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**Power and Powerlessness:
An examination of nurses' experiences
within the hospital environment**

by

Sharon Miller, R.N., BScN.

A Thesis submitted to
The Faculty of Graduate Studies and Research
In partial fulfilment of the
requirements for the degree of
Master of Arts
in Canadian Studies

Carleton University
Ottawa, Ontario
August 25, 1994

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Experiences within the Hospital Environment"

submitted by Sharon Miller, B.Sc.N.
in partial fulfilment of the requirements for
the degree of Master of Arts

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September 1994

ABSTRACT

In this thesis I have examined hospital staff nurses' experiences of power and powerlessness. Interactive interviews were conducted with ten female staff nurses. The interviews were analyzed from a feminist perspective, employing the theoretical frameworks of both Dorothy Smith and Hilary Lips. In addition, I have analyzed historical and contemporary nursing issues which are relevant to the development of nursing as an occupation which is afforded low status within a hierarchal, patriarchal health care system.

Through the interviews I discovered that hospital nurses frequently feel powerless within their daily work lives, as well as within the hospital, and within the health care system.

I theorize that it is through the development of a collective and a feminist consciousness that nurses will be empowered to take control of and work to change their conditions of labour. As well, empowered nurses will be better able to advocate effectively for their clients/patients.

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I would like to extend special heartfelt thanks to the ten nurses who shared their stories with me. They have provided me with much to think about in relation to my own nursing experiences.

Dedicated to my father

Tom Miller (born Knut Magnus Halberg)
May 30, 1926 - July 13, 1993

who was always proud of my accomplishments as a nurse

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CHAPTER 1: INTRODUCTION

...feminists have argued that no single dimension, whether biological, sexual, economic, psychological, political, or historicist is adequate to explain the origins and persistence of gender hierarchies. Rather they have sought to understand women's situation as a multi-dimensional complex of material and ideological forces, fundamentally structured by power relations. (Maroney & Luxton 1987:1)

INTRODUCTION – THE CURRENT SITUATION

Power is an inherent aspect of all interactions, whether those interactions are between individuals or groups, and even when the power dynamics are not apparent to those involved.

Within the Canadian health care system,¹ power dynamics are evident in relationships between physicians and nurses, between nurse-managers and staff nurses, and between members of other departments and nurses.

Several problems exist within the nursing profession in relation to power. Some of these problems include lack of autonomy in the workplace, low wages, poor working conditions, low level of job satisfaction, lack of feminist or political consciousness, and a lack of sufficient public recognition regarding the importance of nursing to the health care system. These problems have arisen because nursing work, commonly characterized as 'women's work' is devalued. Consequently, there is a devaluation of those who

do the work. The problems within nursing prevent a cohesive effort to improve the work lives of nurses because the nurses are often involved with the material conditions of their day-to-day work lives. These conditions include frequent interruptions and high stress related to the nature of the work (ie. dealing with people who are ill and thus have high physical and psychological needs). For many, the addition of family commitments have created a double workload, leaving them with little or no energy for political activity.

The world-wide crisis of capitalism is having an impact on Canadian social programs. Political leaders have implemented cutbacks to decrease our deficit by targeting these programs, including Medicare. Thirty-five percent of Ontario's budget goes toward health care costs (Bob Rae, Interview, CBC Radio Noon, April 19, 1994). As a result, health care costs have been targeted as one means of reducing the deficit. The financial cutbacks within the health care system have resulted in nursing layoffs. With the ever-present threat of more layoffs and other cost-saving measures (such as 'Rae days', or non-paid work days, in Ontario) nurses are unlikely to assert their power to effect change.

DEFINITIONS OF POWER

Conventional definitions describe power in terms of dominance, or as the influence or control one institution, group or individual may exercise over another (Galbraith, 1983; Lukes, 1974). These definitions are reproduced in mainstream literature as well as in much nursing literature. They reflect the forms of power which have typically been employed and validated in our patriarchal society. These modes of power require the existence of a hierarchical system which facilitates the creation of a hegemony and supports hegemonic control by the more powerful groups over those with less power.

Feminist scholars and activists have endeavoured to re-define power in terms of women's experiences. Their conceptualizations of power center around the empowerment of women and differ from the traditional definitions of 'power over', denoting instead a 'power with' and "interpersonal relations of reciprocity, ability and energy" (Flammang, 1983:37). Empowerment is defined by Gutiérrez as "a process of increasing personal, interpersonal, or political power so that individuals can take action to improve their life situations" (1990:149).

Deutchman (1991) criticizes feminist reformulations of power, stating that they have a "tendency toward

essentialism, an ahistorical understanding of some non-feminist theories of power and some unresolved contradictions" (p.2). Hooks (1984) also criticizes feminist analyses of power. She believes that women do not view power differently from men, because if they did they would have to analyze their own beliefs about power more closely in relation to the need to dominate and to acquire power within the existing social structure. "Before women can work to reconstruct society we must reject the notion that obtaining power in the existing social structure will necessarily advance feminist struggle to end sexist oppression" (hooks, 1984:90). She argues that obtaining power without structural changes will only gain power for a few elite women.

I agree with hooks that women do not necessarily conceptualize power differently from men. However, feminists working toward a more egalitarian society must consider the traditional modes of power relations as they work toward change in the structures which enable the maintenance of the status quo. An understanding of these relations of power is essential to effect change because there will be resistance to any efforts to alter the status quo.

I believe power is found not only in numbers, but in

numbers where each individual has been empowered and has achieved her potential. Empowerment at an individual level enables powerful action as a group. Power is enhanced where group solidarity, based on common goals, exists: when each individual's strengths are nurtured, and everyone achieves her potential.

Ramazanoglu (1989) writes eloquently of the difficulties for feminists in finding common ground when taking into account differences in race, class, culture, and sexual orientation. She writes that:

Since women themselves hold power over other women, empowering women in general will mean some women losing their power over others. Power is not a zero sum game in which one person's gain has to be another person's loss, but where women are divided by class, by race, or by global inequalities, then the empowerment of subordinate women will mean that, for example, dominant, white, heterosexual, middle-class women will lose their superiority in relation to their categories of women. Putting the strategy of empowerment into practice raises uncomfortable problems for feminists (p.178).

The acquisition of power as a means of being *equal with men*, again, the desire for equality with those who are considered to hold a higher position in the hierarchy (generally white men), has been considered problematic (hooks, 1984; Ramazanoglu, 1989). In the case of nursing, nurses must challenge the system within which they are both validated and oppressed. In doing so they must collaborate with other groups within the system to ensure power is not

acquired at the expense of other less powerful groups.

The nursing literature reviewed for this thesis revealed little discussion of racism, homophobia, anti-semitism, or other oppressions which nurses face from peers, superiors, and patients.² An analysis of these issues should be central to all feminist research. However, this is even more important for nursing, given that the majority of nurses in Ontario are white, middle class, heterosexual women who care for a diverse group of individuals, including people of different sexual orientations, races, ethnicities, and religious affiliations. Nurses must challenge the ideologies which perpetuate all forms of oppression if they are to achieve their full effectiveness as caregivers.³

POWER ISSUES IN NURSING

Historically, nurses have struggled to assert themselves through changes in educational requirements⁴, by attempting to define nursing work as independent of physician control, and through the assertion of their right to control their own work⁵. Despite these struggles, nurses have not been successful in establishing a firm power base. Two reasons proposed for this are that

(1) nursing is and has been a woman-dominated profession and considered to be the epitome of women's traditional role; and (2) the health care system has evolved as a paternalistic one, suppressing the development of nursing and jeopardizing the quality of health care (Stevens, 1983:3).

Nurses' desire for more power embodies a desire for more autonomy, less physician interference, and more collaboration amongst health care workers. The nursing profession has endeavoured to augment nurses' power through: registration requirements; attempts at enforcing a university degree as the mandatory level of education for entry to practice in nursing; and efforts at distinguishing Registered Nurses from other groups who are considered 'nurses', such as Registered Practical Nurses or health care aides. In seeking more power, nurses have adopted strategies of power which perpetuate the status quo. This only serves a minority of nurses, those at the top of the nursing hierarchy. Instead, I believe it is imperative for nurses to embrace new paradigms of power relations. These new paradigms must value the contribution of each individual, enabling a sharing of power and, ultimately, the empowerment of all nurses. Only when individuals with the lowest status within the existing hierarchy have been empowered, will the nursing profession as a whole be truly powerful.⁶

The desire for power for nurses has not been carefully

analyzed from a feminist perspective. Nurses want more power, but the definitions of power which have been expressed within nursing discourse are those which have been the mainstay of mainstream theories of power, which were discussed above.⁷ These theories of power have been formulated on the basis of analyses of the patriarchal structures which exist in society, the maintenance of which has proven harmful to women (Ashley, 1980; Lovell, 1981; Mulligan, 1983; Malloch, 1990; Watson, 1990). Given this, the construction of new theories and new means of exercising power are imperative. Several feminist theorists, including Janeway (1983) and Lips (1991) have de-constructed mainstream theoretical perspectives on power. Janeway examines power as a process between two groups she defines as the 'powerful' and the 'weak'. She writes that the 'weak' possess power, but that "...the powers of the weak are more limited and thus somewhat less likely to carry the groups that practice them beyond the bounds of common benefit" (1983:157). She describes two powers of the weak as 1) 'disbelief' or questioning of what the rulers tell them; and 2) the ability to 'come together', working as a group to change the status quo. Lips' theoretical analysis of power will be used later as one of two frameworks for this thesis and is described later in this chapter. These

theorists have begun the complicated task of examining the meaning of power to women and the construction of new theories.

The struggle to gain power and autonomy for nurses has been and will continue to be fraught with resistance from other groups within the health care system, but especially from physicians, who have been dominant for so long. A current example of their resistance to nurses' autonomy is exemplified by the recent media reports about the Ontario Government's decision to restart the Nurse Practitioners program. The media reports center around the doctors' fear that nurse practitioners would be allowed to practice independently, rather than as a part of a team which includes physicians.⁸ Cohen (1992) writes that "the dominant forces in American society -- a white corporate patriarchy -- would perceive autonomous and assertive nurses as threatening to their hegemony" (p.114). A more detailed discussion of physicians' domination of the health care system will follow in chapter two.

As a result of the crisis in capitalism referred to earlier, politicians and health care administrators have made choices regarding health care budgeting. These choices include the de-listing of various medical procedures (such as wart removal and IVF under certain circumstances) and the

closure of a number of beds in various facilities. A reconstruction of the health care system is necessary in order to maintain the standard of health care to which Canadians are accustomed, while at the same time ensuring cost-control. This reconstruction must improve the quality of health care as well as the work-lives of those who provide the care. In Second Opinion, Michael Rachlis & Carol Kushner outline several ways to improve the health care system. Their suggestions include increased nursing autonomy as central to cost-saving/improved health care measures. Further discussion of means of reconstructing the health care system is beyond the scope of this paper.

Nurses, who constitute the majority of workers within the health care system, must be at the forefront of this transition, involving themselves in strategizing for the future, using their expertise in the promotion of health and healthy communities as a focal point for change. Stevens (1993) writes that

It is imperative for nurses to exercise power in order to realize their full professional potential and maximize their contributions to health care and society at large. Clearly, nursing is at the center of health care, and from this vantage point nursing enjoys tremendous potential to change the health care system to the advantage of both health care providers and consumers (p.3).

Utilizing a feminist, holistic perspective would enable

nurses to lobby for a reformed health care system in which women are empowered, both as users of the system and as workers within it. As Canadians struggle through this transition period, many questions must be answered, including whether hierarchal structures are necessary, and who will be the gatekeepers for this system.

In order to participate in the reformation of the system, nurses must increase their power-base, both individually and collectively. Unless they do so, they will be unable to have an impact on the inevitable transitions. Within the hospital environment, a cohesive and powerful nursing body would have a considerable impact. One of its effects would be the ability to advocate more effectively for both clients and themselves. They would be able to work together more efficiently to transform the bureaucratic structure of the hospital into one that is more user-friendly.

This, however, is an idealistic view. The reality is that despite numbering over a quarter of a million (see Appendix A), Registered Nurses in Canada have little power within the health care system and within society at large, either as individuals or as a group. The operation of the system as a hierarchy which has historically been dominated by male physicians (Ashley, 1976; Coburn, 1981; Melosh,

1982) has prevented the development of nursing power.⁹ Nursing power is the power to act autonomously with regard to nursing care. This includes collaborative work with the other members of the health care team, and it requires an acknowledgement by the team of nurses' knowledge and assessment skills. Nursing power is not 'power over', but rather 'power with'. It combines "leadership with informed consent, authority with social responsibility. We can see ourselves as part of an ethical polity where power is understood to mean reciprocity, ability, and energy (Flammang, 1983:74)."

Nursing's lack of power is related to the devaluation of nursing vis-à-vis several factors, including the labelling of nursing as women's work. This label has been applied because nursing in Canada has consistently been a female-dominated occupation, with only 3% of the work-force being male (Statistics Canada, 1991). As well, perceived and actual similarities with house-work and mother-work have contributed to this identification with 'women's work'¹⁰.

The above factors have added to the undervaluation of the contribution of nurses and nursing to the maintenance of a healthy society. Nurses, whose education is science-based, provide services that are essential to the promotion, maintenance, and restoration of health and well-being (The

Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health, 1987). Quality nursing care is an essential component of this process.

As a result of their relatively powerless position within the hierarchy, hospital staff nurses have not been able to achieve their true potential, either as individual caregivers or as a collective. Nurses must work to reject imposed identities which prevent them from achieving agency.

PURPOSE AND THEORETICAL FRAMEWORK

In this thesis I will examine power and powerlessness in hospital nurses' work lives from a feminist perspective. I will incorporate varied theoretical perspectives derived from both the literature and from personal experience.

In Ontario, the title 'Registered Nurse' refers to those who are registered annually with the College of Nurses of Ontario (CNO), a quasi-governmental body. The largest percentage of nurses work directly with patients in hospitals and are usually called staff nurses. Staff nurses or 'bedside nurses' in Ontario will be the focus of this thesis and will be referred to as 'nurses'. Nurses in Ontario constitute nearly a third of the total number of nurses in Canada (see Appendix B, Table 5). Nursing has been officially recognized as a profession by the state

through legislation, including Bill 43, known as the 'Regulated Health Professions Act'.

In chapter two, I will review the complex, historical foundations of nursing and the health care system in order to illustrate how nursing came to hold its current position within the health care hierarchy. Ten nurses were interviewed for this thesis. Their analysis of the power relations in their workplaces and within the organizations which represent them will be detailed in Chapters Three and Four. In Chapter Five I will outline the means by which nurses can obtain more power.

Cohen calls for

...the need for explicit consideration of status and power issues in nursing research, in theory, and at all levels of nursing education and suggests, as have others, that the concept of power is one that has been too long overlooked by nursing educators, authors, theorists, and researchers (p.113).

This consideration of power issues involves an analysis of the material conditions of nurses' work while acknowledging the power dynamics that have developed as a result of the institutionalization of health care and the resultant development of a hierarchy of care.

An examination of the structure and purpose of nurse-work involves of necessity an analysis of the construction of the health care system. Given that the overwhelming

majority of Canadian nurses work in hospitals (72% in 1989-- of these, 72% work as general duty staff nurses -- Sedivy-Glasgow, 1992) the analysis will concentrate on this aspect of the health care system (see Appendix B). The percentage of nurses in Ontario who work in hospitals is slightly lower (70%) than the figure for Canadian nurses which Sedivy-Glasgow quotes.

My objectives in completing this research are twofold. First, I want to add new information to the existing body of knowledge regarding women and power, specifically, nurses and power. This information will be useful in terms of building on existing feminist research related to women, work, and power. Secondly, I am hopeful that nurses who read this thesis will see themselves in the words of the nurses quoted here, and the seeds of a collective consciousness may be sown. The awareness of common problems may ignite a desire to work together toward change in their daily working conditions as well as in the broader health care system.

Positive change in the structure and organization of nursing and nurses' work can only originate from within the ranks of nurses, and this change will not occur until a new consciousness has been awakened.

Feminist research by nurses about nursing issues

is vital to the development of a feminist and group consciousness. It is also essential to the development and maintenance of a strong collective identity because a central focus of feminist research entails the identification and analysis of common experiences.

Feminist researchers must also work to deconstruct the barriers between research and practice, creating feminist praxis. Hooks (1991) writes that "We must continually claim theory as necessary practice within a holistic framework of liberatory activism." My responsibility as a feminist researcher includes sharing information with other nurses.

My analysis of nurse's power will be guided by the work of two feminist theorists. Neither of these theories by itself is sufficient to the analysis of power within nursing. However, through the intersection of these frameworks, the experiences and analysis of nursing power can be evaluated.

The first framework is Dorothy Smith's method of sociological inquiry known as institutional ethnography. This method of inquiry explores the "everyday world not in itself but as it is articulated to the social relations of the larger social and economic process" (Smith, 1986:6). Women are acknowledged as subjects whose experiences within

a local context must be analyzed vis-à-vis social relations within a broader context, which Smith (1986) labels the 'national' and 'international'.

In interpreting Smith's paradigm I will utilize the unit/ward on which the nurses work to represent 'local'; the hospital to represent 'national'; and the Canadian health care system to represent the 'international' component of the analysis.

Smith (1986) outlines three procedures involved in conducting studies using the method of institutional ethnography. The first involves an analysis of the ideological framework which determines the action of the group within the study. The language and concepts which are particular to a group must be also be examined. Within the everyday practice of nursing, specialized 'scientific' language developed by educators, theorists, and managers, as well as by other health care groups, is utilized to transmit information. This language ensures only those within the group and those associated with it are privy to the information. This use of specialized vocabulary can increase a sense of control over the working environment, but the reverse can also occur because much of the language is imposed and changes frequently, thereby creating a feeling of powerlessness amongst nurses, who are legally

obligated to update their knowledge. As a result, "the work and practical reasoning of individuals and the locally accomplished order that is their product become an expression of the non-local relations of the professional and bureaucratic discourse of the ruling apparatus" (Smith, 1987:162).

In the second stage, an analysis of the work processes enables us to

...engage with the ways in which people are actually involved in the production of their everyday world, examined with respect to how that world is organized by and sustains the institutional process (Smith, 1987:166).

This analysis is carried out within the context of the ideological framework of the institution as a means of deconstructing that ideology. Several ideologies function within the hospital, including the ideologies which drive the increase in technological medicine and the ideologies upon which the 'helping professions' are based.

The third stage involves an analysis of the social relations of work, whereby individuals enter into a system which is larger than the sum of its parts, as their work becomes a fragment of the work processes which enable the institution to function (Smith, 1987:167). Nursing work, while not an industrial production line, has been deconstructed into fragments by the development of workload

management or 'patient classification' systems which have been adopted by many hospitals." These systems result in the depersonalization of both patients and staff, who are represented by numbers. Nurses have no input into staffing for their unit, which is based on the numbers derived from daily calculations of patient-care hours.

These three processes involve the complex relationship of individuals to their work, within the constraints of their individual nursing unit (local), as well as the broader analysis of how this work is organized within the context of the hospital as a system (national) and the health care system as an institution (international). I will use these processes throughout this thesis as a means of providing the broader theoretical framework upon which my analysis of these structures will be based.

The second framework I will be using is based upon Hilary Lips' (1991) analysis of power. This framework provided me with a template for the analysis of the relations of power within nursing, derived from both the literature and the interviews. Lips delineates power into three dimensions: personal power, collective power, and institutional power. Personal power can include the nurse becoming more assertive in her relationships within the hospital hierarchy; collective power may develop within the

workplace as individual nurses recognize the power of numbers, developing a group consciousness, and working together to promote change which is beneficial to all nurses; institutional power is inherent within the structure of the health care system, and it includes roles that individuals hold within institutions, and how the structuring of the roles within the hierarchy works against changes in relative power positions. These three dimensions of power intersect within the daily aspects of a nurse's work-life. This theory will be used to analyze the power relations within nursing.

In Chapters Three and Four I will utilize information gathered through my interviews with the nurses to provide insight into the inner workings of the institutions of the hospital and the health care system as a means of analyzing power and power relations. The nurses' words provide a subjective analysis which is one of the bases of feminist, qualitative research. Analyzing subjective data exemplifies the feminist principle that the 'personal is political', that "systems and social structures, whether concerned with the economy, the family, or the oppression of women more generally, can best be examined and understood through an exploration of relationships and experiences within everyday life" (Stanley & Wise, 1983:53).

There are several groups within the health care hierarchy over whom nurses have power who will not be included in this discussion. These include Registered Practical Nurses, Nursing Assistants, Health Care Aides, and Orderlies. With the exception of orderlies, all the other groups are predominantly female. A discussion involving these groups would extend beyond the scope of my study.

Another group over whom nurses have power are individual patients and their family members. This aspect of nursing power will not be explicitly analyzed in this thesis as it would be an entire thesis in itself, but it will be included within the context of general nursing power.

LITERATURE REVIEW

A review of the literature reveals an abundance of articles, book chapters, and entire books devoted to the analysis of power, from various theoretical and ideological perspectives. The majority of the nursing literature reviewed reflects a mainstream analysis of power. However, a few authors have explored power within nursing from a feminist perspective.

Several nurse authors define power in terms of control or authority, or as the ability to make others do something

(McFarland & Shiflett, 1979; Sandford, 1979; Stevens, 1983). Power is also described as a vital resource which can be a source of order but is susceptible to corruption and as "dynamic and constantly changing with regard to quantity and to form" (Votaw, 1979:52). Stevens (1983) advocates the development of power for use "within the nursing profession, in the total health care field, and in society at large" (p.7). Much of the discussion about power in nursing relates power to political involvement: if nurses become more politically aware, they will have more power (Stevens, 1983; Kalisch & Kalisch, 1982; Votaw, 1979). Further to the mainstream perspective, several nurse authors blame nurses for their lack of power, (Stevens, 1983; Ashley, 1979). As Stevens (1983:5) writes "...the nurse accepts this traditional role. In some respects, it is comfortable to maintain this role because, in holding to the status quo, the nurse remains in a low-risk situation with little accountability." Despite her feminist analysis, Ashley (1979) also blames nurses, writing that nurses have used their power to collaborate with the system that oppresses them and have become merely the means of production within the health care system. Their labour is used to keep the health care system operating smoothly.

What is the source of nursing power? Ashley (1979)

believes that nursing power derives from society's recognition that nursing is an essential service. She also believes that physicians recognize the potential power of nurses and are aware that they must control them, both intellectually and socially. One of the physicians' strategies to control nurses was to develop criteria for "professional" status. These criteria were based on themselves (ie. the medical doctor), and excluded nurses (Ashley, 1979). Other sources of nurse-power include the power of numbers, the power of knowledge, and the power of pride (Diers, 1978).

Diers (1978) advocates the development of nursing power as a means for nurses to take over the health care system in order to expedite the revision of both health care and the health care system. One of the problems presented as a barrier to the development of nursing power is a lack of unity (Christensen, 1990; Diers, 1978). In contrast to this, Hansten (1992) views power as collective and based in nursing expertise. The development of this expertise can lead to change within the health care system.

Christensen (1990:28) describes nurses as powerless "within the male-dominated system in which they work-- a system that makes nurses responsible for much of what happens but gives them little power to control the decision-

making process."

No race/class analysis was included in any of the articles, nor did any of the articles reflect the perspective of the rank and file nurse. One author (Diers, 1978) advocates a concentration on similarities rather than differences in order to conserve nurses' energy. However, our differences must be considered in order to develop a broader, feminist analysis within the discourse of nursing and power. To accomplish this, nurses must evaluate their position within the health care/hospital hierarchy and must develop strategic plans of action.

CONCLUSION

Through this Introduction I have outlined several of the problems faced by nurses and the nursing profession. During the remainder of this paper I will outline nurses' analyses of power issues and some of the means by which they believe the problems can be remedied and nurses can become empowered.

ENDNOTES

1. While many people equate the health care system with medicine, this is only one aspect of the complex system which comprises various therapeutic modalities, including nursing.

2. I was unable to find any work done which related to the Canadian context. Power in caring professions (Hugman, 1991) devotes an entire chapter to racism within the health care system in the United Kingdom, locating it within the context of white racism throughout Europe. Black Women in White, documents the struggles of Black American women to become nurses and clearly outlines the racism they experienced (Hine, 1989). Again within the American context, Melosh (1982) writes that nurses were predominantly white and also briefly outlines the exclusion of Black nurses from the American Nurses Association, resulting in the subsequent formation of the National Association for Colored Graduate Nurses.

3. Kim Bernhardt, a research officer with the Ontario Nursing Association writes that some ONA locals have "an estimated 35 to 45 per cent non-white population" (1993:10). However, few women of colour have held positions of authority within the upper echelons of the various nursing organizations.

Hospital schools of nursing in Ontario refused admittance to black women until threatened with financial repercussions in 1947. These threats resulted in the acceptance of "the first known black student into Ontario nursing school" (Bernhardt, 1993). Any woman who graduated from a school of nursing and passed the registration examination was allowed to register with the Canadian Nurses Association. Any racial biases which existed would have been at the level of the individual school, which could have denied entrance, or at the level of the hospital, which could have denied employment to any nurses who were not white.

4. The Canadian Nurses Association and the Registered Nursing Association Of Ontario both advocate and support the move to have a baccalaureate in nursing as the criteria for entry to practice by the year 2000. The Ontario Nursing Association does not support this. See Ontario Nursing Association (n.d.) Positions on Entry to Practice. Toronto: Author.

5. This is embodied in the efforts by nurses to establish nursing as a profession. See for example Gamer, M. (1979); DeSantis, G. (1982); Hammond, M. (1990).

6. This idea was discussed by Angela Y. Davis in the film 'Speaking of Nairobi' (1986). Dir. Tina Horne. An NFB Production. It is an idea that I have incorporated into my own belief system as fundamental to any challenge to the status quo.

7. See for example, Claus, K. & Bailey, J. (1977); McFarland, D. & Shiflett, N. (1979); Kidder, C. & Gruending, D. (1989).

8. See "Plan to increase nurse practitioners upsets Ontario GP's". Sat. Feb 12, 1994. The Globe & Mail:A5; and "Ontario doctors alarmed over nurses gaining more power". Sunday, February 13, 1994. The Ottawa Citizen:A10.

9. In Canada, the first hospitals were founded by religious orders and lay women. Physicians did not acquire control of hospitals until after 1900 (Coburn, 1981). The case is different in the United States where physicians began to build and control hospitals after the demise of the Popular Health Movement in the mid 1800's (Ashley, 1976).

10. For a detailed analysis of nursing work as house-work and mother-work see Murphy, R. (1988).

11. For a discussion of the analogy of hospitals to industry, see George Torrance (1987) "Hospitals as Health Factories". For a discussion on patient classification systems, see Marie Campbell (1983) "Managing Professionals: Analysis and Critique of Contemporary Document-Based Methods in Nursing" & (1988) "The Structure of Stress in Nurses' Work."

CHAPTER 2: LAYING THE FOUNDATION: FROM HISTORICAL PERSPECTIVES TO MODERN TIMES

INTRODUCTION

In this chapter I will provide an overview of the historical development of nursing. Knowledge of the history and the evolution of nursing and of the health care system in Ontario and in Canada is essential to an appreciation of the existing situation of nurses vis-à-vis the hierarchy of power within that system.

The development of nursing as a sex-segregated and race/class biased occupation can be better understood within the context of a society which was itself biased. For the past several centuries, caring and healing were viewed as being solely the business of women. Some examples of women's resistance to the organization of modern health care as a system dominated by men will also be discussed.

I will also examine the relationship of nursing to the feminist movement. Much of this will relate to the American situation, which is more abundantly documented than the situation in Canada. Parallels exist in the development of Canadian and American nursing as a result of the influx of nursing literature from the United States. Nursing theories have been predominantly developed by American nurses and

there is an influx of American nursing journals into Canada. Both of these have influenced Canadian nursing.

The lack of an articulated feminist consciousness amongst the majority of nurses prevents an incisive, cogent analysis of women's status. The development of a feminist consciousness would enable the empowerment of women and would become a catalyst for change. The adoption of a feminist ideology "...will encourage nurses to exercise power and assert their rights as equal participants in the health care community" (RNAO, n.d.:23).

THE DEVELOPMENT OF 'MODERN NURSING'

Florence Nightingale is credited with the founding of 'modern nursing' in England in the mid-nineteenth century. Many of the ideas which formed the basis for her approach to nursing were developed during her time spent with wounded soldiers during the Crimean war. Before hospitals were cleaned up and re-defined, they were places where the poor went to die. They were considered death-houses and the women who nursed there were considered "too old, too weak, too drunken, too dirty, too stolid, or too bad to do anything else" (Bryant & Byrne, 1990: 154).

Nightingale established a school of nursing at St. Thomas' Hospital in England in 1860, based on a classist

apprenticeship system, which endeavoured to recruit middle class women who had a 'proper upbringing' to the nursing profession. These nurses had to possess "the four cardinal virtues of domesticity, submissiveness, piety and purity" (Bryant & Byrne, 1990:p.153), which are the characteristics possessed within the:

'Cult of True Nursinghood: The Nightingale Nurse', the ideal lady transplanted from home to hospital. Wealthy prominent women and nursing pioneers embraced a Christian belief system which lent an aura of sanctity to the care of those in need, molded trainees into ladies and legitimized the evolution of nursing into an acceptable vocation for women.
(Bryant & Byrne, 1990:p.154).

Frequently, schools of nursing in Canada were established using Nightingale's rigid standards for nursing conduct. These standards were used to mould nurses into 'proper' ladies. Many of her ideals for nursing conduct have now been replaced by more modern ones, which are reflected in standards and ethical codes for nursing as well as in legislation which pertains to nursing. However, the rigid standards she set with regards to ladylike behaviour continue to be communicated to nursing students in hospital-based schools of nursing, which still exist in some areas in Canada, such as Nova Scotia.

Through the development of nursing in the Victorian age, several ideological constraints were imposed on nurses, including the ideologies of femininity, of sacrificing

mother, and of professionalism. These ideological constraints have been fundamental to the development of nursing as it currently exists.

The bourgeois ideology of femininity, which constrained women's work outside the home to work which could be categorized as homemaking, sought to prescribe a complementary set of acquiescent female attributes to nursing work. As long as women's work was defined as an extension of her role in the private sphere, adequate remuneration was not considered essential. Florence Nightingale, the mother of modern nursing, greatly influenced the development of nursing when she wrote that:

Nursing is distinctly woman's work...women are peculiarly fitted for the onerous task of patiently and skilfully caring for the patient in faithful obedience to the physicians' orders. Ability to care for the helpless is women's distinctive nature. Nursing is mothering. Grownup folks when very sick are all babies.

Nightingale (1905) as quoted in Gamarnikow (1978:110)

The ideology of nurse as mother is an extension of the model used to describe the relationship between physician, nurse, and patient, whereby the nurse acts out the role of wife to the physician and the patient is viewed as the child. "Like mothers in a household, nurses were responsible for meeting the needs of all members of the hospital family--from patients to physicians" (Lovell,

1982:211). Christensen (1990), a journalist who at one time was a member of the Board of Directors of the Canadian Nursing Association, writes that nurses have an "image problem" and are seen only as caregivers -- motherly, caring, hardworking -- and as handmaidens to physicians.

The third constraint imposed on nurses was the ideology of professionalism, which purported to elevate nurses above their working class status, but which included many edicts as to how to behave (Coburn, 1981). This will be discussed further in Chapter Four in relation to union activity.

As long as nurses internalize the ideologies which are perpetuated as a result of patriarchal control of media, educational, political, and legal systems, their development as powerful practitioners will be thwarted because these ideologies are antithetical to feminist analyses. Feminism is important to the analysis of nursing work because it lends itself well to analyzing the material conditions of women's work, including both domestic work and work in the public sphere. Feminism also enables a broad spectrum of analyses of the causes of women's condition and the means of overcoming oppression without oppressing others in the process.

THE CANADIAN CONTEXT

The development of the Canadian health care system has been controlled mainly by men, including physicians. Historically, women's role as healers was labelled inferior and relegated to the sphere of private domestic duty, while men's role as physicians was relegated to the public domain. Physicians' work was seen as scientific and, therefore, superior. From this came the falsely dichotomized 'care/cure' ideology, which has formed the basis of the division of labour between medicine as 'men's work' and nursing as 'women's work' ever since.

The first hospital in Canada, the Hôtel Dieu at Québec, was established in 1639 and was staffed by French Nursing Sisters who belonged to the Augustinian Hospitaller order. As early as 1659, the nurses, who were all members of religious orders, were advised by Vincent de Paul of "the necessity of obedience to the physician" (Gibbon & Mathewson, 1947:4). Conformity has been described as "...a sacred tenet in the field" (Smith, 1985:62).

While nurses were (and still are) expected by their employers to conform to certain standards of conduct within the hospital hierarchy, they are also expected to challenge that authority at times when it could be harmful to the patient. This double standard, requiring both submission to and the challenging of authority, especially with regard to

physicians' orders, has led to a form of communication known as the 'Doctor-Nurse Game', whereby nurses communicate their solutions to patient problems to physicians without appearing smarter than them. This manner of communication serves to protect the physician's ego and to reinforce the power relationship (Stein, 1967).

Canadian hospitals developed by utilizing the unpaid or poorly paid labour of women. This included both nuns and laywomen. They worked long hours under terrible conditions. They were often expected to live in the hospital with the patients, and frequently contracted their diseases, becoming ill or dying (Gibbon & Mathewson, 1947). The first Canadian nursing school based on Nightingale's philosophy of nursing, The Mack Training School for Nurses, was founded in 1874 in St. Catherine's, Ontario. The school was founded by a physician and, like all the other schools of nursing, was developed as a means of ensuring a pool of cheap labour for the hospital with which it was associated (Coburn, 1981).

For room and board and an occasional small stipend, the women who enrolled in nursing schools were promised a nursing education. Instead, they discovered that they were expected to work twelve to sixteen-hour shifts, six or seven days a week. Classes were usually held in the middle of the shift or at the end of the shift, if indeed there were any classes

at all. Many of the women were also hired out to private duty cases as a means of supplementing the income of the hospital, while being told that it was to further their education. The hospital schools depended on the free labour of the students for their very existence. Upon graduation, only the rare nurse was hired to work in the hospital, usually as a supervisor. The majority of nurses, however, could not find work in hospitals and had to seek work in private duty (Ashley, 1979; Melosh, 1982; Gibbon & Mathewson, 1947).

It was much easier for physicians and other hospital administrators to control a constantly changing pool of labour. The students were young and eager to become nurses, and were likely willing to deal with tremendously difficult working conditions for the period of their education. Most of them were probably too exhausted to consider organizing to change their working conditions.

Graduate Nurses, on the other hand, were able to organize, forming the Graduate Nursing Association of Ontario in 1904, and, in 1908 founding the Canadian Association of Trained Nurses (which later became the Canadian Nurses Association). The development of institutions which solidified associations between nurses (albeit the élite Graduate Nurses) was a remarkable feat.

The institution of health care has been described as "a hierarchy of healing occupations and professions under a dominant medical profession; hospitals as key institutions; public health, industrial health and environmental legislation; specialized organizations for the training and socialization of health workers" (Torrance, 1987:7). Within the hospital organization, directors were, and still are, predominantly male. Of twelve hundred chief executive officers in Ontario health care institutions today, only forty-seven (3.9%) are female (Lowi, 1994).

While the initiative of laywomen was often responsible for the development of new hospitals in Ontario, these women were not found on the Boards, but instead were the Matrons, or formed the Ladies' Auxiliary. Thus, they were only located on the periphery of the decision-making processes.¹

Physicians' dominance in the health field has resulted from their association with university education and their social and political connections.² Medical hegemony persists because of what Torrance (1987) describes as "strategic accessories". These include "mandatory medical signatures on death certificates, mandatory appointment as public health officers, sole access to hospital admitting privileges, exclusive right to prescribe drugs" (p.7).³

While physicians make medical diagnoses, nurses make

nursing diagnoses. However, nobody except nurses generally utilize these diagnoses for planning care unless nurses bring them to the attention of the physician or other health care groups. Nursing diagnoses are not included on admission forms.

An end to the exclusion of women from positions of power will be a lengthy process as government and other organizations begin redressing the balance. Within nursing, pay equity has endeavoured to ensure that women receive equal pay for work of equal value. But financial redress is only the first step. Obtaining positions on Hospital Boards and Boards of other organizations must be a part of this process. Recent legislation in Ontario mandated a nursing presence on all hospital committees that were previously closed to staff nurses, including vital committees such as the Fiscal Advisory Committee. The process has begun. To facilitate the change process, nurses must develop their analysis and skills.

NURSING AND FEMINISM: TWO WORLDS APART

Historically, nursing involvement in the feminist movement has been sporadic. In the United States,⁴ the American Nurses Association refused to endorse the suffragette's battle to gain the vote until 1915, forty

years after the battle had begun. They also refused to support the Equal Rights Amendment until 1970, adopting a Conservative feminist stance, which argued that different laws were necessary for men and women because of biological differences (Bunting & Campbell, 1990).

Nurses are just now beginning to enter "the feminist reality that other women recognized fifteen to twenty years ago. To make your voice heard in the workplace, in the political life of Canada and everywhere there is power, you need to have influence. You need to adopt the feminist's attitude toward assertiveness training, consciousness-raising -- to develop and sustain your self-assurance and increased awareness of and pride in your glorious past" (Christensen, 1990:29).

While individual nurses may have embraced feminist ideology and praxis, a tension between feminists and nurses has been a reality of the second wave of the feminist movement. Nurses were marginalized and silenced in the early years of the second wave in much the same manner that stay-at-home mothers were silenced: many feminists in the second wave wanted to divorce themselves from female job-ghettos such as nursing (because they were viewed as stereotypically female occupations), and fought instead to enter male-dominated professions such as medicine and law.

"In the eagerness of some women to embrace new roles has come a denigration of old ones...no one with brains should want to be just a nurse" (Muff, 1982:178).⁵ Nurses were considered second-class citizens, handmaidens to physicians, and conspirators in the perpetuation of the patriarchal system. It will be an onerous task to empower nurses to feel pride in their accomplishments and to educate other women to nursing's colourful and political past, while deconstructing the image of passivity and obedience with which nurses are viewed. However, I believe it is absolutely essential if nurses and nursing are going to survive.⁶

The initial stages of the second wave of the feminist movement failed in their analysis of nursing, blaming women instead of the patriarchy for women's limited career choices, (ie teaching, nursing, secretarial work, or motherhood), thereby alienating nurses who liked and desired nursing as a career as well as nurses who may have had no other options available to them. As women attempted to break free from their own oppressions, they became angry with those who appeared to be deeply entrenched in patriarchal work relations. This blaming of one's own group (in this case women blaming other women) is a common characteristic of oppressed groups. The group comes to

identify with the dominant group, internalizing their own oppression, and consequently, become perpetrators of the same oppressions against their own group (Muff, 1982).

Keddy (1993) writes that

Until feminist research, theory, and practice become central to the profession's ideology, nurses will continue to be divided among themselves, unable to provide the necessary caring for one another (p.287).

Nursing embodies many of the characteristics associated with femininity, including caring, nurturance, and obedience. The maintenance of an ancient tradition of caring within the framework of patriarchal work relations has contributed to the impression of collusion with patriarchal gender relations. Eisenstein (1982:102) describes femaleness as being inextricably associated with "second-class status with the willingness to be less powerful than and placed under the authority of a man." These characteristics were, and to some degree still are, considered traits possessed by "good" nurses. Dependent, passive nurses continue to be produced through the current nursing educational system (Kagan-Krieger, 1991).

IMAGES OF NURSING: THE INTERNALIZATION OF OPPRESSION

The low value accorded nurses and nursing by society is exemplified by media images which depict nurses either as

dumb and at doctors' beck and call--as frequently seen in soap operas; as cruel and vindictive, such as Nurse Ratched in "One Flew Over the Cuckoo's Nest"; or as sexually active and available at all times, such as "Hot Lips" Houlihan and the rest of the nurses in the television program M*A*S*H, which aired for eleven years.⁷

Nurses are exposed to the same media images as everyone else, internalizing the same negative messages. They may come to view themselves and their peers as objects of ridicule and scorn, thereby becoming reluctant participants in their own oppression. The following story, related to me by a friend, provides an example of the impact media messages can have on nurses.

I had a friend who was a nurse and I remember we were watching the 'Brady Bunch' one night and the daughter in the family wanted to be a doctor, and didn't get in. So her father said she could still always be a nurse. She said 'I don't want to be a nurse, anyone can be a nurse.' And it was at that moment that her friend decided she was leaving nursing and by the following September she was in law school.

Another example of nurses' internalized oppression is their overwhelming reluctance to recommend nursing as a career. A survey, quoted in December 1991 on TV Ontario's health show "Lifeline", revealed that more than half of the nurses surveyed would not recommend nursing as a career and that over half of those were considering leaving their current job. These numbers certainly reflect a high level

of disillusionment.

Nurses have been described as an oppressed group (Roberts, 1983). Nurse-work is often characterized as encompassing elements of mother-work, wife-work, and house-work (Murphy, 1988), which includes the 'feminine' characteristics of empathy, patience, nurturance, and warmth. With the added burden of the label "caring" profession, it is doubly devalued as women's work, and, therefore, regarded as non-productive. As a result, the end "product" of nursing -- an individual who has been empowered by nurses and has achieved her/his optimum level of functioning (or has achieved a peaceful death) -- is not recognized for its true value. This work remains largely invisible. Additionally, the work of nurses is devalued and not regarded as work because it is done by women. It is viewed as women's work, with the "womanly" characteristics such as empathy, patience, nurturance, and warmth considered essential to the job.

In order to gain power, oppressed group members may believe they have to become like the oppressor (Roberts, 1983) by internalizing the beliefs of the dominant group and incorporating aspects of their behaviour into their practice. One visible behaviour copied by nurses has been the carrying of stethoscopes around their necks, like

physicians are often pictured doing, thereby exhibiting a symbol of higher knowledge. Within the culture of nursing, there exists a hierarchy from one specialty area to another. For example, nurses who work in Intensive Care Units (ICU) are considered by many nurses as superior nurses, while those who work with the elderly are frequently viewed with disdain by many nurses because of the perception that no skills are required by gerontological nurses. However, many nurses believe that ICU nurses consider themselves as better nurses than nurses in other specialty areas. Thus, nurses who work in ICU's, and subsequently all nurses who wear stethoscopes around their necks, are considered to be emulating physicians, and not "acting like a nurse".

Many of the nurses working during the late sixties and into the seventies are today's senior nurses. Many of these women hold management and teaching positions, and could have a tremendous influence on neophyte nurses. However, the lack of feminist curricula in nursing schools makes it apparent that nursing leaders have rejected feminism as feminism has rejected them. Keddy writes that

Not receiving much interest from the feminist movement and not willing to embrace feminist social activism, the nursing profession has suffered as it continues to embrace racist, classist, sexist, and homophobic outdated theories and research practices (1993:287).

In 1973 Wilma Scott Heide, president of the United States based feminist group The National Organization of Women (NOW), and a non-practising nurse wrote that:

•
...my own experiences as a practising nurse were important in radicalizing me to be a feminist...I finally had to leave nursing or suffocate psychologically. I was convinced then, as now, that nothing short of a behavioral revolution would bring about autonomy of, by, and for women, thus of, by, and for nursing, for I saw the problems of nursing as symptoms of the oppression of women. (p.825)

Heide believed that a feminist revolution was necessary to nursing autonomy. Unfortunately, she believed she had to leave the nursing profession to ensure her survival. If nursing is going to change, feminist nurses are going to have to remain with the profession and work from within to change the system. If they all leave, who will remain to carry out the revolution Heide calls for?

CONCLUSION

The development of nursing and of the health care system through the intersection of capitalist and patriarchal ideologies has maintained and perpetuated the gender inequalities and division of labour for nurses. The result has been problems such as job dissatisfaction, burnout, and high turnover rates in nursing. While solutions such as pay equity are a beginning, structural

change is necessary in order to end the oppression of women who work within the health care system, as well as the oppressive treatment of women who are clients of that same system.

Without the benefit of feminist analyses of nursing, the profession is doomed forever to remain oppressed within the patriarchal, hierarchal health care system. Feminist analyses enable women to view their oppression as systemically imposed rather than a factor of individual fault. Until the problems in nursing are analyzed within the larger context of women's oppression within society, changes will only be band-aid solutions.

ENDNOTES

1. Three of these hospitals were the Winnipeg Children's Hospital; the County of Carleton General Protestant Hospital; and the Hospital for Sick Children in Toronto. (See Gibbon & Mathewson, 1947).

2. Judi Coburn (1981); Pat Armstrong (1993); and George Torrance (1987) all document this in their essays.

3. See also Porter (1991) who writes that physicians' greater power within the health care system derives from their ability to name; they apply a label (diagnosis) to a patient and most treatment modalities are derivatives of it.

4. I was unable to find similar information on the links, or lack of them, between Canadian nursing associations and feminists. I am sure they exist and are awaiting discovery.

5. For an insightful analysis of the relations between nursing and feminism see Chapter entitled 'Why doesn't a smart girl like you go to medical school?' in Muff, J. (ed) 1982. Socialization, Sexism, and Stereotyping: Women's issues in nursing.

6. For a discussion of recurring problems which threaten nursing, see Meryn Stuart (1993) 'Nursing: The Endangered Profession'.

7. For discussion of images of nurses in novels, on television, and in films, see Kalisch & Kalisch, (1982a,b,&c). Also see Muff (1982).

CHAPTER 3: POWER RELATIONS WITHIN THE HOSPITAL HIERARCHY: THE NURSES' EXPERIENCES

INTRODUCTION

Nurses often exercise power over other groups within the health care hierarchy. As well, some nurses have power over other nurses, either by virtue of their own personal power, or by virtue of their positions, such as team leaders or presidents of union locals. While nurses have power over some groups within the hierarchy, they are also subject to the authority of others, such as head nurses, nursing administrators, non-nursing administrators (such as hospital directors), and physicians. Chapters Three and Four will analyze nurses' power, employing the frameworks of Dorothy Smith and Hilary Lips, as outlined in Chapter One.

Ten nurses were interviewed for this thesis. The methodology used to acquire the data will be outlined below. The nurses' experiences will be analyzed within the context of hierarchal power relations which sustain the status quo.

METHODOLOGY

Despite their numbers, nurses who work within hospitals exist within the space referred to as the 'margin'. The margin, as defined by Kirby & McKenna, is

the context in which those who suffer injustice, inequality and exploitation live their lives. People find themselves on the margins not only in terms of the inequality in the distribution of material resources, but also knowledge production is organized so that the views of a small group of people are presented as objective, as "Truth." The majority of people are excluded from participating as either producers or subjects of knowledge (1991:33).

With the exception of nurse managers, nurses do not have control over staffing levels, over treatment regimes for patients, nor over the budgetary decisions which affect their work lives.

Research from the margins requires two considerations. First, there must be intersubjectivity, whereby the interviewer and the participant are both acknowledged as knowers in an exchange of ideas. The second requirement is critical reflection of the social processes inherent to people's lives (Kirby & McKenna, 1989). From the intersection of these two, a consciousness of shared concerns and strategies for systemic change (a feminist praxis) can develop.

In order to find participants for this research, I placed posters (see Appendix C) in several area hospitals, which elicited only one response, who was, unfortunately, a male nurse. I then began asking each nurse I met whether she would be willing to participate, until the sample number was obtained. Several of the nurses I approached were unwilling to become involved for a number of reasons, but

eventually ten were found. Nine of the ten nurses work at the same hospital, a non-teaching facility.

These women were very interested in participating in this research, which enabled them to speak of their experiences as nurses, an opportunity which seldom arises.¹ While the selection was not random and the results are not necessarily representative of the hospital nursing population, I believe the extensive information the nurses contributed, in addition to the literature reviewed, can be considered as reflective of the experiences and the reality of many nurses in urban hospitals. The fact that the participants knew me enhanced the interview process because there was an increased comfort level, which contributed to a more trusting relationship. I believe information was shared which would not necessarily have been shared with a stranger.

Each participant was given an information sheet, which provided details of the research (see Appendix D). The research was further explained and, once she decided she would participate, an informed consent was obtained (see Appendix E). She was then given a copy of the signed consent. Confidentiality was ensured and each nurse was asked to choose a pseudonym. However, most of the nurses declined to choose a pseudonym. Therefore, to ensure

confidentiality, only the first initial of each nurse's name will be used to identify her words, except in the case of two nurses whose initials are the same. They will be identified as S-1 and S-2, in the order in which they were interviewed. Once the consents were obtained, interactive interviews were conducted with each of the ten staff nurses. The interviews were tape-recorded and later transcribed. They varied in length from ten to twenty-two single-spaced pages.

Kirby & McKenna (1989) outline eleven components of an interactive interview. These components include the development of the questionnaire; a sense of equality and a belief in the sharing of ideas between researcher and participant; and the positioning of the participant as a collaborator, rather than a subject. Another vital component of interactive interviews is the evolution of the research process. It is not static, but continually evolving as new information is gathered from the participants.²

Only women were chosen for this research, as they represent 97% of the nursing population. In addition, women's experiences of power are different from men's as a result of life experiences and the socialization process. In addition, the conditions of labour within hospitals

differ greatly from those in community health centres, public health offices, or any other nursing workplace. Since nurses who work in hospitals constitute the majority, only hospital staff nurses were interviewed. The length of the interviews varied from forty-five minutes to two and a half hours.

The interview questionnaire (see Appendix F) was based primarily on my experiences as a staff nurse over a twelve year period, in a variety of settings³, as well as a review of my 'Conceptual Baggage'.⁴ It was used as a guide during the interview, and if the nurse wanted to discuss other items which she felt were important, the interview was allowed to flow in this direction. Occasionally, additional questions were required as points of clarification.

DEMOGRAPHIC DATA

The nurses who were interviewed were all between the ages of twenty-two and fifty-six. Their ages are reflective of the general Ontario Nursing Association membership, 50% of whose members are over 45 years of age (Carol Denys, ONA Region 10 Representative. Phone interview, April 14, 1994). One of the women was a woman of colour. Three of the women were single (never married), one was divorced, and six were married (one was divorced and in a second marriage). Six of

the women have children, their ages ranging from five to twenty-seven, with only three of the women having children who still required more intensive parenting. All but one of the women had been or were currently responsible for the majority of child-care/housework.

Of the ten nurses, two work full-time, one works as a casual nurse with both a hospital and a nursing agency, and seven nurses work part-time. All of the women who work part-time stated they do so out of choice: one because she is pursuing further education; two as a means of balancing child-care arrangements; four because they feel their income is sufficient as a second income, but also have the option of working extra shifts should they wish. Part-time work in nursing increased from 20% of nurses in 1966 to 35% in 1989 (Sedivy-Glasgow, 1992). While Sedivy-Glasgow does not provide an analysis of this, it reflects the growing Canadian trend toward part-time work, especially for women. Between 1966 and 1987 the percentage of working women in part-time labour increased from 35.9% to 50.9% (Gunderson & Muszynski, 1990).

All the nurses graduated with a diploma in nursing, eight from hospital schools of nursing, and two from community colleges. Two of the nurses who had graduated from hospital schools of nursing returned to school some

years later to complete a Bachelor of Science in Nursing (BScN). Of these two women, one had completed a Master's degree in Pastoral Studies. The number with a BScN represents 20% of my sample, which is slightly higher than average. Only 13.3% of Ontario nurses hold a Baccalaureate in nursing (Statistics Canada, 1992). However, while the majority had not returned to university, they had completed courses in a variety of subjects, both directly and indirectly related to nursing.

The nurses work experience ranges from three months to thirty-one years. Together, they represent nearly two hundred nursing years, with experiences in almost every nursing specialty, including medicine, surgery, cardiac surgery, operating room, community health, gynaecology, gerontology, psychiatry, nursing management, ophthalmology, and intensive care units. This nursing transpired in large and small hospitals (both teaching and non-teaching), nursing homes, long-term care facilities, prisons, physicians' offices, and even in other countries.

As evidenced by the above, these nurses have a wealth of experience and information which they are able to contribute to research by and about various aspects of nursing.

THE NURSES' PERSPECTIVES

Definitions of power

Overall, the nurses' definitions of power reflected the mainstream definitions of power which were discussed in Chapter One, including such concepts as authority, influence, and control.

Power is having authority and being able to influence others. You can make them do what you want. To have power you don't necessarily have to have respect, but it helps. (A)

Control. To be able to make the decisions that you feel you are able to make. Power would be doing what you want, the way you think it should be done. (S-1)

I think power means that if I have power I have the ability to influence what is going to happen. (S-2)

Power would be if I believe in something and I want it done and I want people to listen to me. And if it is being done and people are listening to me then that is power. I need power to be able to be effective as a caring nurse. (Y)

In defining what she meant by caring, (Y) stated that "Caring means looking after my patients the same way I would look after myself." This was a common theme amongst the nurses, who considered a 'good nurse' to be one who cared for the patient as they would for a close family member. Benner (1984:209) discovered this to be true for the nurses within her study, who "identified with their patients by imagining themselves or their family members in the same predicament". This depicts the high level of personal investment and empathy nurses have for their patients.

On becoming a nurse

The women became nurses for two main reasons. First, their options were limited by social standards for women at the time they graduated from high school so they were directed by guidance counsellors or family members to either teaching or nursing. And, second, they wanted to help people. Reverby (1987) writes that

Particular circumstances, ideologies, and power relations thus create the conditions under which caring can occur, the forms it will take, the consequences it will have for those who do it...Nurses were expected to act out of an obligation to care, taking on caring more as an identity than as work, and expressing altruism without thought of autonomy either at the bedside or in their profession (p.5).

Nurses are expected to be highly devoted to their work. This expectation derives from the development of nursing as the selfless endeavour of religious groups and laywomen, and from the subsequent formalization of obedience to superiors and devotion to the patient as prime tenets within nursing. This belief in the nurse as selflessly devoted to her work includes the expectation by managers that nurses will not rebel against their working conditions. When nurses complain, they are commonly told to "do the best you can." The only legal option for members of the Ontario Nursing Association is to enact the Professional Responsibility Clause within their contract. This clause permits the nurse to submit her complaint in writing. It will then be dealt

with by an arbitration board at a later date. However, the nurse must complete her shift under the conditions which led to the complaint. Nurses cannot 'abandon' their patients.

Part-time work

One of the nurses defined power after a reflection on her feelings of powerlessness as a part-time nurse:

I sometimes think that the position we are in can sometimes be quite a powerless position, especially as a part-time nurse. You just sort of come in and do your job. But I don't know how much power you have as far as running the floor... (B)

As stated above, part-time work in nursing has increased to thirty-five percent. This increase in part-time work reflects the nature of work in society at large. Part-time workers are less likely to participate in group politics, as they are not present in the workplace as much, and it is more difficult for them to develop relationships with other members of the group. This nurse's feelings of alienation from the power structure of the workplace was shared by other part-time nurses who were interviewed. Day (1993) discusses several reasons for women's limited involvement in union activities. About part-time nurses she writes that, "Part-time workers' contact with each other is limited, and thus so are their opportunities to discuss their work problems and to do something about them" (p.92).

Personal power

Personal power originates from many different sources, whether from an individual's educational background or a job which one holds. Typically, when we consider that individuals have power, we view them with esteem and sometimes fear. Frequently, somebody with power controls key resources, including monetary rewards and job advancement. However, this is not always the case, as religious leaders exert power and influence over their followers by promising elusive rewards, such as the 'key to heaven.'

Within the hospital hierarchy nurses rarely control the material conditions of their work. Their work schedules are predetermined by someone else, usually a staffing coordinator, and they are slotted into them, unlike other professionals, such as physicians, dentists, and chiropractors, who usually set their own hours. Supplies required for their work are frequently in short supply or in poor working condition, and they must adapt to new technology, such as computers, which are deemed necessary by bureaucrats. Heather Menzies (1989) writes of the effects of the technology explosion on various groups of workers and their subsequent reduction into being merely technicians. In discussing the impact of computerization on nursing, she writes that "In a single stroke, the patient-care

information system transforms the work of nursing from a social process involving personal judgement within the context of a relationship with the patient into a technical process..." (p.88).

In addition to computer technology, there is a constant barrage of new information on which nurses must keep up to date. This includes: a constant stream of new medications (which means learning indications for use and side effects); new treatment regimes for vascular or decubitus ulcers (commonly known as bed sores, the treatments range from simple dressing changes to the application of maggots to the wounds); and ever-changing types of equipment (some of which use computer chips, such as electronic intravenous pumps). Nurses must also become aware of the various treatment regimes and personalities of each staff physician in order to accommodate his or her wishes or whims.⁵

Increasingly, every aspect of the work is determined by the financial considerations of legislators and hospital administrators. Budgetary constraints have become the "bottom line". Nurses are expected to consider all aspects of patient care in terms of budgetary restraints. It is difficult to merge financial concerns with the ideologies of nursing (such as a caring ideology) with which most nurses are indoctrinated. Frequently, when nurses do offer

suggestions on means of eliminating waste, their suggestions are ignored.

...they make decisions financially and they don't consult us. If we are consulted, we tell them what we think and they don't listen. (P)

When asked whether they had ever felt powerful within their work settings, the nurses' responses varied, reflecting their interactions with managers, physicians, other nurses and patients. One of the nurses felt powerful within the context of patient interactions, but not in relation to other therapies (such as social work, physiotherapy), believing nurses were not respected on equal terms by these therapists. This despite the fact that, at one time, nurses included physiotherapy and social work as part of their scope of care. Because most of the other hospital departments (such as physiotherapy) work Monday to Friday (no night shifts), nurses are expected to add this work to the nursing regime during that time. This is without benefit of added financial remuneration.⁶

Overall, the nurses felt they possessed some power within their personal work settings, but they also felt powerless at times. However, the nurses recognized that their place within the hospital hierarchy was a hindrance to their power.

A few of the nurses experienced power on their unit in relation to direct patient interactions. This power often derived from their ability to assess a situation and provide appropriate interventions.

I think I have felt powerful if somebody has been really sick and I feel that I have really, really helped them. Then I feel powerful. You feel that they feel confident about you looking after them. They feel really good that you are there. They mightn't say thanks, and it doesn't matter. It is just that you know that you are there and doing your best and you are helping them and that's enough. (B)

The only type of power I feel would be coming from a patient. They express some sort of appreciation of guidance you have given them. As far as power in a multidisciplinary setting I don't feel powerful at all. I don't feel that in this hospital nursing is respected on the level that maybe other therapies are. (C)

This feeling of power derives from the nurses' ability to empower their patients toward health. Benner (1984) refers to this as "healing power". She writes that "Nurses establish a healing relationship and create a healing climate" (p.213) through a variety of means. They use their education and their work and life experiences to provide an atmosphere conducive to healing. Nurses expend an enormous amount of emotional energy toward their patients, which is at once both empowering and exhausting for the nurse. This energy often seems to be the only element keeping patients alive.⁷

One nurse, who had years of psychiatric nursing experience, but was working in another specialty while

obtaining further education, made a qualified assessment of a suicidal patient. When she reported her assessment to her unit manager she was rewarded by the positive reception to her input, which she believed would have an impact on the treatment the patient would receive. Her power was derived from the external validation of her work, and, therefore, more susceptible to undermining influences.

That had some implication of power in terms that my impressions might have some bearing on what was going to happen to this man. There was a sense that somebody has given credence to the fact that I heard that man say this and I have reported it. So I suppose it is power in the fact that she wanted to hear what I have to say. I think that is important to give you at least a sense of power...to feel like somebody gives credence to your abilities. (S-2)

None of the nurses considered physicians to be their peers, but rather considered them above nurses in the hierarchy. As a result, their power frequently derived from situations where they could exhibit more knowledge than physicians, or in situations where the organization of the work enabled them to work independently from physicians. The nurses cherished these moments of apparent superiority in a system which infrequently allows such events. This reflects power that is in flux. At a particular point in time, within a particular set of circumstances, oppressed groups, such as nurses, may exercise power over the dominant group. It is then incumbent upon the dominant group to work

toward suppression of the revolt in an effort to maintain the status quo.

Other nurses' feelings of power were derived from the validation of their knowledge and expertise, either by their peers or by those they considered superior to them within the hierarchy, such as physicians.

...part of my feeling of personal power was that if a client came in and I was doing an assessment, 90% of the time the doctors never felt they had to see the client because of my ability to assess. So, I guess that gave me a sense of power in that they gave credence to the fact that I knew what I was doing. The other members of the team weren't constantly making me prove what I was doing. It gave me a sense of personal satisfaction and power. (S-2)

It is kind of powerful to phone the doctor and say you wrote this order wrong, I need this or that. (S-1)

I don't really think you could call it powerful, but you could make suggestions to the physicians because sometimes they don't have a clue as to what they are doing so you can give them direction. But I wouldn't call it powerful per se. (K)

Power is people listening to what you say, and thinking that it is worth something. And I think if doctors are any good they do listen, and nothing will impress me more than a doctor that does listen and actually does look and reads what you write down and it means something to them. What drives me nuts is when they ask a question and they don't make eye contact the whole time you are answering them, or they are off doing something else and you are still answering. I mean, what did you ask me for? (A)

Lips (1991:114) writes that "Being female or male (sex) affects an individual's status in the eyes of others; socialization into feminine or masculine roles (gender) affects the way an individual approaches power relationships." The nurses' ambivalence about their experiences with power vis-à-vis predominantly male physicians reflects

this. While they felt powerful at the time of the interaction with the physicians, they later discounted this feeling. They did not want to appear too powerful in relation to the dominant physician, as this would undermine the relations of power which are central to the maintenance of the status quo. Ashley (1979:29) writes that "very few nurses over the years have bothered to isolate, confront, and examine the way in which nurses have used their power--not in behalf of nursing, but to maintain the very system that has oppressed them." She believes that the education of nurses to work collaboratively and cooperatively with doctors diffuses the energy which is needed to "change a system that needs changing" (p.29).

Change engenders feelings of discomfort in most individuals. Nurses are socialized into the same system of medical/health care as physicians. Without collective action, nurses cannot facilitate/foster change within the health care system because its complexity renders it invulnerable to individual action. Governments and hospital administrators struggle with changes they know are necessary to the improvement of health care, (such as more home-based health care), but change is slow to transpire, and often costly. Given the current deficit situation (economic crisis), these changes are unlikely to occur quickly.

Changes in the financial situation are necessary, but the ideologies of all groups who are stakeholders in the health care system also need to be transformed if the changes are to be permanent and positive. Nurses must consider what impact the re-organization of health care will have on their work, and where they will be located in a transformed system.

Nurses frequently feel frustrated by the demands made on their time by other health care workers. Interruptions are a constant source of stress for nurses. Sometimes it becomes impossible to complete even one task due to the high number of interruptions. Members of other health care disciplines expect nurses always to be available to respond to their demands at the instant they make them. The result is nurses who are torn between their need to care for their patients in the way they know best and accommodating the wishes of others.

I always feel like there are so many different...There is physio, nutrition, and if you have a sick person that has been there for awhile, all these people are involved and I always feel that my work, my time with the chart is always at the bottom of the list and you are constantly being asked questions. Read the bloody chart, it's written down. Why do I have to stop what I am doing and go over the past six days and everything that has gone on. I think I probably get more powerful the more frustrated I get, because sometimes I just lay down the law. No, you can't come in here and do chest physio because I have been interrupted constantly for the past two hours and I have this, this, and this to do and I am two hours behind, and I am going to do it, and you can come back. (A)

While nurses occasionally rebel against this impossible situation, they may also internalize their frustrations and come to believe that they are the problem, rather than viewing it as a systemic one. "...angry nurses frequently are labelled trouble-makers and difficult to work with...Unfortunately, they themselves sometimes accept the notion that something is wrong with them because they are not able to adjust and accept the system as it is" (Smythe, 1982:340).

As previously stated, some nurses hold more personal power than other nurses. The nurses I interviewed described the more powerful nurses as the "ones who are buddies with the head nurse (Y)" and the ones who are "respected by the doctors more than others (A)." Others considered nurses who were powerful to be "more vocal and more articulate (B)." The nurses' power was based on those with whom they associated or how they were viewed by more dominant groups rather than through a superior knowledge base. The nurses overlooked their own or their peers' knowledge or experience as a basis for power, thereby undervaluing their expert power.

Powerlessness

Feelings of powerlessness are commonplace among nurses,

due both to the indoctrination to the work culture, and to an awareness of the realities of the workplace. Hospitals are large bureaucratic organizations which require the socialization process of all new employees to ensure they 'fit in'. As professionals, nurses hold certain expectations of how their work will be organized. When they enter the workplace, they discover that they must adapt, because the system will not adapt to them. When nurses' ideals are confronted by the realities of the hospital system, feelings of powerlessness can ensue.

Donner writes that

It is important to an understanding of the socialization process that nurses usually do not occupy the position of ultimate authority and yet in most hospitals, nursing is the largest group and responsible for the greater part of the hospital budget (1986:22).

Feelings of powerlessness originate primarily from decisions made about their work-lives which are out of their control, and about which they are not consulted. They also originate from a lack of acknowledgement of their contribution to patient care, primarily by their peers, but also by physicians; from the knowledge that they are not always able to effect change, either in relation to the daily work routine, or sometimes in the outcome of a patient's condition; and from the constant mediation and negotiation

between physicians, and between physicians and patients. This last item sometimes seems an overwhelming aspect of nursing work, and one which is not necessarily welcome, nor realistically within the scope of nursing practice.

I feel powerless because with all our patients there is the surgical aspect and the anaesthetic aspect and the anaesthetist looks after all sorts of sedation orders and that type of thing. Rarely are they at the bedside at the same time and they are constantly changing the whole approach to this person's care and orders and you just get going on that and fifteen minutes later the surgical guy will come in and say oh no, I don't agree with that and he changes it... and I don't care what you do, just get your stories straight and together. The nurse is the go-between all the time. Oh no, they would never make the effort to go find the other guy and talk it out and come to an agreement. (A)

One of the most dis-empowering experiences which the nurses described centred around the issue of medication errors. The nurses described the repercussions as 'ridiculous', 'childish', and 'humiliating'. Nurses were asked to complete written assignments if a specified number of medication errors were made in a given amount of time. If more than four were made in a one year period, the nurse faced suspension without pay. The nurses felt the punitive process used in accounting for medication errors was infantilizing and undermined their confidence. The way in which nurses who make medication errors are dealt with fosters tension between their professional identity, which stresses autonomy, and the rules and regulations of the

hospital workplace.

In the following account, (J) poignantly describes her feelings about the process. Her words reflect those of the other nurses.

First of all, I feel awful. I feel so inadequate. You just sort of feel stupid. Then you get to the head nurse level, where she treats you like a little kindergarten student "Now, my dear, how could you possibly have missed it?" I don't know how the hell I missed it! I am human and there were other circumstances that enter into the situation, but I resent so much this slap you on the wrist approach. I am a mature, responsible professional. I really, really resent that. Point it out to me. Discuss what we can do to prevent this happening again, but don't treat me like a two-year-old. I just hate that. I get so angry. My own anger at myself probably relates to the frustration of having made a mistake in the first place, but the anger at someone who is treating me like a child is probably related to the frustration of not being seen as a credible responsible adult in my profession. There is a zero-based tolerance for med errors in particular and as nurses the fear of God has been put right in us about medication errors and we are conscientious about that, but I think that what one has to understand is that we are working in an extremely busy milieu with so many diversions and interruptions that what could one say? We are human and we do make mistakes. (J)

In addition to the punitive actions of the hospital, nurses who make multiple medication errors may be reported to the College of Nurses for disciplinary actions. College legislation requires nurses to report the transgressions of their peers. In my experience, however, the majority of nurses never self-report medication errors, nor do they report other nurses' errors unless they are unable to conceal them. This creates stress for the nurse who made the error, as well as for any colleagues in whom she may confide because of a fear of discovery.

Some nurses, however, do report their colleagues to superiors. This is one means of acquiring power, however temporary it may be. But, it may be a double-edged sword, because neither superiors nor peers respect someone who breaks ranks.

We nurses are hard on each other. We aren't the helping profession at all: we are at each other's throats. (Y)

We really have to support each other as women and as people, rather than always going around looking for some little thing that somebody did wrong. (J)

These nurses describe the ever-present reality of nurses pitted against each other. Muff (1982) assigns the blame for this to women's self-esteem. She writes that

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

Freire (1990) also analyzes the actions of the oppressed against each other, writing that "Submerged in reality, the oppressed cannot perceive clearly the order which serves the interests of the oppressors whose image they have internalized. Chafing under the restrictions of this order, they often manifest a type of horizontal violence, striking out at their own comrades for the pettiest reasons" (p.48).

Infighting undermines nurses' struggles to end their oppression within the health care system because they are unable to develop a group consciousness, which is necessary to collective action.

Institutional power

Institutional power is deeply entrenched within societal institutions, such as law or medicine. Challenging institutional power is difficult, and "...power, once entrenched in the way an institution is structured, can be modified, if at all, only with intense, prolonged, painful effort" (Lips, 1991:11).

Within the bureaucratic structure of the hospital, power rests with only a few individuals, who are mostly white males. While nurses are invested with authority in relation to other nurses or support staff (RPN's, HCA's, orderlies) and often derive feelings of power in this way, they rarely hold positions of or feel powerful in relation to physicians, to their superiors or to other health care occupations.

Power is an authoritative role or person that dictates authority to who does what and where and when. Usually in hospitals it is the physicians or administration. (K)

The nurses were divided about whether they could effect

change on the unit where they worked. Two of the nurses, however, recognized the potential power that exists when problems are addressed by a collective rather than by individual action.

It is hard, but I am trying. We have already made some changes because before we were just told whatever the head nurse wants on the floor, but recently, the RN's have gotten together and have decided that we would like to ask the unit manager to have a regular staff meeting with the RN's and with that she has given us the chance. It is slowly changing, but still it is very hard because she still doesn't listen to us. (Y)

Not by myself. Maybe collectively, if we all got together and felt it was a valid thing to try and change we might be able to, but I think I would need the support of all the other people, too. (P)

The desire for more power

Several of the nurses expressed a pragmatic desire for more power, power which would enable them to improve the conditions of their labour, and improve patient care. This improvement includes the ability to dispense medications such as Tylenol or laxatives to patients without a physician's order. Nurses are not currently permitted to dispense any medications without permission from physicians; if they do so they may lose their licence to practice. The procedure for obtaining medication orders can be time-consuming and frustrating for the nurse, but even more so for the patient who may have a headache, or who is constipated but must sometimes wait for a considerable

length of time before he or she can obtain relief. The length of time usually results because the nurse must contact the physician for the order, which can take anywhere from five minutes to several hours. (One of the nurses I interviewed said when she contacted a physician recently, he was perturbed because he had been on the golf course.)

It would be nice to just be able to have straight orders that you wouldn't have to phone a physician to get a milk of magnesia order. Give you some more authority over that Tylenol. Simple orders like that. That we could go ahead and proceed with matters without having to talk to a doctor. More control that way would be better. I would like to have more control over scheduling, over who got what hours, what shifts. It would be nice if nursing as a whole could receive more power, that they have a larger voice. If we could have a stronger voice in the Ontario Government, that they could hear us. I want more power to give medications without a physician's order; to be able to do more treatments. (K)

...in working in a place like Hospital X when you don't always have a physician there, you think sometimes that you would like to be able to decide this without calling a physician up to ask for something simple like two aspirins...in some instances like that I might like to have that ability to make those kinds of decisions. (S-2)

The nurses also expressed a desire for more power in terms of more control over other disciplines (such as physiotherapy or occupational therapy); in having a stronger voice as a profession in Ontario; and having more say in the scheduling of their work.

As one of the nurses explains, nurses take on a great deal of responsibility, but do not have the power to implement change because they are dismissed by other

disciplines as a means of ensuring they do not challenge the status quo.

I think we need more power. We need to, I think we assume the responsibility but we often wait to be told by somebody else what to do, whereas maybe we could be directing the other disciplines. Why not? Maybe the approach needs to be discussed and if that is not the best approach then maybe they could offer some suggestions. I think we are dismissed because we are threatening their previously acknowledged power. (C)

CONCLUSION

As discussed in the first three chapters of my thesis, nurses have little space to develop their power, either personally or collectively, within the current hierarchal structure of the Canadian health care system. For nurses to fulfil their potential as stakeholders in the system, structural changes must occur. These changes will have to include hospital Boards, District Health Councils, and other municipal and provincial regulatory groups.

Until nurses have input into the regulation of health care at all levels, there is little hope that they will be empowered within the daily organization of their labour.

To achieve this, nurses must begin to develop a group consciousness and a feminist consciousness, generating an awareness that despite differences amongst individual nurses, the development of cohesive strategies is vital to the improvement of the conditions of their work-lives. The

development of a group and feminist consciousness will be discussed further in Chapters Four and Five.

ENDNOTES

1. My experience has been that people do not want to know what nurses do because our presence seems to indicate a potential for vulnerability. We deal with people at their worst and in some of their most intimate and vulnerable moments. During my entire nursing career I have only met one non-nurse who truly wanted to know the details of my work.
2. Kirby & McKenna (1989) discuss the eleven components in more detail in Methods From the Margins, p.66-74.
3. The 'Values' questions were excerpted from Murphy, R.M. (1988), and along with the demographic data, served to put the participants at ease.
4. 'Conceptual Baggage' is a means of analyzing one's biases about the research question. A record of personal feelings is kept throughout the research process. In this way "The researcher becomes another subject in the research process and is left vulnerable in a way that changes the traditional power dynamics/hierarchy that has existed between researcher and those who are researched (Kirby & McKenna, 1991:32)."
5. For example, on a surgical unit they will need to know whether the surgeon wants the surgical area of a patient shaved pre-operatively, and if so, whether it is the evening before or the morning of surgery.
6. Nurses who are members of ONA do receive a small increase in their hourly wage for working evening (\$1.00/hr) and night (\$1.25/hr) shifts, as well as weekend shifts (\$1.35/hr). However, this remuneration covers the inconvenience and physical difficulties of working shiftwork. Nurses who are assigned charge duties are paid only an additional 60 cents an hour.
7. Recently, a colleague expressed frustration over the death of a Geriatric Rehabilitation patient shortly after discharge. She asked "What was the point?", referring to the investment of time and energy the multidisciplinary team had made into the discharge home. The reality was that the patient had achieved her goal of returning home. Unfortunately, her medical problems were complex and she died sooner than expected. This nurse had made a difference, but failed to recognize it.

CHAPTER 4: THE FRAGMENTATION OF VOICE: NURSING ORGANIZATIONS IN ONTARIO AND THEIR IMPACT ON NURSING POWER

INTRODUCTION

My analysis of nurse's power began in Chapter Three and included their perspectives on personal and institutional power. This analysis will continue in this chapter with the focus on organizational power, specifically related to the various organizations which represent nursing in Ontario. The main focus will be on the Ontario Nursing Association (ONA), to which all the nurses who were interviewed belong. This organization represents the majority of staff nurses in Ontario and is, therefore, the main voice for nurses in Ontario. Despite this, many nurses feel disenfranchised from their union. The nurses' insightful comments about group power provide valuable information about the relationships of nurses to each other and to their union.

There are several organizational bodies for nursing within Ontario, each of which has a specific mandate vis à vis the organization of nurses. These are the College of Nurses of Ontario (CNO), the Canadian Nurses' Association (CNA), the Registered Nurses' Association of Ontario (RNAO), and the Ontario Nurses' Association (ONA).

Each organization represents a different facet of

nurses' work-lives, with mandates which overlap, leaving nurses dubious about which organizations have real power and which ones actually speak to their concerns. Additionally, on a more pragmatic note, having separate organizations requires three separate annual fees, which many individuals are reluctant to pay.¹

The existence of these three groups has led to occasional territorial disputes, labelled 'turf wars' by Growe (1991). The most notable polarization which has resulted is between the RNAO, which claims to represent the voice of the 'professional nurse', and the ONA, which represents the majority of the rank and file nurses. Polarizations like these lead to the diffusion of nurses' power and contribute to the public perception of women/nurses as poorly organized and vulnerable to the 'divide and conquer' strategy.

THE MANDATE OF EACH ORGANIZATION

Each of the organizations which claims to represent nurses actually represents only a portion of nurses. But what is important is which nursing population each organization represents.

All the provinces and territories, except Ontario, have two bodies that represent nurses: the provincial

association, to which nurses must belong in order to maintain their registration, and the union. Within Ontario this is complicated by the existence of the three bodies mentioned above: the CNO, a quasi-governmental body which nurses are required to join; the RNAO, which represents the concerns of 'professional' nurses; and the ONA, the union, which is responsible for collective bargaining for the majority of nurses in Ontario.

The College of Nurses of Ontario

The College of Nurses of Ontario was established with government assistance in 1961 as the regulatory body for nursing. Its purpose is to "regulate nursing to protect the public interest" (Communiqué, March 1994:2). They do this by establishing standards for nursing education and practice for Registered Nurses and Registered Practical Nurses, (including input to legislation); by controlling provincial registration examinations; and by ensuring that all members of these two groups register annually with them. Failure to register means an individual cannot work as either an RN or an RPN in Ontario.

The College Council includes PNs and RPNs who are elected by their peers, as well as members of the public, who are government-appointed. Because their mandate is the

protection of the public, they have little input into the daily work-lives of nurses and, thus, their work is not necessarily empowering for nursing, although the experience gained by individuals who work on the Council may be empowering.

The Canadian Nurses' Association

The Canadian Nurses' Association (CNA), the umbrella organization for the provincial nursing associations, is considered the unified voice of nursing in Canada. However, membership in this national organization is remarkably low (about 108,000). Over fifty percent of nurses in Canada do not belong to the CNA, including the majority of nurses in Ontario.² Quebec nurses also do not belong to the CNA, having disaffiliated in 1985 as a result of both financial and political concerns (Meillicke & Larsen, 1988). Growe writes that

The Canadian Nurses Association can no longer even pretend to claim it represents Canadian nurses on a national level. The Quebec nurses' association pulled out of the CNA in 1985, taking the 55,000 Quebec nurses with it, and the 113,000 RN's without CNA membership comprise almost half of the 240,000 registered nurses in the country. (1991:109)

An equity-seeking group whose goal is the empowerment of nurses, the CNA is involved at various government levels with such issues as violence against women, child poverty issues, and health care reform. They have also endorsed

such proposals as making university education the only level for entry to practice for nurses by the year 2000. This has been a contentious issue between the ONA, the RNAO, and the CNA since its adoption. The CNA adopted the policy of the baccalaureate as the minimum level for entry to practice in 1982 (Rovers & Bajnok, 1988). However, nursing unions across Canada are not in support of the policy as it currently exists. The ONA supports the Ontario government position that questions the need for all nurses to be university-educated. The ONA also has concerns about access to the programs, and about what happens to nurses who do not have a BScN after the year 2000.

The Registered Nurses Association of Ontario

Members of the RNAO believe their organization represents the 'professional nurse' (this is in contrast to the ONA, which represents the 'rank and file' nurse).

The organization was formed to provide a registering body for nurses. It was meant to distinguish between individuals who had nursing training and those who did not but were passing themselves off as nurses. Individuals who registered would be officially considered nurses. Ostensibly this was to safeguard the public by ensuring a certain standard be met, but it was also a means of

controlling access to nursing and preventing individuals who lacked any formal nursing education from legally calling themselves a nurse.

The RNAO membership has dwindled over the years, subsequent to the formation of the College of Nurses and the ONA. Its membership of 13,000 comprises mainly managers and professors of nursing. In 1989 only 1,563 (2.9%) of staff nurses who were members of the ONA were also members of the RNAO (Grove, 1991). Of the nurses I interviewed only one, a new graduate, belonged to the RNAO.

The Ontario Nurses Association

The ONA, the collective bargaining agent for the majority of staff nurses in Ontario, has a membership of 53,104 full and part-time nurses, 87% (46,128) of whom work in hospitals (ONA, 1993). While staff nurses are not obligated to join the ONA (at a one-time payment of one dollar), they are required to pay monthly union dues. However, if they do not pay the one dollar fee, they are not permitted to attend union meetings, nor to have any say in union matters. The obligation to pay monthly dues reflects the fact that all staff nurses in the workplace profit from the ONA contract whether they are members of the union or not--salaries and benefits are extended to all staff nurses

who work in the local. All the nurses I interviewed were members of the ONA.

The ONA was formed in 1965 under the jurisdiction of the RNAO as a vehicle for collective bargaining for nurses in Ontario. They separated from the RNAO in 1973. However, they held block membership with the RNAO, terminating that relationship in 1988.

Turf Wars³

The CNO, the RNAO, and the ONA liaise with each other, meeting three or four times per year to discuss various issues in common. As well, the RNAO and the ONA meet twice a year. However, because the organizations all have differing mandates and perspectives, attempts at forming coalitions have failed (Denys, 1994).

An example of the failure at achieving consensus is found in the debate around issues of education. The RNAO supports the Baccalaureate as the minimum expectation for entry to practice by the year 2000; the ONA does not. The RNAO recommends that the nurse practitioner should have a Master's degree; the ONA believes that the program should be a one year Post RN program, whether the RN has graduated from a diploma program at a community college or a degree program at a university (Denys, 1994). "The RNAO seems to

have as its mandate the further education of the nurse, whether the Master's, PhD, etc. They don't consider the financial aspect" (Denys, 1994).

It is common knowledge amongst nurses that the RNAO and the ONA represent two diverse groups of nurses. This has led to a divergence of opinion over several issues, such as the educational status of nurses. As Kerr states "Intolerance of the unique mandate of the negotiating body and the professional body may have clouded perceptions of the appropriateness of the other's actions in the past" (1991:227). As an example of this, in 1990, the CEO of the ONA wrote a letter to the President of the RNAO outlining the problems the ONA had with the RNAO's involvement with the issue of pay equity, specifically referring to the RNAO's news releases, stating that, "Perhaps any news releases or statements related to this subject would be better handled by those groups with developed skills and expertise in this area instead of well-meaning (albeit inept) amateurs" (Slattery, 1990:11). A copy of this letter was included in the September, 1990 issue of the ONA news, providing a very public display of the lack of communication between the two groups. This, and the lack of a visible coalition between the groups has heightened the appearance of powerlessness.

I feel that they could have a lot more power due to their numbers, but I feel that women as a whole have not been able to speak out for themselves and nursing in the past and in the present we seem to be always at odds with each other. The CNO, ONA, RNAO, and CNA don't get together and fight for one cause rather than different components of nursing; nobody seems to be working together, they all seem to be working against each other. If we were all working together we would be very strong and powerful (K)

I think it is very unfortunate that nursing is so fragmented into the RNAO, the ONA, and the CNO. I think that is very unfortunate. I think it's power is weakened by the fact that we are divided into three separate segments. (J)

The existence of unions for nurses has been described by a nursing leader as potentially offensive to 'professional nurses' because of their association with trade unions, whose membership is comprised of unskilled labourers. "The image of nurses adopting the language and actions of general trade unionists may be abhorrent to many professional nurses, the professional nursing association, and other professional associations" (Kerr, 1991:226).

The problems which exist are not surprising, given the membership of both groups; because the RNAO membership includes management nurses, it is not possible for the two organizations to work together to develop strategies for the empowerment of staff nurses. The management nurses, as a result of their position, must always consider the 'bottom line', which despite protestations that it is patient care, is the budget. They also do performance appraisals of nurses, which means they wield a great deal of power. How

many managers want to become friendly with their subordinates; and how many subordinates can develop trust in their managers' ability to work for the improvement of their working conditions? It is apparent that the two groups may never be able to develop the strong ties which would enable them to confront issues which face nurses, because the issues are very different for the staff nurse and the nurse manager.

The existence of several groups speaking for different factions of nurses enhances the divisions which exist between different groups of nurses based on several factors, including educational status (diploma vs degree); workplace specialty (ICU vs geriatric nurse); and position within the workplace (nursing management vs unionized staff nurse). While it is unreasonable to expect that, as such a diverse group, nurses will agree on every issue, "...they should agree on basic goals and have sound rationale to support their positions. Too much internal disparity weakens the profession and undermines the power of nurses" (MacPhail, 1991:49).

The divisions between who speaks to what aspect of nursing has created a rift, one which has weakened nursing's power base. As Smith notes "Nursing has translated the scarcity of its 'real power' within the health care delivery

system to the internal environment of nursing itself. Nurses badly need to applaud and reward one another for the variety of diverse contributions they make to the health care arena" (1985:62). The divisions between nursing leaders and the staff nurse, however, are not new. Melosh documents the dissension between bedside nurses, who were guided by an apprenticeship culture and the elite nursing leaders, who were guided by an ideology of professionalism, writing that

Leaders understood and responded to postwar possibilities, but they were all too ready to abandon the majority of nurses in pursuit of professionalization. As a result, education became a deeply divisive issue that virtually split nurses into two occupational cultures...leaders had little sympathy or understanding for the values and codes of apprenticeship. Confronting their common problems as women and as workers, nurses would often find themselves speaking different languages (1982:76).

Another nursing leader adds that, "With a continuation of prejudicial attitudes, personal competition, and a lack of understanding of the roles of each other, both organizations suffer and the profession is weakened" (Jensen, 1988:473). The message from nursing leaders strongly iterates the need for communication and the formation of bonds between nursing organizations. The failure to develop strong relationships leads to a weakening of nursing's power base.

**ORGANIZATIONAL POWER:
THE NURSES' PERSPECTIVES ON POWER WITHIN THE UNION**

The nurses I interviewed were ambivalent about the need for a nursing union. Some believed unions were necessary as a voice for nursing concerns, while others believed the ONA had lost touch with staff nurses and had become a bureaucracy unto itself.

When asked whether they believed nurses needed unions they responded:

Yes, I feel we should have a union but I feel the union should speak for the nurses and I feel at this point in time that they are not really working for the nurses, but for the union. (K)

I think there is a need for unions, but I think unions overstep their bounds a lot. I think somehow the unions ended up with the power instead of the individual nurses ending up with the power. I think the unions take away your individual power rather than give you the power that they are supposed to. (S-1)

Yes, for power. There is strength in numbers. You can't be subservient in the nineties. You have to present your point of view. I don't think unions are always 100% right but I think it serves as a way of putting across your point of view and not being trod over...I do think it is important as a group to be represented. (A)

Unfortunately, I don't. But the reality of the situation is that because we are such a fragmented profession and we don't act as a group it has become necessary for our socioeconomic well-being. I don't believe that professions should be unionized. I think we should be organized but we should be more...we should have more of an ability to negotiate our own destiny. (J)

While the nurses were ambivalent about the need for a union, most of them didn't believe the union represented them and their concerns.

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No, I think they are a big powerful conglomerate existing on their own. (S-1)

No, not as a part-time employee, that's for sure. (K)

No, I don't. Certainly not in our situation. It just seems like an autocratic situation that I don't know that I have very much to offer. (J)

I think they do. I don't think the union does much more than represent my financial concerns. (C)

However, the nurses were quick to admit that they rarely attended meetings. So common is the poor turnout at union meetings at many institutions that union locals, based on a vote by their membership, have levied special dues against their members (in the range of \$2.00-\$15.00 per month). These dues are returned to members at the end of each year if they have attended a specified percentage of meetings during that year. At the local where I am employed, the attendance skyrocketed initially, but after a year it has again dwindled. It would benefit each local, and the union central, to determine the reasons for poor attendance, rather than enforcing punitive measures. There are many reasons for poor attendance at union meetings, some of which are outlined by Rosemary Murphy

Getting to a professional or union meeting requires an extraordinary effort, as these meetings come after work, children, husbands, and toilet-cleaning. Attending a meeting is not supported and may even be devalued by husbands...Historically, nurses haven't had the time or the energy to attend meetings (1993:56).

Union meetings are usually held after the day shift, whether an eight or twelve hour day. Nurses who work the night shift are expected to attend these meetings as well, despite the fact that for them it means getting up in the middle of their sleep to do so. The analogy for nurses who work eight-hour day shifts would be for them to attend a meeting at eleven-thirty at night. This would be considered an unreasonable expectation.

Gardezi (1989) discusses three barriers to women's participation in the union.

Members have complained that the union is not accessible, that it does not make enough of an attempt to involve its members, and that it often discourages militant action by its members...These features of the union could block or discourage membership participation as members may not have access to information on the union and what it is doing, they may not see the union as representing issues of concern to them, and they may even see the union as working against them (p.22).

In addition to the factors mentioned above, the poor attendance at union meetings could be a result of many other factors, including the indoctrination of subservience and obedience which occurred in the training programmes which most of the nurses I interviewed attended. In fact, given the age group of the nurses, the majority of nurses working in Ontario today went through the rigorous training within hospital schools of nursing. The union in Ontario is relatively young (20 years old in 1994), and nurses who

worked before the union's inception may perceive it with the same disdain which is common amongst nursing leaders.

The nurses' sense of powerlessness as individuals within the union was reflected in their responses when asked whether the ONA has any real power. Again, there was ambivalence in the responses to this question.

I don't know who has the power. (S-1)

I used to think they did, but I am not sure right now. With the political climate right now I feel they have probably lost a lot. (K)

It's questionable. I really don't know if they have any power. (V)

Oh yes, I think they do. We have certainly seen that demonstrated in the recent layoff situation, and maybe that's where the union is important. I don't think it should be getting into professional issues. I think it's more our socio-economic representative. (J)

More outreach to rank and file nurses by members of the union hierarchy would enable the union to educate nurses about the pragmatic and daily benefits of a union, the historical aspects of women's labour, and many other factors which would empower nurses as individuals and as a collective. While this would prove time-consuming, the benefits to the union in increased support and participation would be well worth it. The union must get back to its grassroots before the disenchantment of staff nurses about their union and its leaders results in ever growing discontent and the demise of the union. This possibility

was presented by one of the nurses

Because the nurses aren't working with the unions, they are just giving the union more power because the leaders are deciding what is done instead of the group as a whole. I think you'll see unions come to an end for a while, I don't think it will happen soon, but I think in the next couple of decades they are phasing them out. There are certain people trying to get rid of them and they just need to be re-vamped and they will come back, because right now it is not right the way they work. I think unions are good when used properly but I think they are mis-managed and I think the unions take away your individual power rather than give you the power that they are supposed to. (S-1)

That nurses do not believe the union has power is of vital importance in understanding their sense of personal powerlessness within the realm of the local, national, and international. This belief exists, and is based in the reality of the economic and political times. The ONA Region 10 representative acknowledged that the union's power has been constrained by these realities, that "the union cannot negotiate monetary gains, but can work toward improving working conditions through the tightening of Health and Safety regulations and Worker's Compensation benefits" (Denys, 1994).

CONCLUSION

Each of the organizations discussed above represents only a portion of nurses in Ontario and, therefore, cannot speak for all nurses. However, they continue to do so

despite this lack of representation. Regular re-evaluation of the mandate and practices of each of the organizations is necessary as a means of ensuring that the staff nurse, as the largest group of nurses in Ontario, is truly represented. Each organization must develop means of empowering the staff nurse, rather than blaming her for not becoming involved. Additionally, each organization must develop anti-racist guidelines to ensure representation of minorities.

In the end, though, these are only band-aid measures. The CNA, the ONA, the CNO, and the RNAO are all organized as hierarchies and, at least at the upper levels, have become organizations which emulate patriarchal bureaucracies in that they have entrenched multiple levels into hierarchal arrangements. This has disenfranchised many staff nurses who have little power within the hospitals where they work and view the nursing organizations as replicas of these same bureaucracies.

New ways of organizing nursing groups are necessary for nurses to realize their full power potential, for it is together that nurses' power will be effective in eliciting changes in the system.

ENDNOTES

1. Mandatory registration with the College of Nurses increases annually and was \$75.00 in 1994; Ontario Nurses Association fees are approximately \$600.00 per year (these are mandatory for all nurses working in a union local); and the Registered Nurses Association of Ontario fees are in the vicinity of \$200.00 per year (registration is voluntary for staff nurses).
2. Nurses are not permitted to join the CNA as individuals, but must belong to a provincial or territorial association. Nurses who do not hold membership in their provincial or territorial association, (RNAO in Ontario) or in an association in another province or territory cannot be members of the national association.
3. This title is borrowed from Sarah Jane Gowe's chapter of the same name in her 1991 book titled Who Cares: The Crisis in Canadian Nursing.

CHAPTER 5: MOBILIZING NURSES' POWER: THE DEVELOPMENT OF A FEMINIST CONSCIOUSNESS

INTRODUCTION

As discussed in the preceeding chapters, the nurses who were interviewed frequently feel powerless within the scope of their work-lives as well as within the larger domain of the hospital and the health care system. In this chapter I will discuss some of the means by which nurses can develop their power, ways which empower individuals as well as groups. This is one of the doctrines of feminism.

STRATEGIES FOR EMPOWERMENT

Through the process of interviewing the nurses and then analyzing those interviews, it became clear that nurses themselves have the answers: they are aware that they will become powerful only when they begin to work together.

I think if nurses could get together and work as a team, work as a group I think they could have, maybe not a lot of power, but could have input into how a hospital is run and what kind of care is given. (S-1)

I think nurses as a group could have power in the health care system and I think they have exerted some, but it has been in small doses. I think from the point of view of nurses and nursing there is power to be had in the health care system. We know things in the system that could work, like the nurse becoming the point of entry to the health care system. (S-2)

We still have that mentality of being handmaidens, in the unconscious mind maybe, but we still have that mentality of handmaidens to the doctors and we always put ourselves in the background when it comes to decisions and also as a group we don't seem to get together, to be unified in our ideas. (Y)

The nurses considered themselves to have potential, rather than actual power. Kalisch & Kalisch (1982:12) differentiate between the actual and potential power of nurses, writing that "Nurses collectively... have much more potential power than actual power because they do not choose or are not able to use their power for a number of reasons."

The problem, however, lies in the pragmatic application of their analysis. As Klein writes

The emergence of a mass movement depends on the development of group consciousness. People need to reject old group images for new roles and to understand that the roots of their problems cannot be solved by their individual efforts before they will look to political remedies. This consciousness is learned. It usually arises out of changed social conditions and economic circumstances, which alter people's understanding of themselves and their lives (1981:81).

Nurses need to cultivate means by which they can gather to discuss their concerns, developing both a group and a feminist consciousness. I believe this to be the first step towards the empowerment of nurses and nursing.

DEFINITION OF FEMINIST CONSCIOUSNESS

In a 1981 article, Judi Coburn wrote that nurses were never able to develop a feminist consciousness because of

the burden of the double images of silent nurse and sacrificing mother. This lack of a feminist consciousness has impeded nurses' progress toward increased empowerment.

Feminist consciousness has been defined as "an entirely new way of perceiving reality" and a "consciousness of women's victimisation" (Humm, 1989:35). Friere (1990:31-32) wrote that "To surmount the situation of oppression, men must first critically recognize its causes".¹ The development of a feminist consciousness includes the analysis of the systemic oppressions which women have faced through history and continue to resist today. For nurses, a feminist consciousness would include knowledge of the historical background of nursing, from the time before Florence Nightingale, returning to the times of the community healers and wise women, who came to be known as witches.²

Additionally, nurses must study in detail the means by which men were able to prevent women from continuing their curative practices and designated women as care-givers instead, thus perpetuating the private (care)/public (cure) division. An understanding of the history of women's oppression is imperative for effecting change in the present. Nursing education which includes the historical foundations of nursing as part of its curriculum would

facilitate this understanding.

Further to this, a feminist consciousness would provide frameworks for the analysis of woman's role within the modern health care system, both as consumers and as workers. Political action, which would involve strategic planning and network-building, would result.

I do feel that regardless if you are only one voice you still have to do it, because one does it, then another does it, and so on, and eventually you are going to build a network. (S-2)

DEVELOPMENT OF A FEMINIST CONSCIOUSNESS

Before nursing can move forward, becoming more powerful, nurses must come together as a group, recognizing their similarities while acknowledging their differences.

...they must develop an identification with and allegiance to other nurses; they have to see their problems as similar to those of all nurses, and realize that improvements occur only as they work collectively. For these things to happen, nurses *must recognize their current powerless state and envision a new identity for the future...* As group consciousness develops, nurses will no longer blame themselves individually, referring to their own shortcomings for the current inadequacies in health care, but instead will view such problems as the result of an inappropriate distribution of scarce resources. Then nurses will recognize that they are discriminated against in the overall health care system and recognize that their concerns are not being taken into account in the process of developing health policy and in making decisions for the distribution of resources (Kalisch & Kalisch, 1982:445 italics in original).

Cultivating a feminist consciousness necessitates engaging in a process that is neither quick nor easy,

whether for an individual or a group, because it includes a deconstruction and a microscopic analysis of all that seems familiar, leaving no area unexamined. The undertaking of such a process can be painful and disconcerting because it calls into question one's prior ideological framework.

The development of a feminist consciousness, as studied by Klein (1984), comprises three phases.³ The first phase involves a process which begins with the sense of belonging to a group and the recognition of common interests shared by the members within that group. For nurses these commonalities could include the fact that nursing in Canada consists of 97% women and that, despite the diversity of employment situations, our main *raison d'être* (to promote or enable the restoration of optimum individual level of health) is common to all nurses.

The second phase involves a "rejection of the traditional definition for the group's status in society, to make way for a new group definition" (Klein, 1981:3). Only when nursing has rejected their image of subservient handmaiden to the physician and adopts a new assertive persona based on knowledge, assertiveness, and autonomous decision-making capabilities will they be able to reject the gendered nature of their work and their oppression.

The third phase involves the realization that

individual actions are not sufficient to resolve the inequities with which women are faced. Only by developing a group consciousness and becoming politically active as a group can solutions be developed to the problems within the scope of nurses' work-lives as well as within the broader realm of the health care system, lobbied for, and implemented.

Being a feminist nurse, in my own experience, results in being labelled as too intense and perhaps a bit crazy, resulting in marginalization and being silenced in the workplace. As an individual, fighting for the validation of one's reality and the reality of the situation of all nurses becomes an exhausting uphill battle, with little hope for making gains in the near future. Colleagues are afraid of change, afraid of making waves, because of the reality of nursing's lack of power, as well as the reality of the current state of the economy. The fear of repercussions overrides any desire for change. "...their struggle for freedom threatens not only the oppressor, but also their own oppressed comrades who are fearful of still greater repression" (Freire, 1990:32).

One of the benefits of adopting a feminist perspective in nursing would be that it would

...encourage us to embrace our rich cultural heritage within nursing and value our predecessors, who made brave and courageous strides in developing the foundations upon which nursing is built (Chinn & Wheeler, 1985:76).

Other benefits would include the ability to develop a cohesive, powerful standpoint based on feminist principles which would enable the rifts which exist between the various nursing associations to be mended.⁴ Nursing groups could join feminist groups, such as the National Action Committee on the Status of Women, as one unified body, to benefit from the invaluable expertise and support the many diverse member groups would have to offer.⁵ A common political agenda would give a stronger voice to nursing's views regarding such issues as pay equity and nurse abuse.

Developing a feminist consciousness can be realized in several ways, including through consciousness-raising groups and through the inclusion of feminist pedagogy in nursing curricula. Consciousness-raising groups need to be organized around topics of interest to nurses. Issues such as pay equity, the current political climate, and health care reform provide sufficient space for a feminist analysis. Groups organized at lunch hours, and facilitated by feminist nurses from the ONA would provide ample learning opportunities for nurses. The sessions would also enable nurses to feel connected to their union, and would

facilitate the development of solidarity.

CONSCIOUSNESS-RAISING: NURSING'S HOPE FOR THE FUTURE?

A deepened consciousness of their situation leads men to apprehend that situation as an historical reality susceptible of transformation. Resignation gives way to the drive for transformation and inquiry, over which men feel themselves to be in control (Freire, 1990:73).

Despite occasional outbursts of resistance, such as the 1988 Alberta nurses' strike, the Quebec nurses' strike in 1989, and the Manitoba nurses' strike in 1991, nurses do not appear to be making an organized effort to struggle against the oppressive health care system, nor against individual oppressors, such as physicians or managers. They have not yet fully developed a cohesive, organized struggle against unfair wages or sexist physicians.

There must be an impetus for change in order to stimulate the process towards the development of a feminist consciousness. What will be the impetus to change for nurses? Given our diversity as a group, can it be the same for all nurses? These questions cannot be answered at this time, but one can hope that nurses will eventually gain a feminist perspective and fight against these manifestations of a systematic oppressions which nurses/women face.

The treatment of nurses in 1983 following the deaths

of several infants at the Hospital for Sick Children in Toronto, as well as the Grange Inquiry which followed, provided a stimulus for the development of a new consciousness within nursing about the systemic barriers which exist in the health care system and prevent them from improving conditions. The Inquiry was labelled a "20th Century Witch Hunt" by Day (1987). Nurses became scapegoats, and their testimony was not considered expert testimony as was that given by physicians. Day (1987:28) writes that "this treatment bolsters and sustains male dominance through the suppression of women's knowledge."

Following the Grange Inquiry, the RNAO made three recommendations in its report entitled "RNAO Responds". One of the three recommendations encourages the adoption of feminist perspectives into nursing education, practice, and research. The belief of the RNAO is that the adoption of such an ideology will empower nurses and increase self-esteem. As discussed in Chapter Two, images of nurses in the media are often negative, and can foster internalized oppression for nurses. The RNAO suggests that nurses "shed their acceptance of destructive stereotypes, myths, and images that impair their self-esteem and devalue the nursing profession ", and that "it is essential for nurses to become aware of their complicity in promoting negative

images and behaviours" (p.23). While promoting the adoption of a feminist perspective, the RNAO blames nurses for contributing to the negative images of nurses in society. This presupposes that nurses have power within the health care system and society, which is not true at this time: nursing power lays dormant still. Blaming nurse-victims individualizes the problem and prevents a broader systemic analysis of the causes of women's oppression. Feminism, on the other hand, enables women to develop this analysis and to strategize for change.

Despite the recommendations of the RNAO, the anger and motivation to work for systemic change following the Grange inquiry soon fizzled and, for an event which inspired nurses to action, it has quickly been erased from current discourse in nursing. A blatant example of this are two recent Canadian nursing texts which carry no mention of the events surrounding the baby deaths, no mention of the investigation, no mention of the Grange inquiry, no mention of Susan Nelles.⁶ What purpose does the erasure of nursing history serve? Who benefits from this erasure? The answer is that the male-dominated institutions of medicine, law, and the hospital hierarchy benefit. If women/nurses are not educated about their history, any achievements or information vital to the self-esteem of individual nurses

and the profession as a whole will go unrecognized. Additionally, without a historical perspective nurses will be unable to contextualize their current problems.

Historically, we have seen women's achievements rendered invisible through their lack of inclusion in male-stream history textbooks. If events of great importance such as the Grange Inquiry are omitted from nursing literature who will learn from them? And who go on to confront the oppressors?

The key to the development of a feminist consciousness within nursing lies in the powerful process known as 'consciousness-raising' (C-R). Consciousness-raising is "a form of verbal self-examination taking place with the support and collaboration of other women in small groups" (Humm, 1989:35). C-R entails the gathering together of women to discuss experiences they have in common, and from personal experience deriving theoretical analyses and devise strategies for political action. Nursing must begin its journey to feminism here.

Nurses share several things in common, the most important being that the majority of nurses are women, and as women suffer many of the same oppressions, such as inadequate pay, sub-standard working conditions, and too many demands placed on them by society, their families, and

friends. C-R would serve nurses well in that they could deconstruct their role within the health care system, enabling them to place a higher value on their work, and on that of their peers.

Several nurse authors promote consciousness-raising for nurses as a first step towards liberation⁷, beginning with Heide in 1973 and Starr in 1974, and more recently, Banning (1990), and Baumgart (1982). The calls for C-R are similar in tone: nurses must talk to each other to develop links with who they were historically and who they are now. Consciousness-raising can be incorporated into classroom settings, work-settings during lunch hour, or any other time when nurses come together in a relaxed, safe atmosphere.

While it may appear to be an uncomplicated recommendation, the organization of nurses' gatherings is anything but easy. The attendance at union meetings is low, and, as outlined in Chapter Four, few staff nurses belong to either the RNAO or the CNA. Despite the poor attendance at union meetings, the union probably remains the best hope of disseminating information and organizing nurses at the grassroots level.

As discussed in Chapter Four, many nurses feel disenfranchised from the union, viewing it as a large bureaucratic organization which does not meet their needs

as women/workers. As one method of ameliorating this situation, representatives from the union must return to their roots, discussing matters informally with locals, with the nurses whom they represent.

In addition to consciousness-raising, nurses must work together on coalition building and the transformation of nursing as it now exists within the hospital system. Women must

...ensure we maintain the level of accomplishments we have made, thus we must institutionalize our collective power, setting up actual organizational structures that protect women's interests rather than relying on the hope that social attitudes, once changed in favor of gender equality, will remain stable (Lips, 1991:12).

Economists tell us we are now in a post-industrial society, referred to by some as the 'information age'. This transitional phase renders the patriarchal structures of society vulnerable to change. This does not mean the transition will necessarily be a smooth one, but nurses must act now to ensure their place as stakeholders in a re-organized system.

Robertson (1978) has delineated fourteen "transformation roles" which people occupy in this era, leading to the development of the new society. Of these roles, there are several ones which nurses could incorporate into their analysis, their work, and their political lives.

These roles include:

1. The demolition role, in which people work to facilitate a speedy deconstruction of the current system;
2. A liberating role, whereby people work to end their and other's dependence on the old system;
3. A decolonizing role, which entails working towards the amelioration of the distress created by the end of the old era;
4. An enabling role, the purpose of which is to empower themselves and others to develop agency.

Baumgart (1982) considers the adoption of these roles by nurses as integral to nursing's new consciousness. With the benefit of a feminist analysis, nurses could adopt the above roles and have a pivotal role in the transformation of the hierarchal health care system.

One of the means of changing the practice of nursing towards one that is more empowering for the nurse is through the development of feminist curricula in nursing schools. The education of nurses about feminism, within the framework of feminist pedagogy is vital to the transformation of our position within the health care system and society. Kagan-Krieger (1991) wrote that the feminist education of nurses would enable them to reclaim their power and that

A subsequent nursing practice based on feminist principles could -- in conjunction with other changes in our society -- revive the essence of nursing and change the subordinate position of nurses within our health care system (p.30).

In order for nurses to be effective in adopting the

roles described above, they will have to become effective as a group.

There are over a quarter of a million nurses in Canada. The amount of power which has lain dormant for too long must now be realized before the window of opportunity provided by the need for economic reform closes.

FEMINIST THEORY: FEMINIST PRAXIS

Freire (1990) wrote that

One of the gravest obstacles to the achievement of liberation is that oppressive reality absorbs those within it and thereby acts to submerge men's consciousness...To no longer be prey to its force, one must emerge from it and turn upon it. This can only be done by means of the praxis: reflection and action upon the world in order to transform it.

The process of C-R will enable nurses to become active participants in the process of change, rather than passive recipients, and by doing so, they will be empowered.

Hooks (1984:84) writes that "women cannot gain much power on the terms set by the existing social structure without undermining the struggle to end sexist oppression". The transition towards a more egalitarian society requires a transformation of the patriarchal ideologies and the structures which have arisen from these ideologies.

Like most other occupational groups, nurses are not a homogeneous group with similar values, but rather represent

the spectrum of women from conservative right wing women to radical feminists; nurses vary in sexual orientation, age, educational status, race, and ethnic origins. Given this diversity, although it will be difficult to develop a strategic plan for empowerment, it is not an impossible task.

Ramazanoglu (1989) writes that

There are a number of problems in linking feminist theory and practice...conceptions of liberation also depend on what views we take of the relations between different sources of power, such as those between modes of production and patriarchal sex/gender systems. The development of feminism has shown that 'women' cannot be treated as a unitary category, and so the interrelations of the sources of divisions between women must be identified... (p.179).

It is imperative that nurses who organize evaluate differences between nurses and form strategic plans which empower all nurses.

CONCLUSION

The lack of a feminist consciousness within nursing hinders our ability to develop a broad-based assessment and analysis of society and our place within it. Without the development of a feminist analysis, staff nurses may never be effective in transforming the structures which oppress them, or at the very least, they will be at the mercy of the winds of change. Any revisions which occur will be slow

and will face many challenges from those who support the status quo, including physicians, managers, (including nurse managers), as well as the public.

I do not believe that there will be one catalyst for nursing's movement towards the adoption of feminist awareness, but rather small pockets of nurses may react to events which affect their lives, such as the social contract implications. As small groups become radicalized, the murmur may eventually turn to a roar, leaving behind the old world of nursing and in its place a new, woman-positive one.

ENDNOTES

1. While Friere addresses his call for consciousness to men, his ideas are applicable to any oppressed group.
2. See Ehrenreich, B. and English, D. (1973). Witches, Midwives, and Nurses: A History of Women Healers.
3. Gurin, Miller, & Gurin have identified four steps in the process. See Cook, E. (1989). Measuring Feminist Consciousness.
4. For an interesting insight into the politics within and between the various nursing associations in Canada see the chapter "Turf Wars" in Growe, S.J. (1991). Who Cares: the crisis in Canadian Nursing, which was referred to in Chapter Four.
5. While the RNAO is a member of the NAC, neither the ONA nor the CNA are members.
6. The two books to which I refer are: Kerr & MacPhail. (1991). Canadian Nursing: Issues and Perspectives. & Baumgart & Larsen. (1988). Canadian Nursing Faces the Future (the second edition of this book has included the Grange Inquiry).
7. These include Heide, (1973); Starr, (1974); Christenson, (1990); and Banning, (1990)

CHAPTER 6: CONCLUSION

The purpose of this thesis was to examine hospital staff nurses' experiences of power and powerlessness through interactive interviews which were conducted with ten female staff nurses. This was done from a feminist perspective, employing the theoretical frameworks of both Dorothy Smith and Hilary Lips.

In addition to interactive interviews conducted with the nurses, I also located nurses' current status within the health care hierarchy from within a historical context.

While the results of my study cannot be generalized to all nurses, they can be considered to represent at least some portion of hospital staff nurses. They can also be used as the basis for further examination of the experiences of hospital nurses, who comprise the majority of nurses in Canada and in Ontario.

The nurses I interviewed most frequently felt powerful vis-à-vis patient care situations when they were able to use their expertise to influence the course of treatment or the outcome of the illness. However, through the interviews it became apparent that nurses frequently experience powerlessness when they are unable to control the material conditions of their work, or when their abilities are not validated by peers, physicians, or superiors.

Part of the problem with the lack of nursing power rests with the organizations which represent nurses. The ONA, which represents the majority of staff nurses in Ontario, is of primary importance vis-à-vis the empowerment of staff nurses. The nurses I interviewed felt disenfranchised from the union, feeling that the communication from the union executive was poor, and that the union did not heed their concerns. They believed that the union executive had become more concerned with their own power and had forgotten about the average staff nurse.

I did not address the range of personal factors which have impacted on nurses' personal power, such as violence, although self-esteem and socialization processes were discussed in a limited way. However, one of the nurses addressed this, stating that

A lot of people demand power or require power because it helps their inner self esteem. I don't see power as being used for esteem. I see power as being used to help my associates and to help my patients. (J)

Further research is necessary to discover the extent of nurses' feelings of powerlessness. Nursing educators need to develop feminist pedagogy within their curricula to empower nurses as they develop their expertise.

A race, class, gender analysis has been incorporated within this study when possible. Unfortunately, little

information is available which explicitly relates to race within nursing. More research is needed on racism within the health care system and within nursing and other health care professions, not only for the sake of research, but rather as a means of effecting change.

Issues related to power within nursing have seldom been addressed from a feminist perspective. Instead, nurses have maintained a focus on the acquisition of power as defined in mainstream theory. In this thesis, hospital nurses themselves were asked about their experiences of power and powerlessness. Although their experiences are not representative of all nurses, it has provided a glimpse into the realities of nurses' work worklives. While I conclude that many nurses feel powerless, further research would need to be conducted to determine if these experiences are widespread. Further to that, research is necessary to determine whether the experiences of nurses other than those who work in hospitals are comparable to the ones portrayed here.

I have argued through this paper that, in order to rectify the situation, nurses must develop a collective consciousness of their oppression from within a feminist perspective. Only then will they be able to work together to deconstruct the system which oppresses them and build a

new, healthier health care system. Four of the nurses I interviewed stated they were feminists. However, they tended to hold stereotypical views of what feminists were ("bra-burners", "castrating, male bashers", "masculine in their dress and approach and more gruff"). Their analysis of the goals of feminism was limited to media portrayals of feminists. This is reflected by Valentine (1992:21) who writes of a 1988 study which examined nurses' lack of a feminist consciousness and concluded that

Five out of six of the participants regarded power and ambition negatively...ambitious nurses who fought for or demanded rights were seen as uncaring and undeserving... Three participants thought that identification with the radical image of "bra burners" was unpalatable to most nurses and made them feel very uncomfortable. Three others contended that most nurses were conservative and therefore rejected a feminist stance.

Remkes (1991:11) writes that "Raising a feminist awareness is key to developing independent nursing practice." It is evident that a great deal of education about feminist ideology is necessary before nurses will find it acceptable to adopt a feminist analysis of their oppression. This education and the subsequent development of a feminist consciousness are the key to the liberation of nurses from the oppressive conditions of labour experienced within the patriarchal, hierarchal health care system.

***** STATISTICS CANADA *****
 REGISTERED NURSES MANAGEMENT DATA -
 REGISTERED NURSES SURVEY - 1991

APPENDIX A
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PROVINCE OF REGISTRATION BY ACTIVITY STATUS,
 SEX, HIGHEST LEVEL OF EDUCATION IN NURSING
 TABLE 2

CANADA

ACTIVITY STATUS BY SEX	HIGHEST LEVEL OF EDUCATION IN NURSING					
	Total	REGISTERED NURSE DIPLOMA	POST-BASIC DIPL/CERT	BACCALAUREATE	MASTER'S/HIGHER	NOT STATED
Total	262,288	181,088	42,843	35,561	2,796	-
Employed in Nursing	170,273	114,982	28,479	25,018	1,874	-
Employed in other than Nursing	5,787	4,279	639	730	59	-
Not employed	11,858	8,411	1,686	1,608	133	-
Not stated	74,470	53,496	12,039	8,205	730	-
MALE						
Total	8,595	6,159	1,340	1,025	71	-
Employed in Nursing	3,541	2,364	705	435	37	-
Employed in other than Nursing	98	69	15	12	2	-
Not employed	89	56	15	17	1	-
Not stated	4,867	3,670	605	561	31	-

***** STATISTICS CANADA *****
 REGISTERED NURSES MANAGEMENT DATA -
 REGISTERED NURSES SURVEY - 1991

PROVINCE OF REGISTRATION BY ACTIVITY STATUS,
 SEX, HIGHEST LEVEL OF EDUCATION IN NURSING
 TABLE 2

CANADA

ACTIVITY STATUS BY SEX	HIGHEST LEVEL OF EDUCATION IN NURSING					
	Total	REGISTERED NURSE DIPLOMA	POST-BASIC DIPL/CERT	BACCALAUREATE	MASTER'S/HIGHER	NOT STATED
FEMALE						
Total	253,693	174,929	41,503	34,536	2,725	-
Employed in Nursing	166,732	112,538	27,774	24,583	1,837	-
Employed in other than Nursing	5,609	4,210	624	718	57	-
Not employed	11,749	8,355	1,671	1,591	132	-
Not stated	69,603	49,826	11,434	7,644	699	-

***** STATISTICS CANADA *****
REGISTERED NURSES MANAGEMENT DATA -
REGISTERED NURSES SURVEY - 1991

EMPLOYED IN NURSING
PROVINCE OF REGISTRATION BY PLACE OF EMPLOYMENT
BY AGE GROUP
TABLE 5

ONTARIO

PLACE OF EMPLOYMENT	AGE GROUP									
	Total	UNDER 25 YEARS	25-29	30-34	35-39	40-44	45-49	50-54	55 YEARS AND OVER	NOT STATED
Total.....	80,912	900	9,934	10,854	14,873	14,117	12,092	8,524	9,570	48
HOSPITAL.....	56,444	851	8,683	8,786	10,938	9,466	7,498	5,101	5,164	37
NURSING HOME / HOME FOR THE AGED	5,316	9	163	280	690	904	1,011	917	1,335	5
COMMUNITY HEALTH.....	7,828	15	643	1,015	1,486	1,593	1,311	847	916	2
PHYSICIAN'S OFFICE/ FAMILY PRACTICE UNIT.....	3,237	7	113	223	575	677	671	457	513	1
EDUCATIONAL INSTITUTION.....	2,111	1	50	161	336	426	491	298	348	-
OTHER.....	5,567	12	253	437	793	1,002	1,035	857	1,175	3
NOT STATED.....	609	5	29	32	55	47	75	47	119	-

APPENDIX C (notice)**ATTENTION
STAFF NURSES**

I am a Registered Nurse with 12 years experience in various work settings. I am currently working towards a Masters of Arts in Canadian Studies at Carleton University.

My experiences in nursing have made me aware of some of the problems nurses face in the workplace. I am interested in investigating and documenting the problems which nurses encounter with the hope that I can facilitate positive change in our work-lives.

I am looking for volunteers to participate in research which will examine the experiences of power and powerlessness within nursing in relation to work within the hospital environment. As a staff nurse you have a wealth of information to contribute.

This research will involve a two hour interview with myself as researcher. While the interview will be tape-recorded, confidentiality will be maintained.

I am certain that your experience and knowledge will contribute a great deal to my research. I hope you will be able to assist me by participating in the manner outlined above.

**IF YOU ARE INTERESTED
PLEASE CONTACT ME!**

Thank you.

**Sharon Miller
tel: (613) 565-7797
School of Canadian Studies
1108 Dunton Tower
Carleton University
1223 Colonel By Drive
Ottawa, Ont.
K1S 5B6**

APPENDIX D

INFORMATION SHEET

Dear Participant:

I am a Registered Nurse with 12 years experience in various work settings. I am currently working towards a Masters of Arts in Canadian Studies at Carleton University. This research is part of that work.

My experiences in nursing have made me aware of some of the problems nurses experience in the workplace. This study has been designed to examine the concepts of power and powerlessness within nursing in relation to your work in the hospital environment. As a staff nurse you have a wealth of information to contribute.

This research will involve a two hour interview with myself as researcher. While the interview will be tape-recorded, confidentiality will be maintained. Your feedback may be required after the interview has been transcribed if clarification of any response is necessary.

I am certain that your experience and knowledge will contribute a great deal to my research. I hope you will be able to assist me by participating in the manner outlined above.

Thank you.

Sharon Miller
School of Canadian Studies
1108 Dunton Tower
Carleton University
1223 Colonel By Drive
Ottawa, Ont.
K1S 5B6

tel: (613) 565-7797

My thesis supervisor is Greta Hofmann Nemiroff, Joint Chair, Women's Studies, University of Ottawa/Carleton University. Should any concerns arise regarding this thesis she may be reached at 788-6644.

APPENDIX E

RESEARCH CONSENT FORM

A summary of the purpose and design of the research project and my participation in the project has been explained to me by the researcher, Sharon Miller.

I understand that the data will be collected in an interview which will be tape recorded. I understand that my feedback may be required after the information has been transcribed if clarification of any response is necessary. I also understand that confidentiality will be maintained.

My participation is voluntary and I understand that I may withdraw from the study at any time without penalty. I also understand that there will be no direct benefit to me from my participation in the study.

I have read and understood the consent and the nature of my involvement and I agree to participate in the research.

Date: _____

Name: _____

Address: _____

Telephone: _____

Signature: _____

Signature of Researcher: _____

I agree to have my statements quoted in the research report on the condition that my name not be mentioned.

Signature: _____

Signature of Researcher: _____

I have explained the purpose of the study and the nature of the commitment to the above-named and I believe she has understood it.

Name: _____

Signature: _____

APPENDIX F

INTERVIEW SCHEDULE

BACKGROUND INFORMATION

Age _____
 Single \ Married \ Common Law \ Widowed \ Divorced
 Year of Graduation as a nurse _____ Diploma? BScN? Post-RN?
 Other Post Secondary Education history _____
 Do you belong to ONA? RNAO?
 Do you have any children? How many? How old are they?
 (If a single parent) Are you the sole supporter of your
 child(ren)?
 Who does the majority of child care?
 What child-care arrangements do you have while you are at work?

EMPLOYMENT HISTORY

1. Where do you currently work? (floor _____; service _____)
2. For how long have you worked there?
3. What type of nursing is it? (primary nursing, team nursing, etc)
4. Could you outline your other work experiences for me?
5. How many years in total have you worked as a nurse?

VALUES

1. Why did you become a nurse?
2. What do you value in nursing?
3. What is important to you about nursing?
4. What does "caring" in nursing mean?
5. What does "responsibility" in nursing mean?
6. What does being a "professional nurse" mean to you?
7. What types of nursing care are neglected when you don't have time? What tasks have the least priority in practice?
8. How would you describe a "good nurse"?

DEFINITION OF POWER

Could you define what power means to you?

PERSONAL POWER

1. Do you have any choice in your daily work assignment? Explain how the assignment is organized and who is responsible for this.
2. What do you do if you disagree with your assignment? Does what you do have any effect? Explain.
3. Who makes up your work schedule? Is your input requested for scheduling?
4. Have you ever felt powerful in any situations at work? Could you give a couple of examples?

5. Have you ever felt powerless in any situations at work? Could you give a couple of examples?
6. Do you want more power as a nurse? Describe what having more power means--in what areas do you want more power?
7. Do you consider that you have power on the ward where you work? Explain. In the hospital? Explain.
8. Do you believe you are able to bring about change on your ward? Examples. Within the hospital? Examples.
9. Do you consider that you, as a nurse, have any power within the health care system?
10. How would you describe this power? Could you give any examples?
11. Describe what happens when you make an error. How do your peers, your head nurse, physicians, or others react to errors?

INTERACTIONS WITH PEERS

1. Who do you consider peers within your workplace?
2. Do some nurses on your ward have more power than other nurses?
3. If yes, why do you think this is so? (education? seniority? personality? something else?)
4. Do nurses who work in particular areas within the hospital have more power/prestige than other nurses? ex. ICU, CCU, Emergency, etc.
5. If yes, why do you think this is so?
6. How do you resolve conflict with your peers?
7. Do you socialize with your co-workers?

INTERACTIONS WITH PHYSICIANS

1. Do you address medical students by their first names? Interns? Residents? Do they address you by your first name?
2. Do you address staff doctors by their first names? Do they address you by your first name?
3. How do you decide which doctors you will address by their first name?
4. Do physicians solicit your input into solutions to patient problems?
5. Do you believe that in some instances you have a better solution to a patients problem than a physician?
6. Do you tell the physician this? If so, how do you tell her/him?
7. What is the general reaction to your input, whether solicited or not?
8. If a physician has made an error, do you tell her/him? Why/why not?
9. Do you ever give up your chair to a physician? Why?
10. Do you socialize with physicians?

INTERACTIONS WITH OTHER GROUPS

1. Describe the relationship between Registered Nursing Assistants and RN's on your ward.
2. Do you have any control over the work of RNA's? Describe.
3. If you work in a supervisory capacity over RNA's do you receive financial compensation or other recognition for this?
4. How does the work of RNA's differ from the work of RN's on your ward?
5. Do you socialize with any RNA's?
6. Do you feel you have more or less power than RNA's? Explain.
7. Do you address RNA's, health care aides, orderlies by their first names?
8. Do they address you by your first name?
9. Who makes out the RNA's daily patient care assignment?
10. If an RNA makes an error who is accountable?

(ASK THE FOLLOWING IF APPLICABLE):

1. Describe the relationship between orderlies and RN's on your ward.
2. Do you have any control over the work of orderlies? Describe.
3. If you work in a supervisory capacity over orderlies do you receive financial compensation or other recognition for this?
4. How does the work of orderlies differ from the work of RN's on your ward?
5. Do you socialize with any orderlies?
6. Do you feel you have more or less power than orderlies? Explain.
7. Who makes out the orderlies' daily patient care assignment?
8. If an orderly makes an error who is accountable?
9. Describe the relationship between Health Care Aides (HCA's) and RN's on your ward.
10. Do you have any control over the work of HCA's? Describe.
11. If you work in a supervisory capacity over HCA's do you receive financial compensation or other recognition for this?
12. How does the work of HCA's differ from the work of RN's on your ward?
13. Do you socialize with any HCA's?
14. Do you feel you have more or less power than HCA's? Explain.
15. Who makes out the HCA's daily patient care assignment?
16. If a HCA makes an error who is accountable?
17. Do you address RNA's, health care aides, orderlies by their first names?
18. Do they address you by your first name?

ORGANIZATIONAL POWER

1. Do you feel nurses as a group have power? Explain.
2. Do you think nurses should have more power?
3. What form do you believe this power should take?

4. What do you think it would take for nurses to increase their power?
5. How do you think having more power would impact on relations with patients, physicians, other groups within the health care system?
6. Do you believe there have been any increases in nurses' power, either as individuals or groups, since you entered nursing?
7. Do you sit on any hospital committees?
8. Who chairs these committees?
9. Is your opinion as a nurse-representative solicited?
10. Do you think nurses should have unions? Why or why not?
11. How do you feel about being a member of the ONA?
12. Do you think the union represents you?
13. Are you an active member of the ONA? If not, why?
14. Do you think the ONA has any real power?

FEMINISM

1. Reflecting on what we have talked about, to what extent do you think nursing issues are women's issues?
2. Do you consider yourself a feminist?
3. Does feminism have any answers for some of the problems we have talked about?

RE-DEFINITION OF POWER

Could you define power for me again in light of our discussion?

Do you have any other comments you would like to add at this time?

THANK YOU FOR YOUR PARTICIPATION.

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