurses were asked "If you could go back in time would you still choose nursing? Those who answered 'no' were then asked to respond to the open-ended question of "Why not? What has changed?" At the conclusion of the survey respondents were asked for "Any comments or suggestions which you would like to make about nursing or other issues in this survey?" In all, 1564 qualitative (written) responses were available for analysis by the research team.

A constructivist interpretivist approach was taken in the research process related to these qualitative data (Patton 1990). We were interested in understanding and interpreting nurses' constructed views of nursing (Denzin & Lincoln 2000). We sought to give nurses a voice.

We developed categories of meaning from initial iterative coding and refined these using the constant comparative method employed by grounded theorists (Locke 1996). The enormous volume of qualitative data (some nurses wrote several pages in response to the last question) was entered into multiple text files. Using NVivo

(QSR V 2.0, 1999) for the text management system, the text responses were carefully analysed using qualitative content analysis (Patton 1990, Altheide 1996).

The nurses' voices we record here are from nurses in all areas in Western Australia: country and metropolitan hospitals; aged-care facilities; psychiatric facilities; public and private sectors; and community nursing as well as some who are registered but not currently practising. While some of the comments are specific to a particular location of nursing practice such as a country or a teaching hospital, many more are reflective of what nurses from all fields of practice are saying.

Research results: Perceptions of Western Australian nurses

The major results of the iterative and grounded analysis were grouped into four major categories: 'Working in the Health System'; 'Nursing as a Profession'; 'Nursing as a Job'; and 'Being a Nurse'. Each of these categories was in some way affected by two pervasive institutional or structural influences: NPM and Managerialism, and Women's labour market position.

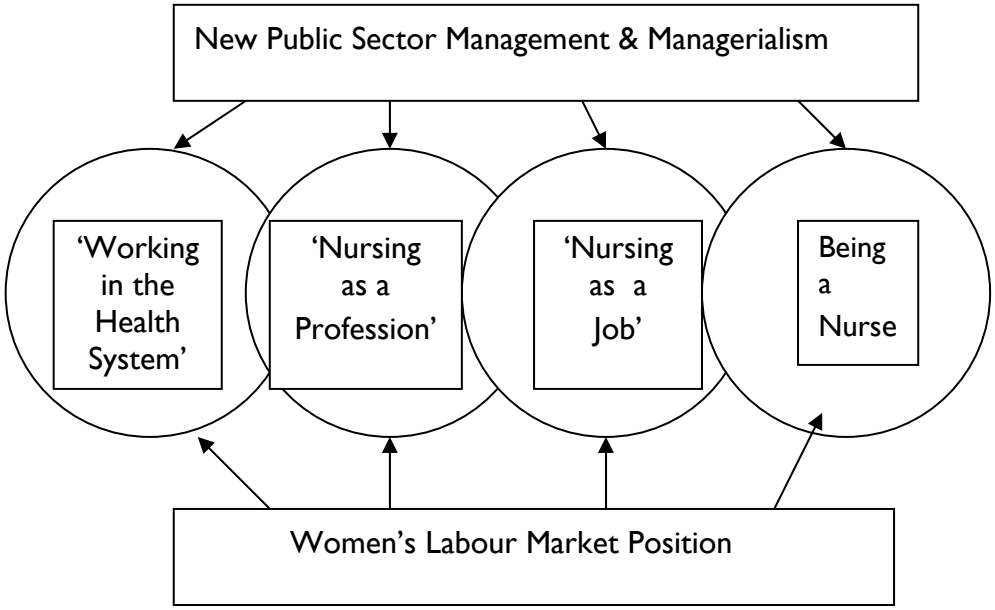

Figure 1: Results framework of content analysis of nurses' qualitative data

In this paper we have focused on the outcomes of the rapid changes in the health industry over the past ten or more years. These changes have been identified as consistent with the broad scope of NPM and involve elements of what has been termed 'managerialism'. We report on nurses' voices as they experience what it is like 'Working in the Health System' and also report on 'Nursing as a Profession'. This latter category includes nurses' focus on patient care, professional leadership, education and support. Each of these findings is discussed below using examples of the participants' reflections.

Other views raised by the respondents included issues relating to 'Nursing as a job': pay, conditions and job design issues, and 'Being a Nurse': work/family balance, stress, self-efficacy and self-esteem. These together with the impact of women's labour market status will be reported in other forums.

'Working in the(is) Health System'

Nurses were very concerned about both the general political trend towards a market oriented system and its implementation by management. As workers in this new health system they perceived generic, hospital level management and nursing management as distant, uncaring of nurses and failing to communicate with or listen to nurses. Their voices on three aspects of this are provided below.

(1) Working in a market-oriented health system.

Nurses strongly pressed their view that the health industry has changed to be focused on either cost/financial issues or, for the private sector, profits; they were highly critical of this approach. For many this was the defining reason for quitting nursing or considering doing so. The quotes below provide some of the flavour of their comments.

> */sadly they are only concerned about dollar cost…/ I feel very strongly that …any health care facility should not be 'money making'…/ only interested in making money …/ always battling with management to get increase in staff… / The government budgets just keep cutting health budgets more and more…/ It's a pity the money crunchers, senior management outside nursing, seem intent on destroying systems established over years of good practice…/ I hate the growth of luxury private health and the profiteers in the health system…/*

Some of the strategies of NPM and managers are blamed by nurses for what they see as a failure to remedy problems in the health system.

> */since the creation of business divisions in hospitals it is all very disjointed…/With individual budgets in departments…there is not a global approach to what is best for the most productive outcomes for patients/hospital/staff…/the perceived lack of long term solutions management and governments seem to be implementing…/Waste money on a bypass plan and don't institute any measures - not thought out…/ I have no faith in managements abilities to see the BIG PICTURE`*(emphasis in original) …/

(2) Working under managerialism.

Many nurses saw disconnect between the rhetoric and the practice of managers, that is, they did not see management "walking the talk".

> */Health service management needs to believe the rhetoric that they give out and implement it, i.e. a whole cultural change is needed…/There is much lip service given (but)…/Management level 4 and up do as they please. Ask your thoughts and opinions and don't follow through…/the buck never stops anywhere…/*

Nurses perceived an explosion in the ranks of management particularly 'non-nursing management' with the consequent rise in meetings and administration generally. They see these trends as unproductive and draining healthcare of resources.

> *…/the growth of administration in the last 20 years…/too many chiefs and not enough Indians…/ I see so many people doing, applying out of 10,000 buckets of money…/ special project officers…health teams who prepare research papers…/ increasing bureaucracy…/growth of administration…they hold the purse strings and set the priorities…new admin and clerical areas while patients waited…/ disproportionate amount (of resources) allocated to higher levels of management/non-clinical aspects of nursing…/Health institutions are becoming top heavy with office workers…/*

Despite the perceived increase in management at all levels there was a strong view that management did not communicate adequately with, nor listen to, nurses' issues, concerns and suggestions.

> */nurses should be seen and heard by management…/unit managers willing to toe the line would sacrifice nurses for bonuses…/after consulting with management and receiving no support…/management expect loyalty…but are not prepared to give it in return…/behaviour of patients…this is rarely addressed by management…/no one in power ever listening to what nurses have to say…/ hierarchy does not respect or value its nurses…/little encouragement…of "job well done thank you"… / little discussion with workforce prior to change in role, working area, equipment…/*

(3) Doing the 'paperwork' of accountability.

Many, many times respondents decry the 'paperwork', especially in the aged-care sector. They reacted angrily to the increase in documentation associated with both certification and audits, and the accountability requirements of the purchaser/provider models of service delivery.

> */too much documentation …/…administrators increase (waste) with all their paperwork…/ drowning in documentation. The documentation and auditing requirements of the RCS are ridiculous and hinder nursing practice…/RCS and accreditation systems place an enormous and increasing burden on staff…/*
> *…we are covering our decisions with intense documentation… / documentation is duplicated and repetitive…/*

The overall dilemma identified for nurses working in the health system is expressed by one nurse who claimed *"I no longer believe the health system supports clinicians".*

'Nursing as a profession'

Respondents to the RN survey were in the main committed to their profession; at the same time they expressed considerable dissatisfaction with their work environment. As one nurse expressed her view, "management play a huge role in degrading the enthusiasm of nurses to continue to care". Many of their experiences reflected the implementation issues associated with working in a health system which no longer reflected, valued or nurtured their professional values.

(1) The 'BUT' of nursing.

Nurses' qualitative responses are reflective of ambivalence towards their current role as professionals as a result of the changes in the health care system described

above. They repeatedly qualified their positive comments with a 'but'. This is well captured by the following;

> */...intention of leaving nursing but I never made it/…I love nursing. But... sadly…/I have enjoyed my career and have been happy to go with change (but)…if I started out now I would not consider nursing/ …I have enjoyed the years I've worked as an RN. However…/I do love nursing or should I say I did love nursing…/*

The tensions between their roles as hands-on patient carers and workers in the NPM health care system are reflected in their comments on 'paperwork'. This tension lessens their self-perceptions of being a 'professional nurse'.

> */I went into nursing to nurse…not lots of paperwork, computer work …/ paperwork…WHERE IS THE TIME TO BE WITH THE PATIENT* (emphasis in original)*…/ accreditation demands…have lessened hands-on time with patients …/the paperwork has taken time away from the patient…/ and the paperwork has increased 'to prove' we have been thinking of patients' needs leaving less time for connection (with patients)…/ I chose (nursing) because I had visions…where I could offer support/compassion...but…/*

The elevation in importance of technical aspects of the job compared with the more traditional carer role was decried by some nurses. This elevation, as with the increase in paperwork, is an expected side-effect of the increased emphasis on measurable outcomes, which is a major focus of managerialism and NPM.

> */too technical or doctor oriented and the basic nursing skills of care being forgotten or haven't time to carry out…/the modern RN is not a bedside nurse but a highly skilled technician... /*

(2) Loss of professional autonomy and compromised professional practice.

There was a dominating theme which goes to the heart of the potential for conflict between NPM, managerialism and a workforce which sees itself as professional and adhering to a view of appropriate professional practice and professional autonomy. We heard the repeated clash between the personal and professional value systems of nurses and the culture of their health care organisations operating in a climate of managerialism. This seems to us likely to probe the deepest vein of discontent.

> */…at the end of the shift feeling guilty that you have not (been able) given people good care …/ my ethics/values differed from those in senior positions…/ care falls short of comprehensive/holistic approach learnt during training… results in feelings of frustration, dissatisfaction, inadequacy…/I entered nursing because I care and I can nurture, however these skills are not valued…/ main stressors for me include…not being able to give my patients great care …/ I was taught problem solving and decision making and ended up having to follow orders from management …/nurses are not involved enough in ethical decision processes…/I left …because my ethics/values differed from those in senior positions…/I now try to continue good health care and pure nursing ethics by keeping people away from*

> *hospital…system fundamentally flawed…/The dilemma associated with providing sub-standard care weighs heavy…/*

For nurses the capacity to provide 'care', 'good quality care' was one issue at the heart of what they saw as the assault on their professionalism. 'Care' in this context is partly bound up with the concept of 'emotional labour' already discussed (Bone 2002, James 1989). It is useful to allow the nurses themselves to define what they understand by 'care'.

> */to sit and talk with patients, to give all-encompassing care, physical, emotional and spiritual…/ where I could offer support/compassion to those in need…/talking to patients and families, hands-on patient contact…/to see people more holistically and not just dish out pills…/ only essential medical/surgical care* (can be given*), falls short of comprehensive holistic care…/ time for good old fashioned 'tlc'. …/find out how your patients feel or what is really bothering them…/*

Nurses in the study understood 'care' to require a holistic approach, providing for the simple physical comforts (hygiene, personal grooming, feeding) for those unable to meet their own needs, and emotional support and understanding in addition to medically determined tasks. This accords with James' (1989 :26) definition of caring;

> "Caring…could be described as having emotional labour, physical labour and organisation as its component parts (James 1987), so that the emotional labour is carried out within the context of the organisation and the physical labour."

The overall call from these nurses is well summed up by the nurse who stated "*we (in health care)have lost sight of the fact that our priority is to give clients/patients the best care possible. "*

(3) Nursing is managed by non-nurses

One of the historical characteristics of a profession was self-management; in the case of nurses, nurses were managed by other nurses. Today this has changed in the health system and nurses are unhappy about the lack of understanding of their profession which has resulted. Nurses perceived that generic management, a strong feature of managerialism and NPM, was not able to encompass an understanding of the needs and issues for nurses.

> */turmoil created by non-nursing, non-medical staff… / Too many non-nursing managers and other admin people telling nurses how to do their work…/the use of generic management …to reduce 'nursing costs' has made most of us resentful of our uncaring administration…/ nursing is now managed by non-nursing personnel … they are only concerned about dollar cost…/ decisions made further up the managerial line which make my working life stressful…/*

(4) Nurse Managers no longer play a professional role.

These nurses were concerned at what they saw as the demise of nursing leadership in the face of the major changes which had assailed them.

> */nursing is divided they need to get their house in order…/there is no longer a clearly identifiable culture or spirit that enables nurses to be unified and forward looking…/support of nursing leaders has been eroded…/very few dynamic contemporary leaders …/ the few highly skilled and knowledgeable nurses in leadership positions are used up…/the system is sick and the leaders absent…/*

They also complain that nursing management positions are lost to management. Issues included loss of experienced mentors at the hands-on level and the absorption of nurse managers into the broader management culture.

> */…The L3 is a combined manager/clerical position and their main job is management…we desperately need L3…who can set standards for others to work to…/a lot of nurses are now in management dealing with budgets, staffing issues, quality issues, OHS…/ CNMs, once they move into this position… become puppets of nursing management, hospital management, CEOs and the Health Department…/*

One of the important issues for nurses was the feeling that no one in a management or leadership position ever expressed appreciation to them, encouraged them or showed understanding of the pressures and stresses under which they worked. In general nurses did not feel supported by or within their workplaces. As one nurse expressed it, there was a "lack of empathy" from management.

(5) 'Customer Focus' rhetoric does not mean better patient care.

The focus on the customer/client is a key element of NPM and Total Quality Management. However the perspective of many nurses in this study is that patient needs are not being met and that, more importantly from the perspective of NPM, the customers are expressing dissatisfaction, sometimes in unorthodox ways. It is notable that nurses rarely used the language of the new discourse hegemony, preferring 'patient' to 'customer' or 'client'.

> */you find yourself everyday doing a catch-up job , no wonder they (our patients) get angry and depressed…/ patients are neglected and complaining… /I quite often hear patients saying their needs have not been met…/There are huge gaps between public expectations and what the health service provides… nurses bear the brunt of peoples' frustrations…/*

Nurses are critical of the impact of implementing cost savings and related financial requirements on what they see as their ability to provide professional and safe levels of care to patients.

> */ closer to profit making 'business' management our workplace becomes the more difficult it will be for us to provide care…/now nursing is all about cost saving and not those in need… /I find private hospitals are only interested in making money for*

their investors. They cut staff to a dangerous level…/ always having to trade off conditions …and still the Health Department and Government bitching over staffing levels /

Discussion of findings:
In this research we followed in the path of other interpretivist researchers who, like Edwards (2002), have sought to share the research participants' experiences and understanding of those experiences. We have sought to "amplify the voices encountered in the research, present them fairly ….place them in context" (Edwards 2002:81)

Four themes emerge from the critique nurses have of their 'vocation' rather than 'industry' and their role as professionals in health workplaces.

(1) Professional dissonance
In essence, the basis for professionalism and the need for the intervention of expert professional judgment (Malin et al. 2002) is the existence within human and social contexts of situations, problems and issues which involve uncertainty; i.e. it cannot be assumed that there is a linear and certain cause/effect relationship for predicting outcomes. Hence the emphasis on professional 'practice', which develops and supports the necessary accretion of information to support expert professional judgment for decision making in uncertainty. With this expert judgment goes the necessity for autonomy in the exercise of judgment and professional accountability for that (Malin et al. 2002). There is very apparent dissonance expressed by the responding nurses resulting from the tension between the workplace processes, roles and accountability requirements ensuing as a result of the hegemony of managerialism, and their own professional values and expectations of appropriate professional practice. This resulted in the nurses expressing feelings of guilt, frustration and inadequacy in regard to the 'care' they provide. We have developed from the nurses voices an understanding of what it is they mean when they talk of 'care' in this context. For nurses 'care' requires a holistic approach to the person, providing the simple physical comforts for those unable to meet their own needs, plus emotional support and understanding in addition to medically determined tasks.

These nurses underline the loss of professional autonomy; "…skills are not valued". They were frustrated by the downgrading of, or inability to, exercise professional judgment; "…not involved enough in the ethical decision processes", "reduced capacity to progress and offer services that might best address community need…". Above all, there is a refrain from the responding nurses that 'care' as they define it is substandard or below the standard they believe appropriate and that they constantly face ethical dilemmas in the decisions the system requires of them. The last word goes to a nurse who described an occasion of health care, concluding "This is very poor care in our society and I am ASHAMED *(emphasis in original)* to be part of it".

The nurses provided evidence that they felt a sense of disarray in the face of challenges to the profession. One recent response from the profession is to seek to rebuild and re-engage its leaders in the debates on healthcare directions in ways similar to the medical profession. The report of the Steering Committee of the West Australian study of nursing and midwifery, (Pinch & Della 2001:7), argued that this will require nurses

> "to be included in strategic decision making, have enhanced career paths and a comprehensive transition from education to practice as well as develop a visionary leadership and an investment in the long term future of the profession."

This is a response which holds to the professional identity and seeks to strengthen it.

(2) Career choice dissonance

The nurses responses provide clear evidence that, in the process of workplace change, the relational or in Bone's (2002) terminology the 'emotion work', which nurses hold as an important part of their role, is neither valued nor given space within the workplace requirements of NPM and managerialism. The workplace dissonance this creates for nurses is very evident from nurses' responses in the RN Survey 2002.

Respondents are very insistent that they went into nursing to provide care. This is consistent with the quantitative data reported in McCabe, Nowak & Mullen (2005). "Ability to help others" and "Ability to work closely with people" are ranked as two of the top three reasons for choosing to be a nurse by the respondents to the RN Survey. These two reasons had similar levels of importance to student nurses (also reported by McCabe et al. and Dockery & Barnes (2005) and were significantly different from the stated reasons for choosing a course by other first year tertiary students. This desire to help others and to work with people has been increasingly at odds with the actual workplace experience of the responding nurses. As one nurse responded "WHERE IS THE TIME TO BE WITH THE PATIENT" *(emphasis in original).* Nurses report their efforts to continue to provide care through unpaid overtime and increased intensity of work. As one nurse expressed, "…you find yourself everyday doing a catch-up job." It is apparent, however, that concern at the decline in the 'care' component of their role is a significant cause of stress to nurses. One nurse expressed it thus: "Main stressors for me include …not being able to provide my patients great care."

(3) Ideological dissonance

Nurses identify a clash between the commercial and clinical cultures in the WA health system. Nurses in this study do not support the use of the profit motive or the commoditisation of health care and to this extent experience an ideological dissonance with their environment. This dissonance is not only evident in the private hospitals and aged-care facilities but also in the public sector hospitals which have imported private sector financial management protocols as a result of government market-oriented reforms. These WA nurses appear to share the view of Barnett and Barnett (2003:45), who condemn the market approaches to the delivery of health care preferring instead that "the ultimate goal of a health system should be the equitable, efficient and effective provision of care, not the profitable sale of commodities".

(4) Resistance to the implementation of managerialism

Nurses in this study clearly felt the burden of several of the elements in NPM and managerialism (Beattie 2000, Baum 1996, Malin et al. 2002) such as quantifiable

outcomes and process focus, responsiveness to cost rather than care, and quantifiable performance-based contracts. They were faced with the implementation of these measures without any apparent capacity to influence the original decisions prior to implementation. They felt even nurse managers were impotent or not supportive. The consequent expressed burden of 'paperwork', 'audit documentation' and too much time on what they perceived as 'administration' was evidence of this. They contrast the rhetoric of reducing waste while observing increasing managerial superstructures. This corresponds with the political analysis by Miller & Rose (1990), where compliance at an atomistic level with the new 'technologies of government' becomes the centre of resistance. Nurses emotionally and professionally resist what Bolton (2004:318) terms "the instrumental motivations of managerialism". In this study there was little evidence of nurses acknowledging benefits of the new management practices. WA nurses clearly felt a resistance to these burdens but, under pressure for compliance, did so at the cost of patient care or through an acceptance of work intensification. This experience reinforced nurses' feelings of powerlessness similar to those reported by Daiski (2004) in a Canadian study. However, this WA study provides evidence that nurses perceive an expansion of the culture of nursing subservience beyond the traditional subservience to the mainly male medical profession (Davies 1995) to the growing hierarchy of non-nursing managers as well.

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