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**The Political Economy of Nursing in the Industrialized World:
Impacts of Caring, Professionalism and State Policy
on the Everyday Practice of Nurses.**

by

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Abstract

This thesis examines the impacts of caring, professionalism and state policy on the everyday practice of nurses in Canada, France, England and Italy, under policy reform strategies of cost containment. The thesis aimed to provide the basis for the analysis of nursing with a broader scope, to assist nurses in their strategies for progressive transformation. It argues that there are inherent contradictions built into the different assumptions of the concepts of caring and professionalism, as well as the conditions in which both concepts are engendered; while at the same time creating tensions within. In addition, it contends that tensions and contradictions exist, not only in the institutional matrices in which this occupational group is embedded, but also in the relations of ruling that sustain the structure of control in nursing and at the same time providing nurses motive for resistance, changes and transformation.

The study links feminist theory with political economy and connects them to theoretical work on structure and agency in a comparative perspective. With this approach it was possible to ascertain and disturb the taken-for-grantedness of the concepts of caring and professionalism and their related ramifications; equally the taken-for-grantedness of their instruments of operationalization, thus demonstrating how new understandings are created through and against contested and contradictory processes, over time and space. Similarly, at the operational level the analysis demonstrates that the state contradictory policy initiatives have an effect on the nursing profession, from the scope of practice, to

the labour process. Furthermore, these contradictory policy initiatives influence also the everyday practice of nurses, beginning with nurses' knowledge and action, to the professional practice and the context of professional activities. While these initiatives have to some extent enabled nurses they have also shown to engender more impediments than the so-called enablers. The analysis demonstrated a significant departure from the way nursing issues are approached. The merit is in the demonstration that such analysis can be done.

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List of Abbreviations

CNO	College of Nurses of Ontario
CREDES	Centre de recherche d' étude et de documentation en économie de la santé
EU	European Union
GDP	Gross Domestic Product
ICN	International Council of Nurses
ILO	International Labour Organization
IPASVI	Infermiere professionali e assistensi sanitarie visitatrici
OECD	Organization for Economic Co-Operation and Development
OIIQ	Ordre des infirmières et infirmiers du Québec
ONP	Office of Nursing Policy
RCN	Royal College of Nursing
RNs	Registered Nurses
RNAO	Registered Nurses Association of Ontario
UNESCO	United Nations Education, Scientific and Cultural Organization
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

Political economy understands politics and economics as integrally related. For a political economist an adequate study of the whole cannot be developed from the separate study of individual parts. Nor can it be developed without attention paid to the people who are the subjects of history. States, markets, ideas, discourses, and civil society are not independent variables but interrelated parts of the same whole. This whole is shaped, but not determined, by the mode of production, that is, by the means of producing and reproducing for socially determined needs ... This mode of production, like the markets central to its culture and representation, is seen as a social construct, not as a natural, or inevitable mechanism governed by immutable laws. Its particular construction and the relations among its parts change over time and within particular contexts (Armstrong, Armstrong and Coburn 2001: vii).

1.1 Introduction

Nursing and caring in the mundane sense of the words are as old as mankind born out of the historical traditions in women's commitment to care for the family and the sick (Bullock and Bullock 1964). Women have always been central to the provision of health care, both in and out of the home. The incorporation of caring services into the welfare system at one point in history has profoundly influenced the development of nursing work and led to the emergence of male medical dominance, similarly the expansion of hospitals as institutions (Abbott and Wallace 1990). Most often, in order to differentiate themselves from other occupations, nurses articulate, in some form, the importance of caring to their

work. Nurses and society-at-large generally recognize this, implicitly and explicitly, and see the nurse as a health caregiver. Arguably, nursing¹ is an occupational group, which represents the paradigmatic case of the caring professionals who, in their work, have a primary commitment to care for their clients. Personalized care with a service ideology is central to their practice as professionals (Etzioni 1969; Abbott and Wallace 1990; Macdonald 1995). In this case, nursing's collective knowledge claim is formulated on the basis of a collective experience. However, it is crucial to understand nursing's collective experiences within the context of larger social structures and processes, to illustrate how these structures and processes influence and are influenced by nurse's work (Armstrong and Armstrong 1990).

During the last century, nursing in its broadest sense has undergone major

¹ This refers to the official positions for a definition of nursing and nursing practice. The reference to these positions should not be interpreted as a blind acceptance of them. They serve as a springboard to investigate the subject. Officially, nursing is defined as both an art and a science that requires an understanding and application of the knowledge and skills specific to the discipline. It also draws on knowledge and techniques derived from the humanities and the physical, social, medical and biological sciences (Canadian Nurses Association (CNA) 1994; International Council of Nurses (ICN) 1998; College of Nurses of Ontario 1994).

Nursing practice is the therapeutic relationship which enables the client to attain, maintain, or regain optimal function by promoting the client's health through assessing, providing care for, and treating the client's health conditions. This is achieved by supportive, preventative, therapeutic, palliative, and rehabilitative means. The relationship with an individual client may be direct practice role or it may be indirect, by means of management, education, and research roles (College of Nurses of Ontario). This definition is drawn from the ICN position paper and also from World Health Organisation (WHO).

In its publication *Health for All Nursing Series: Mission and Functions of the Nurse* (1991), WHO's states: "The mission of nursing in society is to help individuals, families and groups to determine and achieve their physical, mental and social potential, and to do so within the challenging context of the environment in which they live and work. This requires nurses to develop and perform functions that relate to the promotion and maintenance of health as well as to the prevention of ill health." Nurses also work as partners with members of other professions and occupations involved in providing health and related services.

and significant structural, educational and professional changes. As a whole, the nursing profession includes local, national and international professional organizations and individual practitioners in the search of common goals, such as legitimacy, market power and capacity to provide quality care. The profession supplies nursing services to consumers, employers, and other purchasers. The statistical significance of nursing worldwide is evident. Even when limited to registered nurses, the nursing profession is huge (Begun and White 1995). They are employed, for the most part, in the health care labour market. However, for the past two decades or so healthcare cost-containment has become a major policy issue which drives healthcare reform in the industrialized world. This certainly will affect the profession.

This study examines the impacts of caring, professionalism and state policy on the everyday practice of nurses in the industrialized world² in an attempt to answer the following set of questions: Do mainstream traditions of professionalism conflict with nurses' caring work? If so or not, how do these paradigms work in the practice setting and in the everyday life of nurses? What are the links and contradictions between nurses' knowledge and actions?

The claims made, in this thesis, are threefold: conceptual, theoretical and operational. The first is at the conceptual level. This asserts that there are inherent contradictions built into the different assumptions of the concepts of caring and

² The industrialized world, in this investigation, is in reference mainly to Canada, England, France and Italy.

mainstream professionalism, as well as in the conditions in which both concepts are engendered; while these, at the same time, create tensions within the profession. On one hand, internal to caring are the notions of wholeness and subjectivity³. The notion of wholeness, in theory, denotes that the individual patient is viewed in his/her entirety. This entails not only the physical needs, but also the psychosocial and the spiritual elements. Subjectivity implies that the nurse has to be involved in the care process. Similarly, feeling and intuition are an integral part of proper therapeutic relationship. However, the underpinning notion of subjectivity built into the concept of caring contributes also to its invisibility. On the other hand, internal to professionalism, there is, in theory, a connotation of speciality and objectivity⁴. Here, the health problems of the individual are partitioned and objectified in diseases. There is, to some extent, an expectation to keep a distance from the recipients of care. Unlike the subjectivity, the objectivity notion, in which the professionalism is premised, makes it more visible.

Moreover, caring is formally accepted as a nursing philosophy, this is implied, in theory, not only to providing the care but also having the attitude and values attached to it when carrying out interventions. The therapeutic relationship is very important, as individual nurses must strive to view patients

³ These notions are reiterated in Chapter Three and subsequently.

⁴ These notions are discussed in Chapter Three and in the subsequent chapters.

as a whole. Professionalism, on the other hand, is closely associated, to some extent, with the medicine's ⁵ curing philosophy, which entails specialization or fragmentation in the form of body parts and diseases. An emphasis is placed on the diagnosis and treatment, and most importantly, it is the prevailing model in worldwide hospital sectors. All of these become more complicated in a cross-national study when the different translations and interpretations enter into play, specifically with the concept of caring not so much with professionalism, which tends to be more standardized.

The second claim is the theoretical level. The thesis argues for a feminist theory of nursing subjectivity based on Dorothy Smith's practical approach to epistemology and her ruling relations ⁶ tenet to interrogate the ways in which nurses/subjects apprehend their social world (discussed in Chapter Four). At issue are those practices that transform what nurses experience directly in their everyday/everynight world, into some forms of knowledge where nurses as subjects disappear, and where their views on their personal experience are altered and subjugated by the relations of ruling (Smith 1999). In addition, the dissertation takes the position that the key to understanding the formation and transformation of the nursing professional caring work — is an understanding of the way the practice of nursing is implicated in the historical construction of a

⁵ This is not to say that nurses have the monopoly on caring — doctors and other health professionals do provide care.

⁶ Referred to the process of separation and specialization, similar to the relations of "consciousness" and agency. They are mediated by text and text-based structures of communication, knowledge, information, regulation, and control et cetera. See Smith (1999:77-82).

self-sustaining social structure with all the inherent contradictions, tensions, struggles and changes that are part of these processes. Therefore, the thesis posits that a feminist theory of nursing subjectivity focuses on relations of ruling, and feminist political economy opens up that possibility.

The third claim is at the operational level. Here, the thesis asserts that in the industrialized world and everywhere else from Canada (Quebec and Ontario), United Kingdom (England), and France to Italy, with which particularly this investigation is concerned, the state with its various contradictory policy initiatives affects the profession and every aspect of nursing practice. Here, the state⁷ is conceptualized as not only as decision-making bodies and bureaucracies normally associated with governments, but it also encompasses the legal and judiciary systems as well as other institutions, such as hospitals that are financed by governments. The state also refers to the relations concerning individual citizenship of a particular nation (Armstrong and Armstrong, 1990:113). Thus, policy initiatives affect not only the production/reproduction⁸ and the scope of

⁷ This conceptualization is in line with the intent of the thesis. Therefore, keep this in mind whenever this term is referred to. See Armstrong and Armstrong (1990) in *Theorizing Women's Work*.

⁸ Here, the mode of production of nurses is the act or process of producing a new influx of nurses for the healthcare market. This consists of nurses graduated from basic nursing educational programs; nurses already credentialed from other jurisdictions or countries, as well as those returning to work after a period of unemployment in nursing. Reproduction is viewed here, as the process of retaining nurses within the system, and replacing nurses who are leaving the market. This notion also implies daily reproduction or reproductive labour in the feminist tradition of household labour, which linked home and workplace. However, this perspective on reproduction is excluded because it constitutes a study on itself. Production and reproduction are closely linked (further elaborated in Chapter Five).

nursing practice⁹, but also the labour process. The influence of the state also encompasses the everyday practice of nurses, starting from the nurses' knowledge and action, to the professional practice and context of professional activities. However, there are variations over time and space related to the political economy, the cultural and legal institutional arrangements of individual state, and jurisdiction.

In this, policy is viewed as an "objectified"¹⁰ set of procedures mediated by "text", which serves as apparatuses to operationalize and sustain the ruling order. Furthermore, tensions and contradictions exist, not only in the institutional matrices in which this occupational group is embedded, but also in the relations of ruling that sustain the structure of control in nursing and provide, at the same time, nurses a motive for resistance, changes and transformation. All of these make the problem of nursing professionalism very complex. It is within this multifaceted complexity that evidence is gathered to demonstrate how these paradigms work for nurses in practice and in everyday life, as well as in establishing links and contradictions that exist between knowledge and actions.

⁹ The scope of practice of a profession includes the activities for which its members are educated and authorized to perform (Risk 1992). It is within the scope of practice that caring and professionalism can be actualized. For more discussion see Chapter Five.

¹⁰ Term borrowed from Dorothy Smith 1990 a) It is part of the epistemological foundation of this thesis to deconstruct the mainstream notion of knowledge. "Objectified" is viewed by its practitioners as an important set of procedures that serve to separate the discipline's body of knowledge (in reference to sociology or social sciences. Here, it is referred to the nursing discipline body of knowledge). In this, there is the notion of objectivity. The ethics of objectivity and the methods used in its practice are concerned primarily with the detachment of the knowers from what they know or experience, and in particular with the separation of what is known from the knowers' interests, "biases," etc., that are not endorsed by the discipline.

The contribution lies in linking feminist theory with political economy, and connecting them to theoretical work on structure and agency in a comparative perspective. With this approach, it is possible to ascertain and disturb the taken-for-grantedness of both concepts and their related ramifications, similarly, as the taken-for-grantedness of their instruments of operationalization, thus demonstrating how new understandings are created through and against contested and contradictory processes, over time and space. The aim is to provide the basis for the analysis of nursing caring, professionalism and state policy initiatives in nursing practice, in general and in everyday practices, to assist nurses in their strategies for progressive transformation. To my knowledge, no study on nurses uses this approach.

What will ensue, in the remaining part of this chapter, is an argument for the relevance of political economy in healthcare policy issues and, for that matter, in any study of nursing issues related to the impact of healthcare policy strategies. At the same time, it will try to position nursing in the global healthcare market with a focus on the declining number of nurses related to policy initiatives of cost-containment in the hospital sector. Given health professions cannot be discussed in isolation, reference is made to medicine. Subsequently, it will briefly explain the complexity in approaches used in this investigation, followed by the thesis outline and a diagram representing the framework of the study.

1.2 Towards a Political Economy of Nursing in the Industrialized World

Evans (1984; 1990) contends that the industrialized societies invest a very large proportion of their economic resources in the production and distribution of 'health care'. As such, the "health care industry which assembles these resources and converts them into various health-related goods and services is one of the largest clusters of economic activity in all modern states. This concentration of economic effort has meant that public or collective health policy has been predominantly health care policy" (1990:1359). For the author, health care has characteristics, which make it intrinsically different from 'normal' commodities traded through private markets, and this is reflected in the peculiar and complex collection of institutional arrangements, which surround its provision. In addition, healthcare systems¹¹ are critical determinants of health service provision/delivery, of healthcare financing and resource allocation (human, healthcare facilities, technologies and others). In this, there is a point for contention. Evans¹² seems to equate healthcare policy as solely an economic issue. One would argue that whenever there is allocation of scarce resources, it becomes very much a political issue.

¹¹ In the literature, the word "system" is thus used in a fairly loose fashion and does not necessarily imply an organized and interrelated structure of activities, but it encompasses, all formal activities directed at health problems.

¹² In all fairness, the Evans' claims are made within the context of health economics. Here the dispute is that health issues cannot be purely economic.

Furthermore, the healthcare system reflects different philosophical approaches regarding the balance between, for instance, primary and secondary health care, public and private provision and institutional care as opposed to community care, as well as, categories and proportion of human resources (health care providers) allocated per population (Lassey and Jenks 1997). There are also differences emanating from the forms and functions of government, and the resources available. In addition, the framework and the conceptual variations in which different countries have chosen to address the financing and administration of the health care system reflects the political system and the ideology concerning social versus individual initiative and responsibility (OECD 1998; Esping-Andersen 1999; O'Connor et al. 1999). Therefore, politics and economics are integrated. In addition, given health care is related to people¹³ “an adequate study of the whole cannot be developed from the separate study of individual parts. Nor can it be developed without attention paid to the people who are the subjects of history” [here the focus is on nursing as an occupational group] (Armstrong, Armstrong and Coburn 2001: vii). Given also that health care is entrenched in the policy regime of the industrialized world (Esping-Andersen 1999; O'Connor et al. 1999), any study of healthcare policy must take into consideration that “States markets, ideas, discourses, and civil society are not independent variables but interrelated parts of the same whole” (Armstrong,

¹³ People are referred to not only those who are receiving the care, but also those who are providing it.

Armstrong and Coburn 2001: vii). For that matter, policy analysis of health care is inevitably predicated upon conceptions of domestic political economy (Björkman et al. 1997). Therefore, political economy is indubitably relevant to healthcare policy issues, and relevant to any study of nursing issues related to impact of policy initiatives on nurses.

However, despite the different philosophy and conceptual variations in the domestic political economy, there is one common denominator. All OECD countries, throughout the 1990s, have reduced or modified their percentage Gross Domestic Product (GDP) of total expenditure on health to contain costs.

Table 1: Total Expenditure on Health

% Gross Domestic Product (GDP) 1993– 1999		
Countries	1993	1999
Canada	9.9%	9.1%
Mean annual growth rate	-1.4%	
France	9.4%	9.3%
Mean annual growth rate	-0.2%	
Italy	8.1%	7.8%
Mean annual growth rate	-0.6%	
United Kingdom	6.9%	7.2%
Mean annual growth rate	0.7%	

Source: OECD health data 2003

For example in Table 1, the cross section from 1993 to 1999 shown that the growth rate on health expenditure in Canada, France and Italy slows down to a mean annual below zero varying from - 0.2 to -1.4%, except in the United

Kingdom where it was increased at 0.7%. However in comparison to the other countries, UK spends less of its GDP on health. Consequently, all healthcare systems have undergone dramatic changes. As governments have restructured their healthcare systems, they have without exception focused their cost-containment strategies on hospital care. For instance, health expenditure by hospitals' services has declined to an annual mean growth rate below zero ranging from -2.5 for Canada and -0.6 for France¹⁴. Precisely, because this sector not only consumes the largest portion of national health spending for most industrialized countries, but also hospitals account for a large share of the health care system employment which is mostly human resources intensive (Aiken and Fagin 1997; Decter 1997; McKee and Healy 2002). Thus the reduction in national health expenditure will certainly affect the human resources, which are an integral part of the whole.

Pressures to achieve better expenditure control and/or greater productivity and efficiency need to be balanced against deeply rooted moral imperatives to maintain universal access to necessary care, and to improve the equity with which services are distributed across social classes (WHO 1996). Almost everywhere, reforms are being contemplated, organized or implemented, some in direct contradiction to others. Each has claimed to make the system more

¹⁴ The current health expenditure by hospitals' services as per % total expenditure on health in Canada has decreased from 37.8% in 1993 to 32.5% in 1999. In the case of France it has changed from 44.2% to 42.6% for the same period (OECD health data 2003). Data were not available for Italy and UK.

responsive to user needs, yet most are really designed to bring its component parts under particular financial control. More specifically, hospital care absorbs a great share of the national health expenditure for most countries. As such, the pressure to contain hospital costs has increased (Anderson 1997; Sochalski et al., 1997). Given the majority of the nursing workforce (largest occupational cluster in the healthcare system, mainly female) is concentrated in hospitals, any pressure or cost-containment measures in this sector will certainly have an impact on the nursing labour market employment and, by the same token, will have a ripple effect on the labour processes.

The health care or hospital restructuring and fiscal pressures have reduced the nursing workforce.¹⁵ Although this study focuses on hospital registered nurses¹⁶ where three-quarters of the nursing workforce, predominantly women, are located, it recognizes that the nursing occupational group is heterogeneous. Others — registered nurses such as community nurses, educators, researchers, administrators, as well as, registered practical nurses working in different

¹⁵ The nursing workforce is designated officially in these jurisdictions as nurses who are registered or regulated under the protected titles of Registered Nurse (RN) and Registered Practical Nurse (RPN) or Licensed Practical Nurse (LPN). Therefore, only those qualified nurses, who have met the set standards in the regulations and are members in good standing with no pending case of misconduct or disciplinary measure, can use the title. For instance, in Ontario and Québec, there are two groups: the RNs and the RPNs (Ontario) or LPNs (Quebec). In France, Italy and England (UK), there are only RNs. Prior 1993-1994, England had two categories, RNs and enrolled nurses, but the latter is no longer regulated (Feroni and Kober 1995; Com-Ruelle; Midy and Ulmann 2000; OECD Data 2003). In reality, under the rubric of nursing, there are other workers such as, healthcare aides, nursing assistants, etc.

¹⁶ The equivalent in France is the "Infirmiers Diplômés d'Etat" (IDE) and in Italy, the "Infermiere Professionale."

agencies — are facing the same struggle on different fronts, and changes are also occurring in their work-life as women — as nurses.

In many countries, the cost of nursing services — provided mainly by registered nurses responsible for general care in hospitals — are under attack. Specifically, during the '90s, the number of registered or qualified nurses has steadily decreased or capped as one of the consequences of health care reform; however, as seen in Table 2 they remain in all nations and jurisdictions of this investigation — substantial in number with close to one million and a half headcount¹⁷.

Table 2: Registered Nurses by Country and Jurisdiction

Year 2001		
Countries and Jurisdictions		Headcounts
Canada: 1*		231,512
Jurisdictions	Ontario	80,590
	Quebec	58,482
France 2 *		412,231
Italy 3 *		322,074
United Kingdom: 4 *		530,000
Jurisdiction	England**	330,535
Overall total		1,495,817

OECD Health Data 2003 *** 18

¹⁷ The data are introduced only to demonstrate the magnitude of the number of RNs in all jurisdictions. The intent is not to discuss whether the number of RNs is right or wrong, since this will be a study in itself.

¹⁸ *** Sources:

1* - CIHI (2002) Number of RNs Employed in Nursing by Province/Territory of Registration. www.cihi.ca (16 Nov. 2003).

2* - OECD Health Data 2003 – The number also includes non-practising nurses (non –practising

The RNs represent a quarter to one-third of the total health employment in the healthcare system with variations from nation-to-nation and jurisdiction-to-jurisdiction (OECD 1998). The hospitals sector absorbs a great proportion of the total RNs workforce (Decter 1997; Buchan and O'May 2002). However, health professions cannot be discussed in isolation especially with respect to medicine and nursing, the most traditional group in the healthcare system. Both nurses and doctors were under scrutiny as part of cost-containment. Some of the strategies on the enrolment side were to reduce or to cap the quotas of medical and nursing students. In the work setting, there were several strategies from restructuring, staff substitution, hospital merger and bed reductions. All of these were done in the name of cost control.

In fact, the medical and nursing staff constitute the largest cost element in the healthcare workforce. Table 3 shown that in Canada, France, Italy and England (UK), the head count health employment and practising nurses' density per 1,000 population, by far, outnumbered the headcount health employment practising physicians density per 1,000 population, except in Italy where the difference is only by a marginal density of 1.2 to 1. France and Italy are below the average standard of 6.9 nurses' density per 1,000 population for the OECD countries, with France closer to the standard at 6.5 and Italy behind at only 5.2.

means the person may work in administration, research, in another field or be unemployed).

3 *- www.ministerosalute.it 'Personale delle ASL e degli Istitute di cura pubblici (published annually) and at ISPAVI www.ipasvi.it

4 *- OECD Health Data 2003.

** The England statistic was obtained from: NHS Hospital, Public Health Medicine and Community Health Service staff and General Practice workforce. www.statistics.gov.uk (2Oct.2003).

The cross section from 1995 to 1999 in Table 3 has also shown that cost-control strategies have managed to maintain or alter the mean annual growth rate with variations among countries ranging from 0.00% to 2.7% for the physicians and from -1.9% to 2.1% for the RNs. There is a slight increase in 1999 in France, England and Italy

Table 3: Health Employment Practising Nurses

Density Per 1000 Population (head count) *					
1995 – 1999					
Countries	Physicians		Nurses		
	1995	1999	1995	1999	
Canada	2.1	2.1	10.7	9.9	
Mean annual growth rate	0.0%		-1.9%		
France	3.2	3.3	6.1	6.5	
Mean annual growth rate	0.8%		1.6%		
Italy	3.9	4.2	5.1	5.2	
Mean annual growth rate	0.5%		0.5%		
United Kingdom	1.8	2.0	8.1	8.8	
Mean annual growth rate	2.7%		2.1%		

Source: OECD health data 2003 - * OECD average density per 1000 is 6, 9.

For some countries, such as Canada, the growth slows down to an annual mean below zero at -1.9%. The overall number of RNs in Canada has decreased because of the important drops in the registered nurses number which is estimated at 4% in Ontario and 5% in Quebec CIHI (2001:48). The ratio profiles of nurses to doctors are introduced here to give a general idea of the division of

labour in these particular countries. They are not intended to match available registered nurses to the health needs of the population, because individual needs for nursing care are different from the needs for medical care.

All of these trends are happening at a time where the work intensity was increasing as a result of the increase in the complexity of the care and the reduction in the patient length of stay in hospital. Nurses contend that changes in the healthcare policy¹⁹ and healthcare systems have made nursing work very task-focused, resulting in lost continuity of care, related to the heavy workloads and deteriorating working conditions. Study after study (Buchan et al. 1997; Shamian and Lightstone 1997; Aiken et al. 2001; Midy 2003; Dunleavy et al. 2003) has validated the grievances of the nurses. There is now more documentation on the deterioration of nurses' working environments, the shortage of nurses, the absenteeism, the ageing of the workforce and their potential consequences on the quality of patient care. Moreover national and subnational associations (CNA 1997; RCN 1998; FIIQ 1999; RNAO/RPNO 2000; Skene 2001; Wahl 2001) are voicing their concerns and urging governments to address the problems if they want to ensure the future care for their citizens. The 1990s have also witnessed labour unrest in the nursing frontline throughout all jurisdictions — from strikes in Quebec, France and Italy or manifestations in Ontario and England — to ask

¹⁹ Here, the healthcare policy is referred to as state legislation, professional standards and regulations, collective agreements, and hospital and nursing management policies which affect, directly or indirectly, nursing work and strategies. For more discussion on healthcare policy at this level, see Chapters Five and Six.

for better working conditions, with some degree of improvement in the economic conditions. While these issues are taking the spotlight in the local, national and international medias and in literature, one would argue that they are, to some extent, the results of the latent and endemic problems deeply rooted not only in the historical foundation and structure of the nursing profession, but also in the structural matrix in which this occupational group is embedded. The difference now is that the healthcare policy reform strategies have exacerbated a situation, which was already bad, and brought it to the surface. The intent is by no means to play down their importance. There is no question that the problems are real in the field. On the contrary, it is a plea for a more comprehensive analysis to address the complexity of nursing issues. This thesis will attempt to do just that.

1.3 Complexity in the Approaches Used in the Study

This section identifies more specifically the epistemological, conceptual, theoretical and methodological points of departure of this thesis. At this point, it will be too cumbersome to undertake a review of the very extensive multidisciplinary literature used under each theme throughout the study. Here, the intent is only to highlight the processes, which were utilized in this multifaceted investigation. Indeed, the complexity of the issues requires gaining exhaustive knowledge across an extensive body of literature (for example, nursing, sociology, women's studies, political science, policy studies and political economy). All of these were done while keeping in mind an international

perspective. Developing such an approach has required the grasping of not only multiple languages and negotiating the constant risk of conflict with disciplinary boundaries, but also because of the cross-national nature of the study, it has necessitated becoming acquainted with this literature in French and Italian. Its complexity requires multiple theories and methodologies; thus, the ramifications are not only at the conceptual and theoretical levels of analysis but also at the methodological level. In feminist practice, which is one of the analytical underpinnings of this investigation, multiple theories and methods²⁰ are paramount (Agger 1991; Code 1995; DeVault 1996; DeVault 1999) to make sense of the complexity of everyday life. What will ensue is a brief threefold discussion on the level of analysis involved in this study and their implications.

Firstly, at the conceptual level of analysis, several arguments are put forward to examine the contradictory nature of nursing caring and the mainstream professionalism. To achieve this, the study takes the position that professional caring or nursing work is women's work. It is a 'women's' or 'subjective' professionalism that operates differently from traditional professionalism (Lorentzon 1990; Abbott et al. 1990; Armstrong 1993; Davies 1995; Benner and Gordon 1996), in that some of the traditional arguments on the concepts of caring and professionalism are disputed. Literature is confronted with empirical materials gathered from key informants in the field. This method is introduced throughout the investigation, except in Chapters One and Two, in

²⁰ This is in opposition to the positivism perspective on singular theory and methodology.

some instances to confront the rhetoric with the reality, in other instances to develop theory as well as to displace preconceived notions, and to propose other alternatives. Some may argue that all empirical evidence should be in Chapter Five or Six where the bulk of the findings are located. However, I upheld the position that given the complexity of this investigation, the feminist practice of multiple methods has helped me to unpack a problematic that I would not be able to otherwise accomplish. For that, I am in debt to feminist processes for 'liberating methods in social research'²¹. During the process, the traditional view was refuted and deconstructed. The study contends that caring and mainstream professionalism are the dual contradictions in nursing. Therefore, there is a need for an alternative approach, which can find its expression in feminist theory.

Secondly, at the theoretical level, the study takes a feminist practical approach to epistemology²², and engages at both theoretically and empirically, in order to make the case of nursing professionalism on a different standpoint than the traditional and critical approaches to professions. In addition, it argues that there was a need to link the feminist theory with other approaches to stimulate the debate toward progressive action for change, which found its expression in

²¹ For more details, see DeVault (1996; 1999). Multiple theories and methods are considered to be one of the feminist contributions to social sciences. See also sampling procedure and sample and interview guideline in Appendix One: Methodology.

²² Here, I borrow heavily from Dorothy Smith's practical approach to epistemology, in her disagreement with the mainstream approach to the sociology of knowledge. See Chapter Four, Section 4.2 of this dissertation for more details.

the discourses of political economy²³ from a historical materialist approach. Here, it is contended that a crucial key to understanding the complex field of nursing work and its object of transformation (Clement and Vosko 2003)²⁴ is to locate it within the context of the past and larger society in order to promote change. The study of the past has a particular significance for 'historical materialism'. It helps reveal the specific nature of the present. This requires one to examine the development of nursing, the healthcare structures and the agencies but also the political economy in which they are embedded and the struggles around their development, likewise the pressure of changes and contradictions (Armstrong and Armstrong 1996; 2003).

The link between feminist theory and political economy has facilitated the process and improved the point made by Lane (1993:275) that one of the shortcomings of much comparative research has been the problem of developing an "appropriate comparative theory" (Lane 1993:275; Maurice 1989). This makes it difficult to encompass "cross-national differences and universal social trends" within a single framework (Lane 1993:275). With this analytical tool, the study posits that in working with these premises, such as resistance and struggle, and pressure of changes and contradictions²⁵, one can attempt to account for

²³ Refer to Armstrong and Armstrong's school of thought. See Chapter Four, Section 4.3.

²⁴ In this, I share the Clement and Vosko's (2003) notion of transformation as a means to gain understanding to promote social change.

²⁵ The pressure of changes and contradictions constitute one of the cornerstones of the theoretical analysis. This debt is owed to Armstrong and Armstrong's school of thought

variations in time and space of the impact of caring, professionalism and state policy in nursing reproduction and everyday practice of nurses in the selected OECD countries. Thus, improving, to some extent, the shortcomings identified above by Lane (1993). At the comparative level, the study takes the form of a cross-national study.

Building on the Canadian experience of the health care sector as a departure point, the theoretical framework is utilized to analyze and compare: firstly, the nursing scope of practice and the labour process transformation under the conditions of cost-containment in this sector along with the implications for nursing as an occupational group; and secondly, nurses' skills and knowledge, including the link and contradictions between knowledge and actions. However how caring is mediated or contested under cost-containment was not explicitly discussed in the literature. For this specific question, computer assisted, qualitative research methods were utilized to identify common themes. Most importantly, what are the conceptual ramifications with the internal contradictions inherent not only with the concept of professionalism but also with the concept of caring. How did reality contrast with the theory? (See Chapter Six and Appendix One: Methodology for more details).

Countries and jurisdictions were compared under each theme more in breadth than in depth. It is asserted that, although the national healthcare delivery systems of these countries are different, the issues and challenges faced by nurses are similar. It is expected to find, on one hand, a trend toward

convergence in the intent of nurses' training and on the other hand, great variations and dissimilarities in the implementation process over time and space, related to the political economy of different countries/jurisdictions. Moreover, given the nature of hospital bureaucracy and the predominance of the medical model, it is assumed that there are to some extent, similarities in the labour process (which is embedded in a gendered and classed hierarchy) that make the operationalization of nursing caring work problematic.

This investigation is processed throughout thematically. The comparison was done in breadth within this parameter with the view that approach provides a broader discussion on the topics, as do the conceptual and the methodological ramifications²⁶. However, there are some limitations²⁷ with this approach. While the study makes it possible to understand a broad range of issues common to nurses in the selected countries and jurisdictions, and to account for variations over time and space, it did not focus in depth on the specifics to give a detailed account on each of them. Nevertheless, this fits well with the intent of the study, which aims to look at nursing issues with a broader and not fragmented scope for a better understanding of what is at stake.

²⁶ For more details on unit of analysis, sampling procedure and sample, and data analysis (see Appendix One: Methodology).

²⁷ For limitations related to data collection, see Appendix One: Methodology.

1.4 Outline of the Study

Chapter Two is an overview chapter. It seeks to set the stage for the comparative study by highlighting the landscape of the national health care systems in the industrialized world, as well as the macro policy reform that was taking place under the pressure of cost-containment; likewise, to locate nursing in the broader context. The chapter starts with the conceptualization of welfare regimes in the industrialized world with reference to the debate between Esping-Andersen (1990; 1999) and O'Connor, Orloff and Shaver (1999), and at the same time, situating nursing as an occupational group embedded in the policy regime of health care. Subsequently, it assesses the relevance of the nation state as the unit of analysis for health reform initiatives within the context of the Canadian Federal system and the European Union supra national, national and sub-national levels. In this, it argues that while nation states retain a very powerful and often determinative role in policy development, their influence is increasingly circumscribed and embedded in a dense, complex institutional environment, complicated also by an intense political process deeply entrenched in the nation state and their regional governments. All of these make the reform policy process difficult to sort out. Against this background, a typology of national healthcare systems as well as the overall variations among them is sketched. Finally, the chapter connects the healthcare policy reform with some of the tensions created on the macro-structural issues of nursing, and their ramifications on the nursing labour processes of the countries or jurisdictions

investigated in this dissertation.

Chapter Three focuses on the assessment of the concepts of caring and professionalism, and their assumptions by troubling both concepts along with their conceptual and empirical ramifications. Literature is confronted with the reality, as it exists in the field. The chapter argues that there are inherent contradictions built into the different assumptions of both concepts, as well as in the conditions in which they are constructed. In the process, the prevailing views and the mainstream challenges faced by nurses — when they are trying to express or understand themselves through the lenses of abstraction — are displaced. The case is made for another type of nursing professionalism, which operates differently than the traditional professionalism. Here, it is assumed that an alternative theoretical approach is essential to move the issues forward. This will be the topic of the following chapter.

Chapter Four makes the case for a feminist theory of nursing subjectivity drawn from Smith's (1990 a) practical approach to epistemology and her ruling relations tenet to interrogate empirically and theoretically the ways in which nurses/subjects apprehend their social world. At issue are these practices that transform what nurses experience directly in their everyday/everynight world, into some sort of knowledge where nurses as subjects disappear, and where their views on their personal experience are altered and subjugated by the

“magisterial” forms of “objectifying discourse.” Herein, it argues while Smith’s tenet directs one to interrogate empirically and theoretically, the ways in which nurses/subjects apprehend their social world and how this happens to the knowing subjects as it does. This alone is not sufficient to address the issues in their entirety. What is needed is to link the nursing subjectivity with the political economy for a more comprehensive theoretical framework that could be altered by evidence. This chapter takes the position that working with these premises, such as ruling order, tensions and contradictions, resistance and struggle, one can attempt to account for variations in time and space of the impact of caring, professionalism and state policy on the nursing profession in the selected OECD countries. These alternative theoretical approaches will guide the next two chapters.

Chapter Five utilizes the theoretical approaches put forward in Chapter Four. It looks at the effect of policy initiatives on the nursing profession in general. Herein, it examines the contradictory nature of the evidence, the tensions and struggle from which they emanate, as well as the transformations that are taking place over time and space within the areas of: the scope of nursing practice in relation to physicians and other healthcare workers; the supply and exit problems of a mainly female workforce; and the labour process embedded in a gendered-class hierarchy. It contends that it is crucial for nurses not only to understand the policy process but also to be engaged at all levels if they really

want to move forward.

Chapter Six extends the investigation with a focus on the policy initiatives that affect the everyday practice of professional nursing. The chapter looks at the contradictions in the area of nursing knowledge and actions with reference to the official statement of “nursing is an art and a science” — “nursing is a caring practice.” Subsequently, it examines the nursing work environment, the context of professional activities, and how caring is mediated or contested by other factors under the conditions of healthcare cost-containment. It argues that the ruling order of the policy initiatives enables, and at the same time impedes, nurses to practice their caring work in the way they would like to; therefore creating a theory and practice gap which make the work difficult. Moreover, tensions and contradictions are part of these processes; nurses have to find a way to understand them for progressive transformation.

Chapter Seven provides a brief summary of the findings. In addition, it highlights some of the theoretical and methodological implications of the study with suggestions for future research, followed by a brief conclusion.

The Framework of the Study

CHAPTER TWO

SETTING THE STAGE

2.1 Introduction

This overview chapter seeks to set the stage for the comparative study by highlighting the landscape of the national health care systems in the industrialized world, as well as the macro policy reform that was taking place under the pressure of cost containment and to locate nursing in the broader context.

It starts with the conceptualization of welfare regimes in the industrialized world with reference to the debate between Esping-Andersen (1990; 1999) and O'Connor, Orloff and Shaver (1999), and at the same time situating nursing as an occupational group embedded in the policy regime of health care. Subsequently, it assesses the relevance of the nation state as the unit of analysis for health reform initiatives within the context of the Canadian Federal system and the European Union supra national, national and sub-national levels. In this, it argues that while nation states retain a very powerful and often determinative role in policy development, their influence is increasingly circumscribed and embedded in a dense, complex institutional environment, complicated also by an intense political process deeply entrenched in the nation state and their regional governments. All of these make the reform policy process difficult to sort out. Against this background, a typology of national health care health systems, as

well as the overall variations among them are sketched. Finally, the chapter connects the health care policy reform with some of the tensions created on the macro structural issues of nursing, and their ramifications on the nursing labour processes of the countries or jurisdictions investigated in this dissertation.

2.2 Conceptualization of Welfare Regimes in the Industrialized World

Many governments in the industrialized world are reviewing their national health care systems and the suitability of their existing approaches to financing, organizing and delivering health care services. Cost-cutting reforms are advocated everywhere especially in the most advanced nations with the most universal and comprehensive systems of care. Health care more specifically hospitals care which account for a substantial proportion of the health care resources and budget are under sharp examination and critique by governments, the mass media, and individual citizens. These issues are causing public priorities in a high proportion of countries to change (Field 1989; Roemer 1991; Graig 1993; McKee and Healy 2002). Yet health care reform is inherently a normative as well as an economic and organizational activity (WHO 1996).

Health care is embedded in the social policy regime²⁸ of industrialized world such as, Canada, United States and the European Union Members States.

²⁸ Esping-Andersen views social policy as public management of social risks. Risks can be perennial and go with the tide of history. Some risks, for example old age infirmity, are 'democratic' because they will afflict us all; others, such as unemployment and poverty, are

Equally, nursing as a large occupational group, mainly female is embedded in the health care system labour market. Arguably any changes in the social policy regime focussing on strategies to contain cost in the health care system, which is notoriously human resource labour intensive will certainly affect directly or indirectly this group. For that matter, policy analysis of health care is inevitably predicated upon conceptions of domestic political economy (Björkman et al. 1997). Therefore it is important to understand political economy and the policy process, in order to grasp fully the transformations that are taking place in nursing.

T.H. Marshall (1975:15) defined social policy as the use of "Political power to supersede, supplement or modify operations of economic system in order to achieve results which the economic system would not achieve on its own" This definition is very useful to understand social policy process in the industrialized societies. Espin-Andersen (1999:4) argued that "the divergent kinds of welfare regimes that nations built over the post-war decades, have a lasting and overpowering effect on which kind of adaptation strategies can and will be pursued." He identified three worlds of welfare capitalism: liberal, conservative and social democratic, and claimed that a major aspect of a liberal welfare regime is its reliance on the market to supply social programs. These plans are often

socially stratified. Still other risks are life-course specific, income loss in old age for example. See Esping-Andersen (1999: 36-37).

means-tested and provide only modest universal transfers or social insurance with minimal social rights²⁹.

Conservative or corporative welfare regimes, on the other hand, focus on the preservation of status differentials rather than on the granting of social rights. Such welfare regimes are strongly inspired by the Church, devoted to preserving the 'traditional' family. While, social-democratic welfare regimes extend social rights and universalism to the middle classes and promote equality of the highest standards. These regime types are based on how countries cluster along three dimensions of variability: state-market relations, stratification and social rights. Esping-Andersen classified the Nordic countries and the Netherlands as social democratic regimes and Austria, France, Germany and Italy as conservative regimes. The United States and Canada are classified as liberal regimes; Britain exhibits some deviating characteristics but tends towards a liberal model. The question of how to identify and classify welfare regimes remains open in terms of what attributes are considered vital and how to measure them. Furthermore this typology does not allow for policy contradictions within typologies; it is rather inflexible; it assumes no variation over time and thus is static. While

²⁹ The notions of social citizenship rights refer to rights to economic welfare and security. For Marshall, "the equality implicit in the concept of citizenship, even though limited in content, undermined the inequality of the class system which was in principle a total inequality." See T.H. Marshall (1991:18-19) "Citizenship and Social Class." This implies recognition of citizens' social rights and a promise to bridge the division of class. Espin-Andersen's work is built on this tradition. He contends that we cannot separate the welfare state ideal from its historical context. See Esping-Andersen (1999).

acknowledging the major contributions to the comparative study of welfare regime and the importance of social foundations in the transformation of welfare regimes, the approach was to some extent more macro and micro economic in nature.

O'Connor et al. (1999) tried to correct this deficiency and put forward instead the notion of 'social policy regime'³⁰ and argued for an approach to welfare state³¹ analysis which acknowledges the complexity of social relations and institutional structures. The authors further added that welfare state variation is not just a question of variation in the level and character of state activity in constraining dependence on the market. For these authors the family is also an integral part of the public policy in terms of service provision. They also believe that, neither market, nor family nor the state alone can provide an adequate understanding of the policy dynamic. O'Connor and her associates (1999:12) noted that "regimes are to be found in both individual institutions of the welfare state and in common patterns cutting across domains of social

³⁰ Social policy regimes has been described by O'Connor et al. (1999) as institutionalised patterns in welfare state provision establishing systematic relations between the state and social structures of conflict domination and accommodation. Likewise the concept of policy regimes also indicates patterns of public-private divisions of responsibility or oversight for various areas. O'Connor et al., understanding of regimes has some similarities with Esping-Andersen (1999) although in a more gender-sensitive way and more inclusive. See O'Connor, Orloff and Shaver (1999).

³¹ O'Connor et al., define 'welfare state' (or 'state social provision') as interventions by the state in civil society to alter social and market forces, but they do not judge a priori that all state social interventions are aimed at, or actually produce, greater equality among citizens. They also include not just income maintenance programs, but also the state regulatory apparatus and public service. Similarly Teeple sees the welfare state as a "capitalist society in which the state has intervened in the form of social policies, programs standards, and regulations in order to mitigate class conflict and to provide for, answer, or accommodate certain social needs for which the capitalist mode of production in itself has no solution or makes no provision" (200:15).

provision, such as health, education, income maintenance or housing.” Regime, within this framework moves beyond the narrow conception of welfare state and refers to “the full range of domestic policy interventions as well as broader patterns of provisioning and regulation.”

O'Connor et al. criticized Esping-Andersen for concentrating on women workers rather than on gender relations, and relate to the fact that Esping-Andersen is more concerned with relations among states, markets and families because of the implications of caregiving responsibilities for women's capacities to bear children and to enter paid employment. For O'Connor et al., both issues are significant for states' fiscal concerns but not for women's aspirations of equality as in Marshall' (1950) notion of citizenship. Albeit this concept of citizenship assumes that all citizens equally benefit from achieved citizenship rights. However such rights are closely linked to the privileging of the paid worker over the non-paid worker, which transcribe into inequality for many women. This is very crucial in the health sector market where genders are a real issue, “ women are predominant not only as paid health care workforce, but they also form the overwhelming majority of those who have provided and continue to provide unpaid health care services, either at home or as volunteers in hospital or in the community” (Armstrong and Armstrong 1996:100). Likewise deteriorating health and increasing disability are a frequent, though not inevitable accompaniment of the ageing process and women make up a large proportion of the elderly in the population - especially the 'frail elderly' (Doyal

1995). In this instance O'Connor, Orloff and Shaver (1999:28) contend that " a systematic framework is necessary, one which accounts not only for the basis upon which claims for social rights are made - and the quality of the rights - but also for the overall organisation of services and income (incorporating private as well as public sources), for patterns of class and gender stratification, and for the ways in which labour market policies and the regulation of reproduction affect gender relations, principally through their impact on personal autonomy."

This perspective to some extent is more relevant to address the complexity of health care policy and structure. Moreover, it opened the possibility to examine nursing issues, which are closely tied to some extent with the social policy regimes of health care provision and delivery. After all, policy is about process and power, that is to say, who influences whom in the making of policy, and how that happens, how it will or not be implemented, who will benefit or lose. It is within this framework that we need to find a way in which these variables can be incorporated into comparative health care policy regime analysis. However, it must be acknowledged that the number of variables in the proposition of O'Connor et al. is very large. Since the different factors from each country and the jurisdictions within the country are difficult to weigh, there is a risk that preferred explanations might be highlighted at the detriment of others. To expand this thinking, it is possible to argue for a political economy approach based on the premises of force of changes, contradictions, resistance and struggle. This approach has the potential to account for variations of the impact of the

health care policy, in time and space and decrease to some extent the risk that preferred explanations take precedent to the detriment of the others. In light of the foregoing, the approach will be now to look at the extent to which nation state is pertinent as unit analysis for health care reform initiatives.

2.3 Relevance of the Nation State as the Unit Analysis for Health Care Reform Initiatives

Earlier studies in social policy development and integration were mainly focussed on federalist systems, which are national in nature for example, Germany, Belgium, Canada, United States, etc., However, the more recent cross-national policy studies with the evolution of EU structure and the North American Free Trade Agreement (NAFTA), are shifting from a focus on federalism to the notion of supra-national systems. The enormous influence wielded by the member states within the EU is impossible to ignore (Hantrais 1995). What most clearly distinguishes the EU from traditional federal systems, is precisely the predominant position of the member states which retain a very powerful and often determinative role in policy development, the Union bears a growing institutional resemblance to the established multi-level systems of traditional federal states. At its core, it concerns the extent to which member states exercised their power (Sbragia 1992; Hantrais 1995; Pierson and Leibfried 1995; Banting 1995). The structure of the EU itself, as outlined in the 1957 Treaty of Rome and in subsequent revisions, reserves wide areas of decision-making

authority for member states and gives them most implementation power even in those domains where EU decisions govern.

Hantrais (1995) pointed out, notwithstanding that the Single European Act and the Maastricht treaty revisions have chipped away at important elements of national sovereignty, by any comparative standard the decentralized orientation of the Union's design is striking. She further added that the structure of the European Union reveals roots in a treaty signed by sovereign nation-states: the Union is both decentralized and, more important, marked by strong representation of constituent-unit interests in central decision-making. Arguably, the member states remain extremely powerful, but their influence is increasingly circumscribed and embedded in a dense, complex institutional environment that cannot easily be described in the language of interstate negotiations. As Pierson and Leibfried (1995: 434) have argued, there are four characteristics of the European Union that are not under the firm control of members states: " (1) the autonomous activity of EU organizations;" (2) "the impact of previous policy commitments at the EU level", which lock member states into initiatives that they otherwise might not choose; (3) the growing scope and overlap of issues (or "issue density") in the European Union, which produces spillover to new initiatives and widespread unanticipated consequences; and (4) "the activity of non-state actors", operating independently rather than exclusively through members states. Therefore, the EU social policy is taking place in a very complex relationship, which will make the reform policies process difficult to sort out.

Given the density and complexity of the networks that characterize the decision-making system in health care, it is not surprising that attempts to implement health care reform agendas met with widely varying degrees of success across nations. Nor it is surprising that the agendas themselves varied across nations, although there were some important common themes.

Banting (1995) contends that the social policy process in multi-level systems displays a pronounced regional dimension. Social policy development and integration is a process that involves the interaction of policymakers and policies at the supranational or central level with the political actors and policies of a nation's member units or agencies. In federal systems the territorial units are subnational (for example, provinces, regions, Länder, states ³²); in European Union the fifteen member states are the constituent units. Comparative analyses have usually subordinated institutional and territorial aspects of social policy development to issues of class conflict and compromise, because the former have been less pressing in the centralized political systems that provided the prototypical models of policy evolution for example, Sweden and Great Britain. Even where multi-level social policy structures existed, as in Bismarck's Germany, researchers treated the country in stylized fashion as highly centralized (Sbragia 1992; Banting 1995; Pierson and Leibfried 1995; Hantrais 1995; Esping-Andersen 1999; O'Connor et al. 1999).

³² Canadian federation is divided into provinces; Länder is referred to German federation; Italy in regions; States pertain to the U.S.

Authorities at the central level in multi-level systems coexist with a multiplicity of actors indistinct territorial units. Because public officials at both levels are part of the same system yet partly autonomous, their social policy initiatives are interdependent but often only modestly coordinated. They may compete with each other, pursue independent projects that work at cross-purposes, or cooperate to achieve ends that they could not obtain alone. The constituent units are autonomous political actors with the capacity to pursue at least some of their own policy options. They may also influence the possibilities for the pursuit of social policies at the center (Banting 1995; Pierson and Leibfried 1995). There is a general agreement in the literature that welfare states expanded in all the industrial democracies in part because politicians saw social programs as valuable sources of mass legitimacy.

As Banting (1995:270)³³ observed, “ the power of national and regional/sub-national politics represents an enduring feature of modern societies. Despite earlier predictions that allegiances to local or regional communities would fade away, to be displaced fully by identities rooted in class or functional interests, territorial conflict remains a core element of the politics of Western nations.” The artificial construction of supranational political systems cannot fully deter the drive to explain political interests in regional terms.

³³ To substantiate its claims Banting quotes Sidney Tarrow who contends “ that citizens organize their relations with the state, reconcile or fight out conflicts to interest, and attempt to adapt politically to wider social pressures.” Source: Sidney Tarrow, “Introduction,” in Sidney Tarrow, Peter J. Katzenstein, and Luigi Graziano, eds., *Territorial Politics in Industrial Nations* (Praeger 1978).

Indeed, regional politics, as actualized by the power of member states, forms the central characteristic of politics within the European Union (Sbragia 1992; Hantrais 1995; Banting 1995). Despite the durability of regional identities and interests, sub-national politics has not been adequately incorporated in our understanding of the determinants and role of the welfare state (Hantrais 1995). Comparative analyses on the origins and development of modern welfare states has multiplied. Scholars have debated about the importance of state autonomy, and the development of greater state capacities for state interventions. Recently, interest has shifted from the determinants of social spending or the initiation of modern welfare programs to the most significant factors of restructuring, reform and cutbacks and their impact on social policy. Thus, the notion of previous policy choices, as institutionalized in particular programmatic arrangements affect continuing policy development and outcomes (Pierson et al. 1995; O'Connor et al. 1999; Esping-Andersen 1999). Although the insights that emerge from this tradition are powerful, Banting (1995) believes that they do not fully capture the experience of supranational or large countries characterized by deep regional divisions, socially heterogeneous populations, and fragmented political institutions. For him regional politics can leave a clear imprint on the shape of the welfare state in such countries, and that role needs to be acknowledged in the interpretations of the determinants of social policy. In this instance, European Union is a rich cross-national case study in the subtle interaction between regional politics and the welfare state.

The combination of national institutions, linguistic and cultural pluralism, and regional conflicts has important implications for EU policy development (Sbragia 1992; Hantrais 1995). The complexity of territorial pressures makes policy outcomes particularly dependent on the attributes of formal institutions of the state and on decision rules that vary from one sector of social policy to another, in what DiMaggio and Powell (1991) called institutional isomorphism.³⁴ The authors identified three mechanisms through which institutional isomorphic change happens, each with its own antecedents³⁵: first, coercive isomorphism that stems from political influence and the problem of legitimacy; second, mimetic isomorphism resulting from standard responses to uncertainty; and third, normative isomorphism, associated with professionalization to perform a particular task and specifying the profession responsible for its performance. This explains to some extent why in some sectors, regional politics and multilevel institutions have increased the opportunities enjoyed by reformist forces and facilitated the expansion of the state; in other sectors, complex decision rules have created joint decision traps that deeply constrain change (Hantrais 1995; Banting 1995). As one can see nothing is simple, arguably health care policy is

³⁴ The notion of isomorphism is referred to "a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions" DiMaggio and Powell 1991:66). Institutional isomorphism is viewed as the forces that constraining institutions or organizations toward accommodation with the outside world. The concept of institutional isomorphism is a useful tool for understanding the politics and ritual that permeate much modern organizational life (DiMaggio and Powell 1991). This concept will be referred to later in Chapter Five and Six.

³⁵ This typology is considered to be analytical; the types are not always empirically distinct. While the three types might interact in empirical settings, they tend to derive from different conditions and may lead to different outcomes (DiMaggio and Powell 1991:66-67).

taking place in a very intricate context. Therefore any policy reform under pressure of cost containment will be complicated as well.

Health care is embedded in the social policy regime of Member States. It is governed by a system of multiple, independent action points, which enables both the national and regional governments to take independent action, without the consent of others governments. As such, health care services are provided in a multiple of independent local structures, which create occasions for creativity at the regional level (Banting 1995). If we are to understand national health care system in this era of policy reform we need to have a good understanding of the role of the supranational body, the national and sub-national bodies in the transformation of the policy process. Against this background one can start to sketch a typology of national health care systems.

2.4 Health Care Systems in Canada, United States and the European Union Member States

In an attempt to classify national health care systems, Roemer (1991) proposed a typology by market intervention and argued that the political or health policy dimension, as reflected in the extent of market intervention by government or other forces on the health system, can be scaled according to four steps: These policies are designed as (1) entrepreneurial, (2) welfare-oriented, (3) comprehensive, and (4) socialist (Roemer 1991). In the first instance, there is a powerful presence of private market with minimal government intervention, as

well as, a strong private medical practice. Private corporations usually administer a great proportion of hospital beds. National health programs are practically inexistent, meeting only a fraction of the population's needs. In this type of system, health care is dependent upon your ability to pay. Human resources allocation is part of private enterprises, like any other industries (for instance, United States). In the second type of welfare-oriented health systems, government and agencies' intervention can take several forms. This intervention has focussed largely on the process of financing personal medical care; the financing has often been collectivized without any disturbance of conventional patterns of health service delivery (for example, West Germany, Canada, Japan). The third comprehensive-type, state intervention has been carried still further to the point that all or just about all the country's population are entitled to complete health service and equally available to everyone. Limited or scarce resources in an era of economic constraint can make this system unsustainable (for instance, Great Britain, New Zealand, Norway, Italy). Finally, in socialist health systems, market intervention has been carried to the furthest point. Theoretically, these health systems have set out to eliminate the private health care market completely and replace it with system control through central planning. In reality, they have all found it necessary to retain certain free market operations within their overall socialist health systems (Roemer 1991).

Other authors for instance, Deber (1996; 1998) proposed a typology consisting of financing, delivery, and allocation, and argued that the international

health care systems are built on three dimensions: financing (how the money is raised), delivery (how services are provided), and allocation (the basis on which funds are allotted to services providers). As such, there are three broad categories of health-care systems. In the public financing-public delivery category are the National Health Services, in which service providers are civil servants. This model used to exist in Scandinavia and the UK, but is currently under considerable reform pressure to introduce more client sensitivity. In the private financing-private delivery is the private insurance system, or idealized US system (although in actuality the public sector plays a considerable role in financing such systems - both directly and through subsidies). The public financing-private delivery category contains two variants: the tax-based insurance characteristic of Canada, and the heavily regulated sickness funds characteristic of the "Bismarck" - influenced systems in Germany. Likewise WHO (1996:11) classified countries in Europe Union into two groups according to the predominant method of funding their health system: "the Beveridge model, mainly based on taxation (Scandinavian countries, UK, Ireland, Greece, Italy, Portugal and Spain); the Bismark model, chiefly based on social insurance" (Austria, Belgium, France, Germany, Luxembourg and Switzerland).

Public can imply national, state/provincial, regional, or local activities, whereas private can encompass activities by charitable not-for-profit (by either volunteer or paid workers), small business-entrepreneurial or for-profit corporate organizations, as well as by individuals and their families. It is accordingly

important to recognize that different combinations of public and private apply to different sectors within health care, as well as to different countries (Deber 1998; 1996; Dorland 1996). The problem is that many typologies attempt to classify the entire health care system by taking the country as the unit of analysis. “ This is often not possible, because the state may participate in more than one way within a given system ” (Frenk 1994:27). For example, the Canadian system can be categorized as public financing and private delivery for insured medical and hospital services (Armstrong and Armstrong 1998; 1996). However, a considerable portion of such sectors as rehabilitation, long-term care, and outpatient pharmaceuticals is privately financed and privately delivered (Deber 1996). Similarly, the British National Health service is a composite of two quite different modalities: one for general practice, where the state finances the care that is provided by private contractors, and another for speciality care in hospitals, where governmental organizations directly provide services (Frenk 1994). In the case of Italy, before 1978 the health care system has a similar structure with West Germany which is based on compulsory insurance (sickness funds) and a mix of public, religious and private providers (Dent 2002). The shift to the National Health System seems to be organised according to “Beveridge” principles (funded from central taxation). As it turns out, when accounted for institutional variations, the Italian Beveridge looks like a hybrid of British under-funding and Scandinavian generosity therefore, combining the liberal and social democratic of Esping-Andersen’s typology. Also while the

health system is centrally funded the central government has limited effective power to implement policies. The regions can and do choose whether they will implement central government policy or not (Dent 2002).

2.4.1 Overall Variations Between National Health Care Systems

Canada, the United States as well as all European Union national states manage facilities designed to protect or to optimize public health in respect of such matters as sanitation, water supplies and food hygiene. All of them provide a quantity of statutory medical facilities in the form of public hospitals along with local public or community health personnel. This being said, there are non-the-less significant differences between the various health systems of these countries (OECD 1994; WHO Regional Office for Europe 1996). If the principles of universality, public financing and administration, and expenditure controls are integral features of health care systems throughout the industrialized world, the exception is the US, where employer-based benefits are the norm and public insurance is limited to the elderly and disabled, and to the poor (Maioni 1996; 1998; Armstrong and Armstrong 1998; Fuller 1998). Canada and US have similar health care services. Both countries are classified by Esping-Andersen and O'Connor et al., as representatives of a liberal form of welfare state, or regime type, in which social provision is limited and shaped so as to preserve maximum scope for individual initiative and market forces. However, despite this similarity, Canadian Medicare (universal health care) was introduced to allocate

care on the basis of need, not individual's finances. Whereas in the European Union, at least, two main "models of coverage" can be identified: the "occupational" (or "corporatist") model and the "universal" (or "statutory") one. In the universal (or statutory) model, all citizens are covered in the same way irrespective of their work or family position, while the financial support comes from taxation on general revenues. This model is historically rooted (as in Sweden or in the United Kingdom for instance), it has engendered national systems of compulsory health insurance³⁶ or national health services, directly managed by the State. In the occupational (or corporatist) model the worker paid the contributions from earned income to "sickness funds" (or similar "third party" insurers) according to their employment category, while the remainder of population has acquired the right to coverage either as retired workers or as dependent members of the worker's family in Germany and France for instance, have historically developed this model (OECD, 1994).

Moreover, those states in which the universal model of coverage prevails (Sweden, Denmark, United Kingdom, Ireland, and to a lesser extent Finland), are also those in which the principal source of financing is taxation on general revenues. On the contrary, contributions paid to sickness funds constitute the most common source of financing in those states in which the occupational

³⁶ For instance, Maioni holds that health insurance represents a central pillar of the modern welfare state, both because it can be seen as a "social right" of citizenship and because it is the largest social policy expenditure for most countries (1998:3). While the characteristics of payment and administration differ widely, every industrialized country has some form of government funding for health insurance.

model of coverage prevailed (Austria, Germany, France, Belgium, Netherlands and Luxembourg). Nevertheless, there are some exceptions to this approach. In fact, the Southern European countries (Greece, Italy, Portugal and to a lesser extent Spain), though they have according to their laws a universal model of coverage, still rely upon a high amount of contributions to finance their systems. Moreover, in Southern European countries, the national health service “contract out” for the provision of a vast array of services: from diagnostic tests to minor or medium surgery (OECD 1994; WHO Regional Office for Europe 1996; Deber 1998). For these countries, thus, we may have identified a “mixed” model of coverage, which is formally universal or “statutory”, but in reality, it draws an important proportion of its financing from the contributions paid by occupational groups and “sub-contracts” many public care services to private providers (OECD, 1994).

Briefly, this type of categorization tends to be general in nature and the explanations are done in economic terms with minimal considerations to social policy implications. A crucial segment, but one, which is conspicuously silent in such analyses, is the views of those who are affected by the policy outcomes. Like any classification, this tends to represent an abstraction from real-life complexities. As a result, it concentrates solely on the central axis of health systems, i.e., the relationship between the providers, the population, and the state. As in Esping-Andersen, this level of analysis is inclined to use a top down or macro approach by exploring health care systems policies and aggregating

them into policy regimes or financing, delivery and allocation. As previously argued, health care system models are responding to a complex set of interdependent forces including social and economic pressures internal and external to an individual nation, consequently, transformation is taking place all along this process.

While health care models assist to some extent in the understanding of some health care issues and national policy choices, these typologies however, tend to be overgeneralized. One way to avoid this pitfall is to look at the different conceptual variables of the models, their definitions and functions and try to establish comparison. Further, gender issues, cultural and societal values embedded in any health care systems, albeit complicated, must be part of the process. Notwithstanding the different policy regimes, one must take into account that welfare states are to a large extent gendered. As O'Connor et al, 1999 point out there is no 'gender free' social institution. As a result, these create limitations to cross national studies. One will tend to agree with Field's (1989:22) metaphor that "the study of health systems, particularly when one does it in a historical and comparative perspective, resembles peeling an endless onion: as soon as one issue is uncovered, examined, and analyzed in terms of its consequences and implications, another one emerges just as intricate and just as fascinating, and so on." It is where political economy can find its application, in terms of bringing all the parts together. The study of health systems involves "states, markets, ideas, discourses, and civil society, [as such they] are not

independent variables but interrelated part of the same whole” (Armstrong, Armstrong and Coburn 2001: vii). In this politics and economics are integrally related. An approach that link politics and economics as a whole is more appropriate to address the complex nature of the health care systems. Therefore political economy is more suitable to help understand how nation states react to pressures. This will be the topic of the following section.

2.5 Nation State’s Responses to External and Internal Pressures

There are three main broad goals that national governments generally pursue in health care policy: Efficiency, which entails that quality of care and consumer satisfaction, should be maximized at minimum cost. Macroeconomic cost control, which means that the health care systems should consume an “appropriate” share of Gross National Product (GDP). And equity, which implies that citizens should have access to some minimum package of health care services, and treatment, should be based on need for care rather than solely on income (OECD 1994). Yet commitment to social equity in health care appears directly related to the completeness of other forms of public welfare as demonstrated previously in this Chapter. Moreover, national health care systems come in many organizational variations and are essentially very complex. As Blendon et al. point out, there is no panacea for the problems that face any nation as it tries to provide affordable, high quality health care to all its citizens (1993:1015).

Currently, the health care sector reform is a major political issue in many OECD member countries. Pressure from OECD, the globalization phenomenon and the European Union manifests itself in several forms. Governments everywhere confront budgetary pressures. However, while there is convergence in terms of the problem, countries respond to pressures in very distinct ways. For example, Germany, France and the Netherlands have engaged in redefinition of solidarity within their efforts to constrain rising costs. Only in Britain comprehensive change in the public policies governing the decision-making system was enacted and implemented. More modest versions of the British reform took place in Sweden. In other countries, such as Canada, Germany, and France, no sweeping redesign of the system was attempted, although governments made a number of policy interventions with varying degrees of success (Aaron 1990; OECD 1998, Tuohy 1999)³⁷. Another significant institutional feature of the health system reform is the range of devolution of power to sub-national authorities. In Sweden, on one side of the spectrum, government of health is highly decentralized both functionally and geographically: the county councils, for instance, levy their own health taxes. In France, despite important recent efforts to decentralize, the health administration remains unitary and centralized: local political authorities have only minor responsibilities in health care matters. On the contrary, in Germany and in Italy the sub-national

³⁷ See, Tuohy, Caroline (1999) *Accidental Logics the Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*. New York Oxford: Oxford University Press, pages 5 - 6.

authorities have their own separate health administration (Roemer 1993; OECD 1994; 1998). As mentioned in the previous section, health care is governed by a system of multiple and independent action points, which enables both the national and regional governments to take independent action, without the consent of other governments. As such, health care services are provided in multiple independent local structures, which provide occasions for creativity at regional level, while accommodating for institutional isomorphism.

One can argue that the complexity of health care coupled with the institutional structures and agencies of affiliated national state will make a fair assessment of policy reform outcome very difficult. Moreover, decision makers from EU states must deal or cope with time constraint and limited information in a complex, rapidly changing environment, as well as, governmental or bureaucratic overload. Thus the notion of “issue density” introduced previously is evident. WHO (1996) contends that “there is little empirical evidence of the actual effectiveness of many reform policies, the debate has been driven by ideology and rhetoric more than by evidence that substantiates anticipated benefits”(WHO Regional Office for Europe 1996: 2). While acknowledging the merits of this assertion, in all fairness, it is hard to resist the question of how could one gather evidence, which makes sense given the speed of change? As

Marmor (1997)³⁸ points out, “in the field of health policy, there is now an extraordinary imbalance between the magnitude of the information flows and the capacity to learn useful lessons from them. Indeed, the speed of communication about developments abroad may well actually reduce the likelihood of cross-national learning” (1997:357).

Health policy reform is not simply a mechanical activity but a very complex and intense political process deeply entrenched in the nation state and their regional government. As such, policy reform is not a linear process, neither bureaucrats nor government operate in an isolated world. If they make policies, which are strongly disliked by the public or by a particular interest group, they simply will not be implemented (or if implemented, they will not achieve the expected outcome). Reactions may vary, for example, mass media or an opposition political party may concentrate attention on unpopular decisions and weaken a government's position for the next election. Or there may be urban riots, citizen revolt or demonstrations as is seen taking place all over the world. Conversely, there are many pressure groups outside government, who want to influence government thinking in policy, or in provision of services. Health care is very notorious in this instance given these issues touch everyone, in one-way or another. Likewise policy makers especially those who contract themselves to

³⁸ See, Marmor, T. R. (1997) Global Health Policy Reform: Misleading Mythology or Learning Opportunity in C. Altenstetter and J.W. Björkman, ed., *Health Policy Reform National Variations and Globalization..* London: Macmillan Press Ltd.

reform programs cannot focus their effort only on governments. Consideration must be concentrated upon historical and social dynamics that have forged the profiles of institutional structures of particular countries. National, sub-national coalitions are critical variables to influence bargaining positions over reforms, albeit cross-national comparisons are increasingly used as political ammunition in the battles among these local coalitions. One can conclude with Björkman et al.'s (1997) ³⁹ assertion that "the policy analysis of health reforms is inevitably predicated upon conceptions of domestic political economy. And unless policy-makers, whatever their domestic locale, understand the political economy of reform processes, generalizations about health policy reforms will remain problematic and policy responses will be correspondingly aberrant" (1997:14). Thus the relevance of political economy in any study related to health care policy reform, and for that matter, the relevance of political economy in any study of nursing issues related to policy reform processes.

2.6 Structural Issues Affecting the Nursing Labour Processes

This section looks at the ramifications of the health care policy reform on the macro structural issues of nursing which will have an impact on the labour processes. It will serve as a springboard for further discussion in Chapter Five and Six.

³⁹ See Björkman J. W. and Christa Altenstetter (1997). Globalized Concepts and Localized Practice, in C. Altensletter and J.W. Björkman, ed., *Health Policy Reform National Variations and Globalization*. London: Macmilan Press LTD.

As mentioned previously in the introduction chapter, “Nursing” and “Caring” in the mundane sense of the words are as old as mankind born out of the historical traditions in women’s commitment to care for the family and the sick (Bullock and Bullock 1964). Women have always been central to the provision of health care both in and out of the home. The incorporation of caring services into the welfare system at one point of history has profoundly influenced the development of nursing work and led to the emergence of male medical dominance, and the expansion of hospital institutions. In the industrialized world, health care is a major source of employment, and hospitals employ the most people in this sector. The Medical and nursing staff constitute the largest cost element in the health care workforce. Moreover, hospital as an organization is susceptible to changes in the external labour market, such as skills scarcities and regulation (Decter 1997; Buchan and O’ May 2002).

To reiterate health care is embedded in the social policy regime of the welfare state. Equally nursing as a large occupational group, is embedded in the health care system labour market. Any changes in the social policy regime focussing on strategies to contain cost in the health care system, which is labour intensive will certainly decrease the labour market, consequently will affect the labour processes. Evidently, because hospitals consume a sizeable portion of the health care budget, it is to be expected that they will become the real target for cost containment. The change in hospitals is driven for the most part by organizational and fiscal pressure to put a ceiling on public expenditure or to

slow down any expansion in this sector (Buchan and O' May 2002). Given that the majority of the nursing workforce is located in the hospital sector, it is expected that nurses will become also a target for cost containment. This associated with other pressures will certainly have an impact on the labour force.

2.6.1 The Changing Hospital Labour Force

Labour force changes occur in a multifaceted structure of norms and values as well as within the policies, regulations and traditions, the ruling relations between professions, and between employers and employees. The hospital sectors where the majority of nurses work, have evolved over the centuries in response to social and political changes, and changes in medical knowledge. Similarly, changes in the population characteristics affect not only the demand for care but also have implications for the type of staff that can be hired (Healy and McKee 2002). Although different countries face different challenges, there are some common denominators affecting all advanced industrialized countries. McKee, Healy, Edwards and Harrison (2002:48-49) identified four main issues and trends. First the ageing of the populations, for that matter the ageing of the workforce itself. This has an effect on the labour force at a time when health care needs are intensifying and the pool of potential staff is decreasing, alarmingly so.

Second, the intensity of the increase in the internationalization of the health care workforce with some countries actively recruiting health professionals from other countries. McKee and his associates (2002) pointed out

that this process is likely to be accentuated by the further expansion of the European Union. This clearly has many important implications both for the countries that are attracting skilled staff and for those that are losing them (this will be elaborated in Chapter Five). This trend is taking place on both sides of the Atlantic. Nurses in Canada move from Quebec Jurisdiction to Ontario jurisdiction; from Ontario to the U.S; from UK to Canada and France; France to Quebec; Spain to France; from South Italy to the North, lately Italy is importing nurses from Spain, because the cost of living on the Northern region is a deterrent to nurses from Southern Italy region to migrate North. Spain became the major supplier of nurses in the European Community. Although this is not a new phenomenon, nurses were always very mobile, what is new is the intensity and governments now are actively involved in the recruitment instead of leaving it to their local hospital institutions, because of the severity of the situation, many governments have set this as a priority in their health care agenda. Moreover, on both sides of the Atlantic there is an increase in the number of part time and casual nurses as a way to decrease cost.

Third there is the tendency to substitute the staff or the professionals by people with different skills, emphasizing the importance of "competence" rather than credentials. For instance, physicians perform many tasks that are better carried out by other professionals, and making change has proven difficult as noted by McKee et al. (2002:48) where professionals such as physicians and nurses have established a statutory right to certain tasks in Europe.

Traditionally, hospitals have very rigid lines of demarcation with regards to who can perform which tasks. According to these authors efforts to introduce more flexibility in service delivery through staff substitution have been facilitated in some countries by a management scheme of moving away from historical professional delineations towards a competence approach. This consists first of defining the task and then asking who could perform it most cost-effectively (McKee and Healy 2002). The substitution debate has centred around three main types of initiatives: substitute less expensive and less highly trained staff; expand the task jurisdictions of existing staff; and develop new occupational groups. In North America there are more established professional groups in the health care system than in Europe. Moreover, cost-containment strategies have resulted in substitution of less expensive care assistants or aides for more expensive nurses in many countries (Buchan and O' May 2002). This will be elaborated further in Chapter Five.

Fourth is the necessity for hospitals to make certain that their staff can respond to the rapidly changing environment. Nurses in some European countries already have to prove their continuing competency if they are to remain registered in order to be able to work as a professional nurse (to be discussed in Chapter Five). This process is now extending to physicians (revalidation) (McKee et al. 2002:48)

2.6.2 Change in the Class and the Power Structure

The health care system is a highly bureaucratic and top-heavy administrative system. Nursing within this system is embedded in a gendered class hierarchy labour process. Historically, nurses were the first to operate hospitals (Glouberman 2002). When nurses were in charge, they had responsibility for all patient care and called the physicians only when medical interventions were needed. Administrators are relatively new to the health care organizations although they now hold substantial power to the detriment of both doctors and nurses. Since the era of Florence Nightingale, nursing administration adopted a pyramidal structure similar to the military hierarchy. At that time the senior nurses belonged to the upper classes. Currently academic credentials happen to be the path to access senior position (Glouberman 2002).

Heather Broughton (2001:15-16) pointed out that nursing is still represented at senior levels of this pyramid but has lost its visibility. For her, a distinct entity within the hospital sector has faded from view. In Canada, as a consequence of hospitals restructuring, and the implementation of program management most hospitals abolished their directors of nursing in one form or another. Broughton (2001) commented on the fact that, few nurse executives have the title of 'Directors of Nursing' and habitually the Chief Nursing Officer (CNO) does not have line of authority over nursing. She further added, that some nurses see the scope and level of their positions as an advantage to nursing, in that they sat at the "executive table and have an influence far beyond what

they might have had five 10 years.” Similarly, in most European Community Countries nurses manage nursing and nurses. However the autonomy and status of nurse managers have decreased with the establishment of general management principles and practices, and at the same diminished professional control (Salvage and Heijnen 1997). This trend also affects the doctors, therefore both professional groups perceived the managers as a common enemy. Moreover Salvage et al. (1997) commented that senior nurses who wish to have a management position have to play down their nursing background and skills to be accepted. This observation can also find its application in Canada. In their new role, they are managers dissociated from their nursing background and belong to the new class of hospital executives.

2.6.3 Role in National Policy-Making

Moreover, Salvage and Heijnen (1997:29) observed that nurses in European Union in general, have very limited possibility to participate in national decision-making. Only few nursing representatives have a permanent position in a national body for health care decision-making, as in United Kingdom and in Canada. This was acknowledged by some participants in the interview, as one of the situations in which they would like to see some changes or improvements. In their view it is detrimental to the professions and for society at large, because nursing perspectives are not reflected in health care policy. In the vast majority of western European countries, and for that matter North America, nurses are not

legally entitled to participate in any form of health care decision-making. Except in Quebec, the legislation calls for every public organization where at least five nurses are employed to have a council of nurses. The council is accountable to the board of directors and a representative is duly a voting member of the institution's board (Government of Quebec 1994). At best, in other jurisdictions nurse representatives are sometimes asked to advise on specific nursing issues. In some countries, nurses are legally responsible for regulating professional matters, such as licensure and professional ethics, to be discussed in Chapter Five. However, according to Jane Salvage Heijnen (1997) there is an encouraging trend in all parts of the Region to involve nurses at least in matters concerning their own profession. Furthermore, nurses are increasingly given legal authority to take part in health care policy-making. The level of involvement, however, varies widely between and within countries. Nurses from France and Italy and other western European countries report significant difficulties in influencing policy. Gender is also an inhibiting factor. Female nurses' experience, to some extent, difficulty in asserting themselves to take part in the decision-making process, partly because this is nearly always dominated at the top of the pyramid by male doctors and/or career administrators who naturally assume leadership. Furthermore, socialization and the historical rigid hierarchy within the rank of nursing may teach subordination and passivity (Salvage et al. 1997). All these structural issues directly associated with policy reform will have an impact on the nursing labour processes (will be discussed in Chapter Five and Six).

2.7 Summary

From country to country institutional isomorphism might compel professions to strive to be similar in education, values, and thoughts; however they may vary in prestige and power due to the differences in the political economy and class structure of the society. Of course, one has to take into account the particular context in history. However, what seem to be a constant in modern health care is the power of the medical model ⁴⁰regardless the spatial location; therefore it will be difficult not to talk about medicine in any analysis of the historical evolution of modern nursing. It will be also difficult not to touch the gender issues given Nursing has continued to be largely a female occupational group (McPherson 1996). There is a symbiotic relationship between these two groups. British, Canadian, French and Italian nurses for that matter even within the same nation organized themselves differently and fought different struggles in different locations because the modern health care delivery system is regional and local by nature. Therefore, while some trends in the political economy and the ruling order may be similar, nurses will experience them differently. These are very important factors to be considered in a comparative study. Moreover, regional and local uneven development can create also uneven development in nursing

⁴⁰ It is based on allopathic medicine curative approach of body parts. This model assumes that the determinants of health and illness are primarily biological; therefore health care is about curing illness or disability (see Armstrong and Armstrong 1996; 2003). This model is more predominant in acute care setting.

professionalism evolution for example, education, self-regulation etc., to be discussed in Chapter Five and Six.

In summary, the policy reform with its complexity has brought some complex ramifications at the macro structural level of nursing. These are the pressures for change, which will certainly have consequences for the labour processes. Hence, it was very important to highlight the broader picture for a full comprehension of the issues that will ensue in subsequent chapters.

CHAPTER THREE

CARING AND MAINSTREAM PROFESSIONALISM : THE DUAL CONTRADICTIONS IN NURSING

3.1 Introduction

This Chapter focuses on the assessment of the concepts of caring and professionalism and their assumptions by disturbing both concepts as well as their conceptual and empirical ramifications. The text is confronted with the reality, as it exists in the field. The chapter argues that there are inherent contradictions built into the different assumptions of both concepts, and in the conditions under which they are constructed.

Internal to caring ⁴¹ are the notions of wholeness and subjectivity. In theory, the notion of wholeness denotes that the individual patient is viewed in its entirety, which entails not only the physical needs, but also the psychosocial and the spiritual. Subjectivity (discussed in Chapter Four and Six) implies that the nurse has to be involved. Feeling and intuition are part of the care process for proper therapeutic relationship. Whereas, internal to professionalism with all the attributes, there is a connotation of speciality and objectivity (see also Chapter

⁴¹ Caring is accepted formally as a nursing philosophy, which entails not only providing the care but also having the attitude and the value attached to caring when doing the interventions. Emphasis is put on the therapeutic relationship. The individual nurses must strive to view the patients as a whole. Whereas the professionalism concept is closely associated with medicine's curing philosophy which entails specialization and fragmentation, in the form of body part and diseases. Emphasis is put on diagnostic and treatment (discussed further in this chapter and subsequently).

Four and Six). In this the health problems of the individual are partitioned and objectified in diseases. There is to some extent an expectation to keep the distance with the recipients of care. Furthermore in a cross-national study when the different translations and interpretations enter into play, all of these became more complicated.⁴² In the process there is a displacement of the prevailing views and the mainstream challenges faced by nurses when they are trying to express or understand themselves through the lenses of abstraction. The case is made for another type of nursing professionalism, which operates differently than the traditional one. Herein it is assumed that other theoretical approaches are needed, if one wants to move the issues forward. This will be the topic of the following chapter.

3.2 Conceptions of Caring

The concept of caring as a topic of investigation in the social sciences and in the nursing fields is very recent. In the last two decades, the concept has advanced onto the agenda in the disciplines of sociology (Daniels 1987; Davies 1995), social policy (Waerness 1978), women's studies, the work of feminist and nursing academics (Watson 1979; Graham 1983; Gault 1984; Leininger 1984; Benner and Wrubel 1989; Benner et al. 1996; Baines et al. 1998; Dalley 1998), and feminist political economy (Armstrong et al. 1993; Armstrong and Armstrong 1996). Concurrently nurse theorists and scholars, for their part, have claimed caring as

⁴² This is illustrated further in the Chapter.

the “essence” (Leininger 1984) or the “core” (Watson 1988) of nursing. The concept of caring has permeated nursing philosophy, education, and research. Caring is expected to change theories that guide practice, foster research, tests theories, and modify practice (Norris 1989). This concept is also explicitly expressed in the International Council of Nursing (ICN) Vision Statement⁴³, which stipulates:

Our work together is guided by a common philosophy of nursing: a commitment to caring in the fullest sense, being advocates for our patients, helping people to help themselves, and doing for people what they would do unaided if they had the necessary strength, will, or knowledge (ICN, 1998:2)

The literature on the complex nature of caring and its implication for nursing practice has mushroomed rapidly during the last twenty years. However, this development is not without tensions and contradictions that are inherent in the concepts of care and caring. To date, the endless etymological and epistemological debates on these notions continue to haunt the nursing circle and make it somewhat difficult for the nurses who have to provide care in this era of cost containment working environment. For the purpose of this investigation, it is assumed that the provision of wholistic (derive from whole) care entails both caring for and caring about. Caring for or providing care indicates a set of behaviours during the therapeutic interventions. Caring about suggests an

⁴³ The International Council of Nurses is a federation of national nurses' associations, representing nurses in more than 120 countries. Founded in 1899, ICN is the world's first and widest reaching international organisation for health professionals.

It is located in Geneva, Switzerland. (<http://www.icn.ch/visionstatement.htm>).

attitude or intrinsic value which must accompanied the behaviours. Therefore it is contended that caring for, without caring about disabling to some extent the caring process, because a component is missing (See Chapter Six).

Caring is viewed by authors such as Gordon, Benner and Noddings (1996: xiii-xiv) as “a set of relational practices that foster mutual recognition and realization, growth, development, protection, empowerment, and human community, culture, and possibility.” In this definition, Gordon et al. introduce the notions of “caring practice” and argue that caring is embodied and entrenched in social practices. In addition caring requires skill, education, and community and social resources. In this also, the authors explicitly indicate the type of knowledge required to activate the caring practice is not only formal knowledge from “the liberal arts and science but from social and experiential learning as well.” Moreover Gordon et al. suggest that caring practice exists in tangible interaction with the types of historical and current connections as well as exchanges that nurture them. The concept of caring is also referred to as the “physical, mental, and emotional activities and effort involved in looking after, responding to, and supporting others” (Baines 1998:3). Similarly, Celia Davies (1995:18) extended this definition by adding the notion of “commitment to the nurturance, growth and healing of that other.” She also makes the differentiation between caregiving, carework and professional care. For her, caregiving is the type of work that is provided “on an unpaid basis by family and friends.” Carework on the other hand is referred to as “a variety of paid jobs in the health

and personal service sectors and also to some jobs in the informal economy”, whereas professional care for example, seen in the work of nurses, social workers and teachers⁴⁴, is a “form of public caring work that is undertaken by those who have enjoyed a systematic and formal training” (1995:19-20). Caring work is mostly provided by women in multiple settings such as, at the home, in the community and in the hospitals.

However Davies cautions that there are no acceptable words to reflect and describe the caring work provided by these three groups, and for that matter she dubbed it the ‘conundrum of care’ (Davies 1995). The same concern is also expressed by Benner and Gordon (1996:41) who comment that “the words caring and to care are some of the most heavily freighted in the English language. ... Like veils, they conceal the most complex confusions and elusions.” Earlier writers described similar difficulty and related it to the elusiveness and the impreciseness of the concept of caring (McFarlane 1988; Morse 1990). Despite this agnostic conclusion, the concept of care and caring remains an important issue for nursing. There is growing interest in carrying out research on the nature of caring and its relationship to and ramifications for the profession. This impetus has contributed to the development of a body of nursing literature on caring.

⁴⁴ Nursing, Social Work and Teacher are dubbed in the sociological literature as the Caring Professions.

For instance, Janice Morse et al. (1990: 2-7) investigate the “concept of caring and caring as a concept.” The research was supported by the National Center for Nursing Research and by the Medical Research Council/National Health Research Development Program Award. Those authors can be given credit for their attempt to bring some coherence in this intricate literature. In doing so, they expose the difficulty associated with the concept of caring; and their categorization opened-up the possibility for further research. The study consisted of a content analysis of thirty-five nursing authors’ definitions of caring and the main characteristics of their perspectives with the purpose of exploring the adequacies and inadequacies of these conceptualizations. Likewise Morse and her associates evaluated the applicability of caring as a concept to the practice of nursing, and identified trends and gaps in caring research.

Five categories⁴⁵ of caring, have been recognized in the study by Morse et al. (1990): caring as a human trait; moral imperative or ideal; an affect; nurse-patient interpersonal relationship and a therapeutic intervention. The authors use an epistemological perspective to formulate the classification of the definition of caring. In the first category, caring was conceived as a human trait, authors using this perspective view caring as an “innate human trait, the human mode of

⁴⁵ The researchers acknowledge that the categories are not intended as rigid or inflexible cells, nor is any value judgment intended as to the appropriateness or inappropriateness of the derivations of the conceptualizations. They are merely identified to clarify aspects inherent in the complexity of the literature rather than to imply causal relationships (Morse et al., 1990:2-3).

being⁴⁶, a part of human nature, and essential to human existence" (1990:4). The second group sees caring as a moral imperative or ideal, in this perspective "caring is considered to be a fundamental value⁴⁷ or moral ideal in nursing" (1990:4). Authors in the third category conceptualized caring as an affect which "emphasizes that the nature of caring extends from emotional involvement with or an empathetic feeling for the patient experience" (1990:5). In the fourth category caring is viewed as the nurse-patient interpersonal relationship. This perspective according to the researchers is in contrast to writers who see the relationship as the "foundation of human caring or the medium through which it is expressed" (1990:6). Those who view caring as an interpersonal relationship proposed that "the nurse-patient relationship is the essence of caring" (1990:6). Lastly, caring is seen as a therapeutic intervention. According to Morse et al., the promoters of this perspective have linked caring directly to nursing practice. For instance, caring actions can be 'attentive listening, patient teaching, patient advocacy, touch, "being there," knowledge and technical competence, or caring may include all nursing actions that enable or assist patient'. Likewise two outcomes were identified, caring as the subjective experience of the patient and caring as a physical response. In this perspective the proponents' primary focus

⁴⁶ In reference to: Roach MS. *The Human Act of Caring: A Blueprint for Health Professions*. Toronto, Canada: Canadian Hospital Association; 1987. Cited in Morse et al., (1990:4).

⁴⁷ Cross- reference: Watson J. (1988:25-29) *Nursing: Human Science and Human Care A Theory of Nursing*. New York, NY: NLN. See Morse et al., (1990:4).

is on quality assurance, as they have examined the concept of care by exploring patient physiological or psychological outcomes.

Based on their findings, Morse et al. (1990:2) argue that despite these attempts, caring as a concept remains elusive. Instead of enlightening the reader, the content analysis of the literature only adds to the confusion. In this, there is no agreement as to the meanings of caring, the components of care, or the process of care. Moreover, from the literature it is difficult to make a distinction between the words caring, care, and nursing care. The researchers point to the use of care as a noun or caring as a verb. Care or caring may specify the actions performed, as in to take care of or provide care, or the concern exhibited, as in caring about (Morse et al. 1990:2). All of these inconsistencies and contradictions have serious consequences for nursing work. The same dilemma was illustrated by Kyle (1995:512-513) in her study of the concept of caring. She examined the existing theoretical perspectives in the nursing literature, as well as the research studies, which have investigated this phenomenon in nursing practice. Her review reveals a "marked incongruence between patients' [care recipients] and nurses' [professional care givers] perceptions of caring, which has implications for nursing practice." The importance of Morse et al.' (1990) research is reflected in the further investigations that have extended the findings of the original study (Roy 1993; Kyle 1995; Stockdale and Warelw 2000).

For the purpose of this chapter, the findings more precisely the five categories identified by Morse et al. (1990) are considered to be comprehensive

enough to encompass both caring for and caring about. Therefore they constitute a good starting point for an empirical and conceptual analysis of the caring notion. These categories were then compared with the data gathered recently during the interview process utilized in this study. The responses from the cross-section came back with most of the categories identified by Morse et al.⁴⁸ as well as, the same elusiveness they found. The nurses, who participated in this investigation, allude to the notions of caring as a human trait; moral imperative or ideal (this was contested and not accepted fully); caring as an affect; nurse patient-relationship; and interpersonal relationship. It is worthwhile to mention that, although the participants recognize caring as an important element of their profession, nonetheless they do not elevate it, as a “moral ideal” or the “essence” or “core” in nursing. Therefore, there are grounds for tension with the official line, as well as theoretical ramifications, specifically when the theories prescribed or promoted seem not in synch with the reality, as far as those participants are concerned. It may well be that the reality is blurred by the complexity and the contradictory nature of the concept of caring. These participants represent a cross-section of the different leadership functions in nursing, from education, practice, administration and associations. Part of their function is to produce or promote objectified knowledge⁴⁹ in nursing (to be discussed in Chapter Four).

⁴⁸ Morse et al.'s categories were used to assist with the interpretation and the analysis of comments made in the interviews. Their exhaustive investigation and categorization fit well with the intent of this dissertation and was very useful.

⁴⁹ This term is borrowed from Dorothy Smith. Objectified knowledge is viewed as an important

Evidently, the concept of caring is a challenge for nurses wherever they are located. It was very explicit in their answers that in the context of nursing, the knowledge base and the competence are key to activating the caring practices. In this, they are in total agreement with the notions expressed in Patricia Benner' (1984) classic text "from novice to expert." The participants also acknowledge that nurses are not the only ones who care; the difference is in the approach, in the sense that nurse's look at the patient as a whole as seen in the following quote provided by a nurse academic:

Caring encompasses a very global perspective. Not only being able to assess where your priority intervention should be, but to be able to look at the total picture and then to set your priorities in terms of how you can be most effective with the patient at the center of the family (Interview 1).⁵⁰

The notions of advocacy and communication were also depicted explicitly on several occasions as being an important part of the caring practices. From the perspective of this union leader caring is:

Not just being empathic [category 3]⁵¹ and communicating appropriately with clients, with families, with other health

set of procedures that serve to separate the discipline's body of knowledge (in reference to sociology or social sciences. Here it is referred to nursing discipline body of knowledge) by its practitioners.

⁵⁰ The interviews were processed in the language of the participants (English, French and Italian) to facilitate free expression. I did directly the translation and the transcript of the Italian and the French interviews. The guideline was not given in advance to the participants, because I wanted people to speak candidly about the issue regardless their function. Some participants even asked to decide after the interview, whether or not they wish to remain anonymous, because their comments can be in contradiction with what their organizations are promoting or want people to believe. See Methodology in Appendix One for more details.

⁵¹ The brackets are introduced here and elsewhere in the text as a way to confront the literature

professionals; but part of that caring... if you take it to a greater extent, it's an advocacy kind of role as well. If we were just caring, I don't think we're going to be competent. It's more than caring. It is caring plus competence. But I think the role of communication is extremely important in our interactions with clients (Interview 10).

However the elusiveness, the confusions and the conundrum of words found in the literature are mirrored and summed-up in the following answers as expressed by a hospital Chief Nursing Officer:

Caring is a concept in itself that takes a textbook to define it, but in the realm of nursing I will include a variety of components such as, the interpersonal relationships [category 4] that nurses do acquire with their client, so caring is our approach, our attitude, our therapeutic relationship with our clients – whether they be young infants to elderly to care for [category 5]. It is also an attribute one brings as part of the personality [category 1] as a nurse. I think we can't separate the two but I'm not here to say that all nurses have the same personality either. It is definitely an attribute that they bring, but it is often seen in their way of being with that client/patient either how they communicate verbally or nonverbally [Category 1]. The simple presence of a nurse can be caring as perceived by the patient [this can create conflict between nurse perception of caring and the patient perception] ... so it is relatively complex as a concept in itself. I must also add that we use the word far too frequently without putting definition around it, [allusion to elusiveness of the concept] and it frequently has had that notion of mothering-nurturing side [the taking for granted of women caring notion], but it is beyond mother-nurture – it is broader than that (Interview 4).

Similarly, a hospital Staff Development Director thinks that:

Caring is such a, kind of a non-descript concept in a way. It's very general, in some ways - almost superficial because everyone cares [this is also referred to the elusiveness of the concept. Also care and caring are used interchangeable, no distinction between the two]. I don't think it's specific to nursing. To me, anybody in the public is caring. I know people who have no professional background who are caring

with what is actually taking place in the field, as well as a means of clarification when used with a quote. Therefore, this will facilitate the interpretation and the analysis.

people. But I think when we look at it in the context of nursing we look at what we do and what we bring as nurses. What do we bring as an occupational group to the care of people? Although, I think a large part of the nursing experience is caring [evidence of acceptance of caring as a major component of nursing] (Interview 19).

Moreover, tensions and contradictions exist in the field among the leaders, due to the fact that nurses think and write about caring being central to nursing practice and yet some participants believe that there is not sufficient attention paid explicitly to the knowledge and skills required to enact the caring practices. In their words the profession has paid much attention to the empirical knowledge, the scientific knowledge required to provide sound nursing care, but less attention to the knowledge and skills required to provide the art of nursing; there is a call for a balanced approach because for this professional nursing association leader:

Caring implies both caring for and caring about. The former entails providing the care, i.e., treatment etc... assessing the patient to identify the needs. The latter entails understanding that human being with the proper attitude, with empathy and try to be in his shoes. For example, a nurse can be very competent in providing the technical care, but if she is distant, not connecting with the patient, the therapeutic relation is not complete. The patient expects from the nurse not only the treatment aspect of the care but also the proper attitude, which is part of it (Interview 5).

As Gordon and Benner (1996) point out, caring requires skill education, and community and social resources. Moreover the authors explicitly specify that the formal knowledge comes not only from the study of the liberal arts and sciences but from social and experiential learning as well. Caring is more than a feeling

reaction for the nurses who are working in the field. It implies caring for and caring about individuals who are in need of assistance or support to improve an ailing condition or to maintain a healthy lifestyle. To sustain their claim for a balanced approach, the participants provide examples. For instance, in nursing there are labs to learn how to administer injections to patients, labs to practice vital signs. However there are very few academic programs where there are labs to practice effective communication in its broadest sense, not just listening but interpreting and interacting. A variety of aspects that some believe should be looked at, if nurses as a caring occupational group are serious about a caring practice being central to nursing. In applying one of the different definitions and perspectives proposed above, for example, looking after another person's emotional, cognitive and physical levels, specific knowledges and skills are required to activate the caring practice as well as the communication piece which is an integral part of it. As one of the participants noted, "there are magnificent nursing theories that speak about caring, we fail to teach the concrete skills required to enact these processes" (Interview 13). Based on the above observations, there are obvious discrepancies in the formal knowledge of the art component of the caring practice. To this end, it can be argued that nurses are missing an important part of their formal knowledge; therefore they are to some extent ill-equipped to activate the caring practice. When responding to the question of the role of caring in nursing, the reality proves to be no different from the findings in the literature in terms of confusion, elusiveness, tensions and

contradictions.

Approaching the issue from a slightly different angle, Stockdale and Warelow (2000:1263-1264) examine on an etymological and epistemological perspective the complexity of care and caring. They reach the same conclusions as Morse et al. (1990) and the nurses who participated in the study. The authors remark that the philosophy of caring is obvious and a meaningful ideal for nursing. Caring “very nature, function and expression intimately link it with the daily practices of nurse’s worldwide”(Stockdale and Warelow (2000:1263). For instance, the caring ethos is not only part of the International Council of Nursing Vision statement but also strongly promoted by the Chief Executive Officer in this statement:

Caring has to be an essential element of nursing and has to be with other caring professions one of the aspects that really defines us. Caring is one of the attributes for which we are most respected and trusted. It also happens at this point in time care is the watchword for the ICN’s President. So, from an international organization’s perspective caring has a large role to play in the work that we do, both in terms of our code of ethics, and right now our big campaign that bears the essential tag line nurses care.... For me personally and organizationally, caring is a very big part of being professional (Interview 20).

However Stockdale and Warelow pointed to the difficulties encountered when on the one hand caring is promoted as the essence of nursing, while on the other there is no acceptable definition that can be universally applied. In this, there is a matter for contention; the authors appear to be in a quest for universality or a standard definition, which can fit all. One could argue that such standardization

will ignore for the sake of generalizations the complexities and convolutions of the caring concept. Contradictions after all, are integral to social structure. It is more important to be cognizant of their existence and know how to deal with them and bring about healthy progressive change, rather than to try to avoid them at all cost. Arguably, an acceptance of the tacit idea of a standardized definition of caring is on shaky ground not only because of all the hindrances and conflicts expressed above, but also the dilemmas that exported and prescribed concepts run into when trying to transcend trans-cultural and language barriers. Tensions and contradictions arise in the translation from one language to another and in the cultural interpretation of the concepts. If one judges by the comments the concept of caring is viewed differently from country to country. For example, the Anglophone view of caring is perceived to be dichotomous to curing. Whereas in French (*soigner*) and in Italian (*prendersi cura* or *curare*) caring and curing are part of the healing process, the interpretations are more global. The comments provided by some of the participants from France, Italy and Quebec illustrate the tensions and scepticisms that exist between nations and jurisdictions. For example, in the context of France, one of the nurse leaders accepts the intrinsic value of the concept, however, she disagrees with the “Anglo-Saxon” nursing’ perspective of caring, and expresses some scepticism with respect to that view. As expressed in this quote:

I think there is a philosophical foundation in the caring notion in terms of the relationship between human beings. Say, interaction between two human beings one with his experience of a need and expectations, and another with the competence and the knowledge [these two concepts seem to be accepted internationally as a key component for caring practice], which will help to answer to the need and expectations of this person... The Anglo-Saxon perspective, giving me the impression that caring became the thing or the essence of the nursing discipline [trans-cultural scepticism]. In my view, it is a strategy in relation to an influence or a power, another word, to find a field for the discipline. In this, there is a loss to some extent of the basic philosophical notion, which is caring in the human nature.... There is definitively a zone of tension (Interview 24).

In the context of Italy the difference in the interpretation and trans-cultural resistance are also obvious:

To me cure is part of caring. There is a part that overlaps between the two. You cannot do it separately because as a nurse you are caring for the people in order to heal or to cure. For me it is a whole, likewise, the competence, the skill and knowledge required to intervene. As far as I am concerned this is a North American dichotomy [trans-cultural scepticism] (Interview 28).

In the context of Quebec, nursing is influenced to some extent by the North American view of caring. However as one can see the linguistic and cultural interpretation still prevailed in the following quotes:

I think we do not have an exact translation of caring in French. Although in Quebec we are influenced to some extent by the North American view of nursing. I would say for our English-speaking colleagues, it is more a philosophy of care to differentiate nursing from the medical philosophy of curing. Therefore a dichotomy is created. In French we use "soigner" which encompasses not only the caring philosophy (caring for and about) but also the curing. All are

integral part of the therapeutic relations to facilitate the healing process or to assist the patient to a peaceful death (Interview 12).

I think the caring notion in English is often translated by “soigner” in French. I do not use the word caring which I consider as an Anglicism, which means an attitude, a presence, and a demonstration of compassion in the patient-nurse relationship. Therefore for me “soigner” is more than that. It is a broader concept and caring is integrated in it (Interview 29).

The tensions and the dissensions are evident in the above statements. They reflected to some extent the participants’ linguistic and cultural difference⁵². The dispute is not to some extent on the value of “caring” per se for the profession, but in the translation and interpretation. In other words, how those participants from France, Quebec and Italy conceptualise caring in their own languages. Furthermore there is also the cultural resistance to what they perceive as an Anglicism. Therefore there is resentment to accept a concept foreign to their languages and their way of viewing things. Dissension and resistance with the official position can be encountered not only from the leadership but also from individual nurse to individual nurse, jurisdiction to jurisdiction, and from nation to nation, this is inherent in the heterogeneous nature of nursing as an occupational group. Herein lie the richness and the strength of nursing. Likewise dissension and resistance can take the form of scepticism in leadership as well as, in the rank and file of the nursing community. This to some extent is normal and

⁵² Referred to the difference between the Anglo-Saxon (Anglophone) and the Latin (French and Italian) views and interpretations.

forces people not to take everything for granted. Of course, this is not to say that nurses as an international group did not subscribe to the caring notion or identify themselves as a caring profession, as was evident in the quotation provided in the above section; the dissention arises when the official position attempts to prescribe caring as the essence or core of nursing.

The nurses in the interviews are not alone in disputing the idea of “caring as a core” or “essence” in nursing. Stockdale and Warelw (2000:1263-1264) also recognize from their study that difficulties arise when efforts are made to “elevate care or caring to be a superior ideal to others.” The authors went as far as to say that with these attempts “the profession is actually being set up to fail.” Even the expert nurses regardless of their skill, their knowledge and experience “will not achieve a superior ideal of this nature: perhaps herein lies the paradox.”

These tensions to some extent are echoed by Broughton (2001:10) who argues that, “past definitions of nursing that emphasized caring and downplayed knowledge and skill may have contributed to the disempowerment of nursing.” Moreover she added that “Nurses’ own focus on caring, and undervaluing of their education and broad range of expertise, left them poorly equipped to defend themselves and their profession in the time of cuts.” This is very troublesome considering that it was written within the perspective of nursing leadership and power in an era of an ever-changing health system under policy reform of cost containment. These concerns were also expressed by a large majority of the participants who are of the opinion that while caring is an

important component of nursing; nurses are not the only professionals who care. They also think that nursing care has probably a broader range than a lot of caring professions because there is not only the psychological, supportive aspect of caring but also the physical/physiological aspect of caring in nursing. The participants express also their concerns regarding the trends of downplaying the skills and the knowledge, which are required for effective nursing practice. Most of all, as they put it, nursing is a practice occupation. The way that nurses use those psychomotor skills to provide the care is part of the reflection of nursing caring if they do it effectively, that is to say, in a way that demonstrates to the people or individual patients that they are not only caring for, but also that they are caring about (this will be further discussed in Chapter Six). For those participants, it is also part of an important aspect of the therapeutic relationship that nurses establish with the individuals and groups that they're working with. In their words, we are losing out by downplaying our broad-based experience and expertise. It is very dangerous and dichotomous.

In brief, caring remains elusive no matter where and how it is examined from the literature or in the field. There are contradictions and confusion relating to the concept itself as well to the centrality of caring to the professional identity of nursing. Moreover, there are contradictions emanating on one hand from the official endorsement of caring as central to nursing, and on the other hand, from the findings with respect to the perceived discrepancies in the formal knowledge of the art component of nursing which leave the nurses ill-equipped to activate

the caring practice. Therefore there are discrepancies between the theory and the reality. This is crucial in times of cost cutting, in a milieu where curing prevails, caring about can be considered as frills and potentially adds more confusion and frustration in the field. With regard to the notion of caring there is incongruence between patients'/clients' perception and those expressed by nurses. In other words, the contradictions between patients'/clients' expectations and the actions performed by the nurse. All of these call attention to the complexity and the multifaceted aspect of nursing caring work.

Based on the forgoing section, there are inherent tensions and contradictions amongst the nursing leaders from jurisdiction to jurisdiction and from nation to nation. These are understandable; nursing is a heterogeneous occupational group representing a broad spectrum of the society with different set of values and culture, therefore no one mould fits all. Furthermore, the labour market which provide nurses employment are for the most part government or state-owned and financed institutions for example, the health care and educational sector which are predominantly characterized by fundamental structural contradictions and political-ideological conflicts. As one can see, the debate clearly stimulates more questions than answers. Nursing as an essential health care occupational group has to find a way to understand what is undermining them and eroding their broad base as they clearly express it. At this point of the discussion, one can only provide a word of wisdom that, it is less problematic to be cognizant of contradictions and accept them as a way of life

and move forward. By the same token it is more problematic to try to avoid them or not to understand them at all cost, and live constantly in a dichotomous state. The latter is somewhat detrimental. This leads to the ensuing section, which is an assessment of the other quandary in nursing.

3.3 The Concept of Professionalism

The concepts of professionalism and professionalization have been discussed at length in past and current sociological literature by different schools of thought, and every attempt to come up with a definition runs into trouble. This issue can be traced as far back as Carr-Saunders and Wilson's (1933; 1964) traditional textbook "The professions" which characterize a profession as possessing a prolonged specialized skill and training, a minimum fee and salary, a formation of professional associations, and codes of ethics. Others, such as Greenwood (1957:45-46), come up with attributes such as, systematic theory, authority, community sanction [prestige], ethical codes and a culture. He cautions that in these attributes, the real variation between professional and non-professional occupation is mainly a quantitative and not a qualitative matter. In this, he acknowledges the fact that these characteristics are not exclusive to the professions; non-professional occupations also have them, but to a lesser extent. In his line of reasoning, occupations in society are distributed along a continuum, where the recognized and undisputed professions (e.g., physician, attorney, professor and scientist) are located on one end of the spectrum; and the least

skilled and least attractive occupations (e.g., truck-loader, busboy) are grouped at the opposite end. All other occupations (e.g., social work, nursing) with less skilled and less status than the former, but with more so than the latter, are distributed between these two extremities. More recently, Moore (1970:5-6) identify a scale of professionalism as a way of measuring the extent to which an occupational group can be called a profession. His scale contains characteristics such as, full-time occupation, commitment to a calling, formalized organization, specialized training or education, service orientation, and autonomy. At the core of all these propositions, are esoteric knowledge (substantive or theoretical) and altruism. These two major attributes of a profession constitute the cornerstone of the above lists and others (McClosky 1981; Macdonald 1995). Conceivably the functionalist traits approach to the professions is based on the assumption that the sociological task on this issue was to itemise the characteristics or attributes of an ideal-typical profession. These attributes can be utilized as a tool to measure other occupations as more or less professional (Macdonald 1995).

On these grounds, one can concur with Roth (1974:17) that the social utility of the functionalist trait tenet is to provide an underpinning for claims by occupational groups seeking to improve or sustain their social position, rather than to give an exact account of their exclusive attributes. He should be commended for his observations and harsh critics of the sociologists of this school of thought who give the impression that they were more interested in participating in the process than in studying it. This unending list of attributes

appears to be tantamount to keeping score. More explicitly these sociologists, as described by Roth, “ have become the dupe of established professions (helping them to justify their dominant position and its payoff) and arbiters of occupations on the make, keeping score instead of observing and interpreting the behavior involved in the process of scoring.” Even the detractors of the concept of professionalism cannot escape falling under the functionalist attribute trap (Johnson 1972; Oppenheimer 1973; Larson 1977; Abbott 1981; Freidson 1986). The focus was particularly in relation to medicine and law as one of the ‘model’ professions (Parsons 1954; Etzioni 1969) and social work and specially nursing, as one of the aspiring ‘semi’ or ‘quasi’ professions from within the large, health related occupational field (Etzioni 1969; Simpson and Simpson 1969).

From a different perspective, the ‘interactionists’ proposed the notions of ‘professional power’ or ‘organized autonomy’ as an alternative to the ‘professional traits’ (Freidson 1986; Turner 1987). In fact, the so-called power approach “came close to being a mere label to refer to all those who had abandoned the earlier orthodoxy” (Macdonald 1995:4). Despite that, some authors believe that the interactionists and the Marxian tradition approach to the notion of ‘power’, was indubitably more productive than the functionalists way and their related explanation of professional ‘traits’ (Johnson 1972; Freidson 1986; Turner 1987; Macdonald 1995). However, there is not necessarily any agreement over what makes up a profession and how professions are to be understood, although it has been seen in the past as a desirable and natural occupational goal

(McCloskey 1981; Storch and Stinson 1988; Mac Donald 1995; Parkin 1995). In the same vein, Armstrong and Armstrong (1992:118-119)⁵³ point out that the debate around this issue has “failed to produce a single set of characteristics that marked an occupation as a profession. Instead, they revealed the enormous variation not only in the characteristics but also in the power, prestige and rewards associated with a range of occupations classified as professional.” Their critique was more related to the analytic than the descriptive level. The authors’ main criticism of such approaches is related to the confusion of “professional’s justification for power with the actual basis of power” page: 118. Moreover, they argued that some sociologist such as Johnson who focussed on ‘agency’ and ‘conflicting values’, on ‘power and control’, on the ‘state and clients’ do offer a framework that could provide some explanation for difference among professions. However, with a caveat that this approach does not recognize professions like the world they are part of, because the world comes in two sexes, and assert that “these differences have important implications for how we understand professions and how we develop strategies for change” page: 119.

In the absence of a consensus on how to understand professions, one is left without any choice than to argue that gender was integral to the very definition of a ‘semi-profession’ that according to Etzioni (1969) has two defining features. First is an occupational group must be located within a bureaucratic

⁵³ In reference to sociologists such as Talcott Parsons and Ernest Greenwood with respect to their notions of “traits” or “attributes” that are common to profession (Armstrong and Armstrong 1992:118).

organisation; and second women must predominate (Etzioni 1969).⁵⁴ The sheer preponderance of women constitutes a problem in terms of the extent to which these occupations can professionalise (Etzioni 1969; Simpson and Simpson 1969). Moreover, it has been asserted that 'semi-professions' are not professions because women lack occupational motivation, ambition and any drive toward intellectual mastery or scientific knowledge, and are "less able than men to disagree impersonally, without emotional involvement... [And more likely to] think in value terms rather than intellectualising a problem" (Simpson and Simpson 1969:241). This seems to imply that, because women are not men, 'semi-professions' are not professions. As Roth rightly remarks, "when uncritical commonsense definitions dominate the field, circular and ad hominem arguments proliferate" (1974: 16).

Even in the newer and more critical approaches, the overall trend has rarely gone beyond a simple equation between gender and the status, the rewards or the degree of autonomy enjoyed by practitioners. The debate concentrates mainly on explanations which refer to gendered attributes in the division of labour, such as women's association with caring work and the subordinate relation of, for instance, nursing to medicine (Gamarnikow 1978; Freidson 1986; Rueschemeyer 1986; Mc Donald 1995). There are two problems with these existing approaches. One is that they are static analyses which take the

⁵⁴ It is important to note that Etzioni (1969) also used the concept of autonomy to distinguish the semi- profession from profession. As opposed to the profession, the semi-profession is not considered to be autonomous.

gender of the practitioner as 'already given' and resort to untheorised notions of supposed gender specific attributes, attitudes and 'problems' which women 'bring to' professional employment. The other problem is that they operate with fairly unreconstructed notions of 'women's role' and have no theory of gender relations beyond a basic, taken-for-granted 'sex role theory' (Witz 1992; Armstrong and Armstrong 1992).

Not all theorists accept these notions Terence Johnson (1972), rejects the attempt to formulate a definition in opposition to the prevailing 'structural functionalism'. Instead, he employs the concept of 'professionalization' to denote historical process. In this perspective, professionalization is viewed as economic, political and ideological processes by which an occupational group tries first to develop and then reproduce themselves by creating some relations between its own work, the state and the client. Professionalism was viewed as the result of a professionalization process, by which a "service ethic" ideology is shaped and eventually creating a myth of 'status' that a professional group strived to attain and retain (Johnson 1972; Oppenheimer 1973; Macdonald 1995). However, "the emphasis on process rather than on attributes has, also proven inadequate in explaining the variety to be found among groups claiming professional status. ...No common historical process has been uncovered. Nor has evidence been produced to demonstrate that such stages guarantees similar status and control" (Armstrong and Armstrong 1992:119). Talking about professionalization as a process of becoming a profession is no solution; indeed, a process must first

be distinguished from other processes; only then can it be defined. What is the starting point and direction of the process? Why call it professionalization? What does it consist of? Moreover, the process is already stained "with the ideology and hopes of professional groups rather than independent assessment of what they achieve" (Roth 1974:17). No matter how the problem is twisted and turned, one always seems to be faced with a dilemma.

It is paradoxical that the functionalist paradigm of profession, in which the 'semi-professions' thesis is located, has been largely displaced, but the 'semi-professions' notion implicitly or explicitly lingers on (Witz 1992). It can be argued that the 'semi-profession' thesis is based on an androcentric model of profession, which takes what are in fact the successful professional projects of men at a particular point in history to be the paradigm of profession (Parkin 1979; Witz 1992). In short, one can suggest that sociological studies are reading off women's professional work, because both traditional and critical approaches to the professions continue to reproduce at the level of sociological knowledge professional men's own construction of their gendered self-image (Garnsey 1978; Witz 1992; Armstrong and Armstrong 1992). Female professional projects were ignored in the sociology of professions, until feminist theorists started to challenge and critique sociological conceptualizations and theories that do not adequately reflect the position of women in society. One of the reasons for this neglect has to do with the fact that the generic notion of profession is also a gendered notion (Graham 1983; Gamarnikow 1978; Armstrong and Armstrong

1990; Abbott and Wallace 1990; Waerness 1996). Not surprising, the concept of caring and caring work has a relatively short history as a topic of enquiry in the social sciences. As Keri Waerness (1996) pointed out, conceptual and theoretical tools from our sociological tradition are inadequate to analyze a phenomenon like caring (Waerness 1996).

Historically nursing occupational strategies and beliefs are themselves often based implicitly or explicitly on a 'trait model' of what a profession is (Abbott and Wallace 1990). "Professional and similar terms have a wide range of uses in everyday speech, many of which are value-laden" (Macdonald 1995:1). This was also echoed by Porter (1992) who alluded to the fact that the ambiguity of the term 'profession' has led to its extensive misuse, "not least amongst nursing theorists." The same author argues that whether or not one agrees with the functionalist orthodoxy approach to the professions, this tenet should not be whatsoever neglected, if one is serious about investigating nursing professionalism. For Porter, this is of importance because it has been "central to the justificatory strategies used by nursing theorists who wish to promote the occupation. Whether or not it is mistaken, it has certainly been a major occupational strategy, and for many nurses it remains so" (Porter 1992:721). These are justifiable remarks as evidenced by the views of the nurses who participated recently in the interviews as part of the methodology to gather evidence for this dissertation. Interestingly, an overwhelming majority, thirty-six out of thirty-eight participants regardless of their jurisdictions or countries of

origin including a non-nurse hospital Chief Executive Officer, accepted the functionalist orthodoxy as the right path for any occupational group to follow. The taking for granted of this tenet as a generally accepted professional goal to pursue was unequivocal. The evidence in support of this is demonstrated in the following summary.

The nurses who participated in this study expressed their notions of professionalism as being competent, accountable and responsible for one's own actions and interventions. Professionalism to them means that they have a body of knowledge, complex skill and experience, and use their judgement in the process of making care decision for the benefit of the patient, family or community that they are serving. The participants also believe that nurses use their skills and knowledges (because nursing knowledge is multi-faceted and very complex) to provide the best care that the patients or others deserve. In addition, for them professionalism must also evidence people who are engaged in pursuing knowledge, people who are involved in research. The individual nurse is socialized and expected to demonstrate some of these behaviours. Likewise, they belong to autonomous organizations or associations. Central to all of these are three main attributes: knowledge base, self-regulated bodies that set the standard for practice and a code of ethics or code of conduct. In step with the literature, knowledge for the nurses in this study is considered to be central to all the attributes; the difference seems to be with the notion of altruism. The participants attach more importance to the legal body of a college or similar

organization and a code of conduct. This is not surprising because nurses feel more secure with a legal authority to refer to, when problems occur, paradoxically the college/other organization mandate is to protect the public and not necessarily the nurses. Implicitly nurses feel empowered by a legal body.

Albeit the functionalist paradigm of profession, in which the attribute/trait thesis is located, has been largely displaced in social science, yet it is lingering on in nursing circles. As one can observe, there is some coherence in the participants' views on how they experience their notion of professionalism, although with different emphasis because they belong to different lines of work such as, nursing administration, nursing education, and nursing association (professional and unions), the regulatory bodies or government appointees. What is salient in all of these is the fact that parallel to the functionalists from whom they follow the path, there is no consensus on how to understand nursing professionalism. The traits attributes notion can be seen in the following four cross-sections of the interviewee's quotes:

There are a lot of traditional definitions of professionalism, and certainly I think all the components of those definitions need to be adhered to – which means that you have standards, you have a college which determines not only whether or not you are qualified as a professional and that you have maintained those qualifications, and that you have adhered to the principles and the beliefs and the ethics of your profession, but also that you have the responsibility to maintain a knowledge base that is current, and the expertise. These are all part and parcel of you being a professional (Interview 1).

You can go along with the textbook – a distinct body of knowledge and self-regulation and limitations, that kind of thing. And I think those are important factors. But, I also think there is within

professionalism the commitment to the profession, to the client and client group. Because, I think professionals have the capacity to do a great deal of harm and therefore the need to have external, and internal mechanisms in place, to ensure that, you know, first do no harm. So it encompasses the whole aspect of the competency notion, the knowledge of the well being of other, serving a public need and identifying as somebody who has a unique service to offer to the public (Interview 6).

To me it's the responsibility and the accountability of delivering services based on the strongest evidence to date, and based on a solid body of knowledge. In addition to the knowledge, there are also the behaviours and attitudes by which people enact that knowledge. For example, if I would see a nurse that is absolutely brilliant and has the most up-to-date evidence in her practice but the behaviours by which she relates to people are not in keeping, in track with respecting someone's integrity and respecting that specific individual or group that she or he is interacting with. That to me would not be sufficient to call her, an excellent professional nurse. By the same token, if I see a nurse who interacts in a very humane and respectful of the individual, or group, or community, depending if you are working with individuals or a group but doesn't have a solid grounding or knowledge that also would not do it either (Interview 13).

Even the detractors could not escape falling into the functionalism attributes trap when ask about the definition of professionalism, this was evident in the statement below:

The standard thing that you have a defined body of knowledge, you have to acquire it at post secondary level, of those kind of thing ...you control your own practice all the traditional thing like lawyer and medicine, for me, it is a male model ... I don't worry about it a whole lot I think it is outdated I think the most important thing about any professional group is that you have a define body of knowledge, there is no question that in nursing we have that and, we have doctoral work in nursing research in that area we are very complex profession. We perform our work in the interest of the public we provide a public service we have a relation with client which mean, that we are in a position of "power" and so, when looking at those things, there is no question in my mind that we are a profession (Interview 17).

The forgoing confirms the comments made by Porter that the trait approach has been central to the strategies used by nursing theorists and leaders who wish to promote the occupation. One can clearly see that the leaders who participated in this study are conditioned to reproduce and perpetrate the functionalist trait approach without too much questioning and in turn socialize nurses generally in that mould. Porter (1992:724) severely criticizes this stance and referred to nursing professionalism as an "inappropriate occupational ideology" and has argued that professionalism was the conceptual framework which medicine benefited from the beginning, with such outstanding achievement. Adapting the goal to follow the occupational success of doctors "seems to have blinded nurses to the fact that professions are only one form of occupation." He further added that, "there is no reason why nursing should rigidly adhere to this path of occupational advancement. Indeed, there are very good reasons why nursing should avoid it", because it is not concurrent with what nurses are now searching for. One possible explanation of the persistent influence of the professionalization project could be related to "an increasingly outmoded ideological commitment rather than to any occupational characteristics of nursing per se." To some extent the comments made by the author do have merit, however in relegating the nursing professionalism project to only an outmoded ideological commitment Porter does not leave room to investigate the intricate and contradictory relations that exist between medicine

and nursing; between caring and curing; between the hierarchical structures and the differences in power and pay that exist in health care and in nursing work. Moreover he failed to propose any alternative. This dissertation intends to address this in Chapter Four.

At this point, it is crucial to examine what an occupational group such as nursing does, what knowledge and expertise its practitioners claim to have, how it mediates with state and institutional policies and regulations, how it intersects with other occupational groups in the division of labour and how it changes over time. Likewise, the strategies the group adopts to improve its status 'vis-à-vis' other groups, rather than merely categorizing occupations. In this way one can raise questions about how is this world in which nursing as an occupational group acts and suffers put together? How does it happen to nurses as it does? Likewise questions can also be raised both about the relationships with their clients in those client-centred occupations, the "power" struggles and the transformation in the division of labour between occupations that share clients, and the strategies occupational groups use to maintain dominance over clients and other occupations, how they produce and reproduce themselves. These issues will be discussed at length in the ensuing chapters. However it is worthwhile to acknowledge that "power" in relation to professionalism was mentioned explicitly only once by a single participant, as seen in the last quote above. This notion was mainly associated with the policy context and not at all connected with the concept of professionalism. One can be easily inclined to

deduce that power for the participants seems not to have much bearing. Albeit, this work maintains that it is not a negligible notion.

3.4 The Problematic of Nursing Professionalism

As mentioned in the previous section, in differentiating themselves from other occupations, for example medicine, nurses most often speak of caring in some form. They view their caring experience as a whole, which entail both caring for and caring about. Despite this unrelenting sense that nursing's value rests on the importance of caring work, theorizing such work has proven very difficult (Roy 1993). This can be attributed to the fact that this occupational group embraces an ideology of professionalism in their professional project strategy, which is not at synch with their caring work. Moreover, the concept of caring and professionalism are built on different assumptions and are both contradictory in nature. These differences and hindrances are discussed in sections 3.2 and 3.3.

Writers such as Hilary Graham (1983) and Kari Waerness (1996) from within the caring debate, and sociologists such as Margaret Stacey (1981) and Arlene Kaplan Daniels (1987) from within the study of work more generally, all point out that the theoretical legacy of a social science fashioned by men that has elevated a notion of scientific rationality, has thus denied a place for emotions and in this way restricted the very meaning of caring work (Davies 1995). It can be argued that caring action in the hospital bureaucracy, although highly specialized and critical, has been invisible and devalued because caring practices

have been seen and understood mainly via the medical and administrative (presumably) science and expertise. Viewed and assessed through the lenses of the “culture⁵⁵ of expertise”, the culture of caring loses meaning (Davies, 1995; Benner and Gordon, 1996). Thus, labelling as irrational anything to do with subjectivity, emotions, experiences and intuition. Something quite obvious among staff nurses becomes impossible to explain or justify to the administrators (Daniels, 1987). What Dorothy Smith (1999:49) dubs relations of ruling, which she defines as “internally coordinated complex of administrative, managerial, professional, and discursive organization that regulates, organizes, governs, and otherwise controls our societies.”

Paradoxically, doctors used experience and intuition, as part of the art of medicine to diagnose patients but in a largely patriarchal milieu such as a hospital, physicians’ experience and intuition are labelled as science or art. As one nurse put it:

I think there are some problems. I think there are some issues around nursing professionalism. We’re all struggling within an environment

⁵⁵ Dubinkas (1992) in his Model of Cultural System, conceptualized culture as a system with a coherent pattern of understanding built from the reciprocal relationships among four focal components: Knowledge or beliefs, the shared cognitive or conceptual understandings of what or how things are; patterns of practice, are both the models for doing and the model guided, habituated actions of everyday practice; tools and artefacts which are the means and ends of practical action; and patterns of affect that embody the compelling force of culturally appropriate models. At the core of the culture concept is the relationship between knowledge and action. In essence, culture is never a strictly intellectual or cognitive category but one that is intimately tied to the way people does things. This definition is retained only for its explanatory nature. It is rather static. In this dissertation we are concerned with the cultural practices, which sustain hospital institutions structure of control in the paid nursing labour force in reference to Clement and Myles (1994) “Relations of Ruling Class and Gender in Postindustrial Societies.”

in which nursing knowledge is not provided the same level of respect as let's say medical knowledge. I think there is a tendency within the health care field... all those tendencies that we have in other areas to discount the soft sciences, to discount evidence that isn't quantitatively defined, to discount the fact that you make someone feel better. Although it is difficult to measure that in any hard way, that's still a critically important part of being a professional and carrying out successfully nursing care (Interview 14).

In the same vein, Hilary Rose (1983) advocated for a more wholistic approach to science where emotion, intuition and experience are integral parts. This notion is very useful and opens possibility for legitimating caring work by those such as nurses who are constantly struggling for recognition of their knowledge.

Moreover, nurses cannot rely on nursing literature as a theoretical reference point to articulate what they do. The literature is filled with nursing care studies and theories about caring and care. But operationalization of the concept is not always clear as seen in section 3.2. This generates concern about nursing claims (Norris 1989). Part of it is also related to the fact that caring actions depend on the particular circumstances surrounding each case of caring and cannot be understood or explained without a context.

I think of nurses and what is very special about nursing, is that nurses see a patient in a wholistic framework. When a nurse deals with a child for example (Paediatrics being my background), they're not looking at that child's disease or entity, they are looking at the child from the perspective of being a member of a family, the relationship with the family, what that stay in hospital or the medical condition is doing to that child's growth and development in terms of his physical, social, emotional well-being (Interview 1).

This illustration is typical of the contextual factor that, caring action must be viewed as a whole, which is very difficult to sustain in a highly specialized and compartmentalized environment such as a hospital. As a result caring in this milieu has become compartmentalized, which constitutes a serious block for nurses attempting to care as part of their work. How can an occupational group strive for something that cannot be adequately explained or defined? In this case caring should be a by-product or an important component of nursing instead of the main thrust, as some theorist leaders want it to be. The literature as well as the nurses in the interviews — demonstrate clearly that the notions of caring, as the “core” and “essence” of nursing are creating problems for the profession and vice versa, therefore there is a dialectic relationship. Nurses recognize that caring is very important for them and it is part of their ethos. However, to reiterate Stockdale and Warelow (2000:1263) the difficulties arise, when attempting to “elevate care or caring to be a superior ideal to others.”

Nurses often assume responsibility for communicating information to one party to another — information relevant to the overall care of patients, they scrutinize the environment, select appropriate information for various workers, and deliver this information to the recipients, who can concentrate on their particular domain, confident that they can depend on the nurse for such knowledge when needed. Nurses’ role in this informal communication process often works so smoothly that the coordination involved in these activities are taken for granted. Four decades ago, Georgopoulos and Mann (1962), and more

recently Roy (1993) described such networks of nursing communication, however, they have not been fully investigated as important elements of organizational functioning. Although such function is well recognized in the field of administration and compensated accordingly, nurses, for their part also take this aspect of their function for granted. Could it be that such activity is an expectation that “naturally” takes place as part of the culture of connection – like the notion of women’s caring instinct? In this respect nursing as an occupational group has to do some soul searching. If nurses are taking everything they do for granted, so will everyone else take nurses for granted.

Furthermore, nurses claim a distinct professional field based on proficiency in patient comfort, recovery and wellness. This expertise in theory entails viewing the patient as a whole and establishing the relationship with the proper caring attitude and all transactions that are necessary between the nurse caregiver and the patient care receiver to influence the patient healing process or comfort/relief to the dying. It encompasses health promotion, which is officially recognized in the scope of nursing practice. For example, under The Regulated Health Professions Act (1994) in Ontario, the scope of practice of nursing is described as, “the promotion of health and the assessment of the provision of care and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.” This is at least abstractly separate from the medical field of diagnosis and treatment of illness.

In the current environment in the health care arena, professionalism is alleged to be the path to occupational recognition, but professional recognition implies a relationship with the predominant medical model for such knowledge (Roy 1993). Likewise, prevention and health promotion in hospital organization is only a slogan, not a value⁵⁶. Therefore, the norms of this culture not only describe limited domains of nursing knowledge, but they also make invisible some very important elements of the relationships among nurses, nursing knowledge, patients and others. What solutions can be proposed for this unsatisfactory state?

3.4 Summary

The concept of caring and professionalism are built on different assumptions and are both contradictory in nature. Caring being invisible tends to be subordinate to the alleged visibility of professionalism. Moreover, the complexity of caring has created some conceptual problem for the profession. This makes it somewhat difficult for the nurses, who have to provide care in this era of cost containment environment. Based on the foregoing, it is asserted that professional caring or

⁵⁶ This is due to the predominance of the medical model in Canada and elsewhere. Particularly in Canada the health care insurance still focus on diagnostic and treatment of disease. The care delivery in hospital is founded on an acute-care and physician-centred-model, this is the value, which was attached to the first piece of federal health legislation that was enacted in the provision of funding for the construction of hospitals through the National Health Grants Act of 1948. The same value of cure and treatment is attached to the national health insurance on the form of the passage of the Hospital Insurance and Diagnostic Services and Medical Care Acts of 1957 and 1968, respectively (Ross-Kerr 2003).

nursing work is positioned in a complex relationship to scientific knowledge. In this instance, "formal knowledge is put alongside other knowledges, leaving a considerable place for adjustment, negotiation and connecting in the light of a carefully acquired and detailed understanding of persons and situations" (Davies 1995:22).⁵⁷ Emotions⁵⁸, experiences⁵⁹ and commitment are recognised without any apology as part and parcel of the process of effective caring work (Davies, 1995). Thus, as an antithesis to the 'semi-profession' thesis, it might be suggested that the prevailing nursing caring ideology is not necessarily 'weak' or 'semi-professional'. Arguably, nursing work is women's work. It is a 'women's' or 'subjective' professionalism (the concept of subjectivity will be elaborated upon in the next chapter), which operates differently from traditional professionalism and not simply a 'semi' or a diluted version (Lorentzon, 1990; Abbott et al., 1990; Armstrong, 1993; Davies, 1995; Benner and Gordon, 1996). In light of all the discussion above we come to accept that caring and the mainstream traditions of professionalism are the dual contradictions in nursing. The next step is to examine through other lenses, how the world in which nurses work and endure the constant struggle for recognition is constructed? How does it happen to this

⁵⁷ This dissertation accepts this notion as an important point.

⁵⁸ Not as a detached observer, but as someone who cares about and tries to relate to the individual patients or the people, those that are receiving the care.

⁵⁹ In reference to Dorothy Smith (1999:96), for whom the notion of creating a "knowledge of the social grounded is in people's experience of their own lives. It does not treat experience as knowledge, but as a place to begin inquiry."

occupational group as it does? Expression will be found in the notion of nursing subjectivity and the political economy of caring and professionalism.

CHAPTER FOUR

MOVING TOWARD ALTERNATIVE THEORETICAL APPROACHES

4.1 Introduction

Chapter Four makes the case for a feminist theory of nursing subjectivity drawing on Smith's practical approach to epistemology ⁶⁰ and her ruling relations tenet to interrogate empirically and theoretically the ways in which nurses/subjects apprehend their social world. At issue are these practices that transform what nurses experience directly in their everyday/everynight world, into some sorts of knowledge where nurses as subjects disappear, and where their views on their personal experience are altered and subjugated by the "magisterial" forms of "objectifying discourse"⁶¹. Herein it argues that Smith tenet directs one to interrogate empirically and theoretically the ways in which nurses/subjects apprehend their social world and how this happens to the knowing subjects as it does. However, this alone is not sufficient to address the

⁶⁰ Dorothy Smith views knowledge in term of practices and holds that knowledge from everyday life; everyday dealings with the world is matter a lot. Feminist epistemic approach to knowledge provides an understanding of the socially constituted character of knowledge. In this sense, feminist epistemology poses a real challenge to the mainstream epistemology. Tanesini (1999) points out that women's knowledge has traditionally been practical, and epistemologists have often considered knowledge of this kind to be second rate.

⁶¹ "Discourse" refers to those modes of communication and interrelation that are mediated by texts - journals, magazines, newspapers, books, television, movies and so forth. These are distinctive modern-day forms of social organization, which largely interconnect with the chain of command of state, business, and other formal organizations structures. Their ideological methods provide the mechanisms to manage sites of the ruling apparatus in various jurisdictions. Discourse generates modes of "social consciousness" that are "extra-local" and "externalized" with regard to the local subject. (See Smith 1990b: 214).

knowing subjects as it does. However, this alone is not sufficient to address the issues in their entirety. What is needed is to link nursing subjectivity with political economy for a more comprehensive theoretical framework that could be altered by evidence. This chapter takes the position that working with these premises such as ruling order, tensions and contradictions, resistance and struggle one can attempt to account for variations in time and space of the impact of caring, professionalism and state policy on the nursing profession in the selected OECD countries. These alternative theoretical approaches will guide the next two chapters.

4.2 Exploring Nursing Subjectivity Through the Relations of Ruling

Subjectivity/subject/knower cannot adequately be understood without an adequate theory of “experience.” In feminist epistemology experience is inevitably subjective, because it locates the individual within the internal and external worlds and hence defines its subjectivity (Smith 1987; 1990a; 1990b; 1992; 1999; Tanesini 1999). In this, experience is unequivocally social and constantly carries its social institution. Likewise it is “now and hence embedded in an historical path, coming into being dialogically in the discourse of its time” (Smith 1999:77; 1990b; 1987). Moreover, experience (nursing experience as a mainly women’s occupational group) stands between the external world of discourse, material objects, and the social relations that draw them together, on the one hand, and the processes of representing one’s self in relation to that external

world, on the other. Similarly, “ the subject/knower of inquiry is not a transcendent subject but situated in the actualities of her own living, in relations with others as they are.” In this vein, nursing as a profession exists socially for its deeds (Donaldson 1995) and nursing care is provided by nurses ‘at work’ in their practice setting that is, “active, thinking, intending, feeling, in the actual local settings of their living and in relationships that fundamentally among particular others – even though the categories of ruling produce particular others as expressions of its order” (Smith 1999:75).

Hence, ruling order or ruling relations and the historical path of their expansion are depicted by Smith (1999: 77-82; 1990a; 1990b) as a process of separation and “specialization”, similar to the relations of “consciousness”⁶² and agency. They are mediated by text and text-based structures of communication, knowledge, information, regulation, and control et cetera. She points out that, “knowledge, judgement, and will are less and less properties of the individual subject and more and more of objectified organization.” “Objectified”⁶³ is viewed as an important set of procedures that serve to separate the discipline’s body of knowledge (in reference to sociology or social sciences. Here it is referred to nursing discipline body of knowledge) by its practitioners. In this there is the notion of objectivity. The ethic of objectivity and the methods used in its practice

⁶² In Marx’s denotation of “social consciousness”

⁶³ For more information on this notion, see Smith (1990a: 16).

are concerned primarily with the detachment of the knowers from what they know or experience and in particular with the separation of what is known from the knowers' interests, "biases," etc, that are not endorsed by the discipline.

However, she remarks "while the ruling relations are an organization of power⁶⁴, it is misleading to reduce them to relations of domination or hegemony, or to view them as monolithic or manipulated." For her, the ruling relations take the form of multifaceted synchronized activities, found on paper, and more and more in electronic or virtual format. She contends that text-mediated relations are the structures in which power is produced and sustained in modern societies. Moreover, the texts can be replicated in print or virtually in identical forms of meaning and disseminated in various local sites. This advantage of "replicability" is essential to the ruling relations. The replicability and also the visibility of the text transformed into fact⁶⁵ or practice is the product of complex organization of the media, of formal administrative process, of the "scientific" media of research methodologies, of professional journals, and the like. A fact is such an object; that coordinates the activities of members of a discourse, a bureaucracy, a management, and a profession. It is interpreted to be external to the specific subjectivities of the knowers. Fact presupposes to be the same for

⁶⁴ In this, Smith does not accept Foucault view that knowledge is necessarily a relation of power. For her the intersection of knowledge and power is an effect of the integration of the ruling relations, establishing subject positions within discourse from which experience can be known only externally and from within an order of domination." (Refer to Smith 1999:94).

⁶⁵ Refer to Smith for more details (1990a: 69).

anyone, external to anyone, and, unlike the actual. It coordinates the activities of anyone who is positioned to understand and has gained expertise in the interpretive procedures it intends and depends on (Smith 1990a).

Moreover, Smith (1990a: 13-14) argues that exploring the ruling relations is exploring those odd forms of power that are very subtle and hidden through intricate text-mediated social relations constituting "subjectivity" and agency. For her, these relations rule, and people rule and are ruled through them. Therefore, "objectified knowledges" are part of the social make-up from which our kind of society is governed. Where, "the domestic world stands [subjects/knowers, in this case nurses or alike] in a dependent relation to that other, and its whole character is subordinate to it." For instance, nurses who participate in this investigation see the importance of caring for their work, and they express it or experience their approach to caring in terms of wholeness, which means that they look not only at the physical care, but also at the psycho-social and the spiritual aspect of the individuals, this is due partly because nurses spend more continued interaction with patients and families. However, the ruling order for societal health needs are usually not expressed in terms of wholeness but, rather, as human misery/illness (Donaldson 1995) objectified in medical facts or in terms of engineering model of the body part which is more easy to standardize (Armstrong and Armstrong 1995; 2003). Consequently, nurses caring experience of wholeness became subordinated to the more visible objectified-text/fact of the medical profession. To survive within these peculiar social locations and

relations caring becomes also compartmentalized.

What follows is a society governed by abstract concepts and symbols, and sociology to some extent assists in their creation by “transposing the actualities of people’s lives and experience into the conceptual currency with which they can be governed” (Smith 1990a: 14). These abstract concepts and symbols can be replicated in print or electronic in multiple locals and settings and presented as in real time, albeit outdated. Furthermore, they are objectified as facts and people take them for granted without questioning. This can provide to some extent, an explanation to the nursing professionalism issues, why this occupational group strategies and beliefs still embrace the functionalism trait approach to professionalism, albeit largely displaced in social sciences. In this also, sociology is not an innocent bystander, it assists medicine professional male projects in the creation of their social conceptual currency, as well as in the perpetuation of the myth. The medical profession historically uses its conceptual currency with such an outstanding achievement to the point of successfully governing everyone else in the health care work place. In a sense, these practices reorder the actualities of nurses and everyone else’s lives and experience. As discussed in Chapter Three within our time and in the health care ruling relations, professionalism is alleged to be the path to occupational recognition, but professional recognition implies a relationship with the predominant medical model for such knowledge.

Those odd forms of power that are very subtle and hidden through intricate text-mediated social relations subjugate nursing leaders and nurses at

large. They feel compelled to transpose their actualities into the conceptual currency of the mainstream professionalism despite the fact this ideology is not in synch with their caring work projects. These virtual realities are produced by means of "objectifying discourse"; they are our own making. In using them, we break away what we experience directly as subjects from what we become knowledgeable of as "trained readers of texts " (Smith 1990a: 62). Knowledge as an expert form of social institution gives the impression to be independent of the presence and activities of individuals. It is in this connotation "externalized." Yet as Smith argues, knowledge can only exist in the actions and involvement of subjects as knowers. Herein lies the contradiction. Therefore, "the textual mediations of our knowledge of society do give us difficulty" (Smith 1990a: 66). Moreover, "positing the individuated subject means that problems of knowledge must be solved with reference to states of individual consciousness - perception, cognition, experience - and the objects they perceive, know, experience, or otherwise apprehend " (Smith 1999:108). Thus, the culture of "expertise" in hospital bureaucracy overwhelmed by doctors blocks this route to knowledge by making nursing caring work invisible.

Nurses interviewed for this study are very clear in terms of their role and their contributions to society. Yet, as seen in the previous chapter they are bogged down when they are trying to express or understand themselves through the lenses of abstraction. As Smith (1999:151) observes "however oppressively the burden of particular circumstances may weigh upon us, we feel ourselves to

be free in the sense that we decide upon an action in the light of what we know about ourselves, the context of our activities and their likely outcomes." In this, when nurses freeing themselves regardless of their functions and jurisdictions they are able to express their experiences as they actually live it, as the following quotes will illustrate. For instance, a hospital Director of Nursing who was also President of the Professional Association in Italy viewed nursing as a:

Caring profession that provide health services to the public in order to help them manage their illness or their health both as individual and as community (Interview 18).

Across the Atlantic, the Director of Nursing of a Quebec hospital perceived that:

Nursing is a health profession, a caring profession that is concerned with the whole health picture of the individuals. This entails working with clients; be they individuals or families or communities, to promote health, restore health and ease to a peaceful death. So it is very broad, for me this is one of the great strengths and richness of nursing, although I must admit difficult at times to sustain (Interview 3).

A Nurse leader from the professional association in Ontario experienced nursing as an occupational group that:

Provides care to people in need and by that I mean it in the broadest sense of the word. Care to individuals, groups and communities across a broad spectrum. And I also strongly believe that nurses cover a much broader scope than physicians, our focus is very different. For example, we talk about prevention, health promotion, cure, care, rehabilitation, and palliative care, all aspect of care such as, comfort that are needed from prenatal, birth and death and everything in between (Interview 16).

For the Dean of the Health Science Faculty the definition of nursing:

Incorporates both the prevention of illness, the education of the public about health matters, appropriate interventions based on the knowledge and expertise required to deal with specific populations of patients. Nurses are well prepared and cognizant to act on those. Our frustrations are due mainly to the bureaucratic straightjacket that the hospital structure strives to impose on us (Interview 1).

The Chief Nursing Officer of a hospital in Ontario conceived nursing as an activity that:

Brings relief to individuals, as they struggle with illness or concerns of different kinds in their lives. Nursing can go from the technical to the non-technical aspects of caring, but my view is to bring relief to the people we care for (Interview 4).

These foregoing statements reflect the broad scope of the nursing profession and it is conceptually different from medicine's notion of body part. In the quotes, there is evidence of wholeness, of prevention of illness, and of the comfort aspect of caring to provide relief, as well as, a sense of struggle to hold on to that value. Yet there is also a message of frustration when they cannot sustain it, as noted in the remarks of the nurse in interview 1. The difficulty is associated not only with the fact that health needs are usually expressed in terms of illness or problem body part in which, the notion of wholeness does not have any bearing, but also to the fact that prevention and health promotion in hospital organization are slogans not a value. Likewise, the drawback can be attributed to what Smith (1999) calls the "objectified bodies of knowledge" entrenched in discursive organization and are known by the members of the related discourse (nurse theorists; leaders who are in charge to promote ideas of the ruling order

despite what the practitioners are experiencing; and nursing's official stance) through regulations, practices and teaching, those members support a body of knowledge externalized in texts; they become its knowers. Likewise become the rulers and these are part of our own doing, although not necessarily by our own choice. "As the text's proxy, the reader is accountable to the text; she is its enforcer. ... The text's trap is that its dialogue with the reader is reader-activated. In becoming the text's proxy, she takes on the text's organizing powers as her own. Just knowing how to read it enables the text to creep into her consciousness and take over – not necessarily forcing the reader to agree with it, of course, but to adopt its organizing framework in selecting and interpreting other texts" (Smith 1999:150). This could be another explanation why the nurses who participated in this investigation take the professionalism notion for granted.

The official position of nursing mediated by text appears to some extent, to be contributing to the annihilation of nursing knowledge or what nurses really know and nurse's action beyond what is mediated and accounted for in the text. For instance, if one follows and accepts the same argument one may perhaps be inclined to say with Campbell (1995:232) who is in fully consonance with Smith, that nursing as textually mediated activity diminishes and replaces "care-centred nursing." Or acknowledge with her that the "accounting process to nursing obscures and organizationally annihilates nursing knowledge and nursing action beyond that which is mediated and documented." An unconditional acceptance of this stance will ignore people's resistance to the ruling order, and will in turn,

imply that nurses for that matter, the participants in the interviews automatically comply with the prescribed official position, when evidence proves that there is resistance even among the leadership. Equally we will ignore the dialectical relationship, which is intrinsic to the ruling order. As Choiniere (1993:67) noted with reference to Campbell's stance, it is rather "deterministic", because nurses "are portrayed as passive victims of this situation." After all, caring may very well be indeed central to nursing work, and it gets lost in the confusion in an effort to find a way out of this quandary, conceivably caring is equally lost in the contradictions of the objectified text-mediated relations. Coupled with that, are the difficulties of measuring the full extent of the benefit of nursing caring work, although there is some break-through with Aiken et al (1994) study on the benefit of nursing caring work in the patient healing process.

Obviously, Dorothy Smith's notion of the relationship of ruling offers to some extent a way of exploring the inherent contradictions of nursing caring and professionalism issues within the context of health care institutional arrangement (Smith 1987; 1990a; 1990b; 1992; 1999). However, there is disagreement with her position that the knowing subject is located in a lived world in which both theory and practice go on, in which theory is itself a practice. In this, there is a caveat for contention. In my view, if one subscribes blindly to this, there is a potential to be, in a standstill position or enticed to revert to the Campbell deterministic view. Although, I acknowledge that Smith's (1999) tenet was very helpful in explaining to some extent, the epistemic dilemma of nursing within the context of specific

institutional ruling order, yet, I contend that relying merely on her notion of the knowing subject, will not only be insufficient to test the whole reality of nursing's collective knowledge/experience, but will also be inadequate to assist in the development of strategies for progressive change. For that matter, Armstrong and Armstrong (1990:13) open up the possibility by arguing that " unless the kind of labour done mainly by women [in this instance nurses] is integrated into theories of work, the way people survive on a daily basis – the means employed to provide food, clothing, shelter, and care [in this dissertation the word care is retained, in application to nursing caring work] – cannot be understood."

Briefly, Smith's (1999) tenet directs us to interrogate empirically and theoretically the ways in which nurses/subjects apprehend their social world and how it happens to them as it does. Likewise, how is this world in which nurses act and endure the struggle for recognition constructed through the relations of ruling, which, are not necessarily their own choosing. As an analytical tool, it is an important one but an insufficient component of this inquiry. As Armstrong and Armstrong (1990:139) suggest, "it is necessary to begin with an explicit theoretical framework because theory is what guides us to select the area and people of concern. ... We need a clear theoretical framework that could be altered or transformed both by the research and the women's [nurse's] descriptions and analyses of their daily lives." At this point, it is asserted that a feminist theory of nursing subjectivity will act as a premise which serves as a useful position for argument and dislocation from the mainstream standpoint. It will need to be not

only linked with other theory, but also be tested and changed by the evidence. Arguably a phenomenon like nursing caring work calls for multiple theories and multiple levels of analysis to grasp the magnitude of its complexity and thus stimulate us to do something about this understanding.

4.3 Linking Nursing Subjectivity and Political Economy of Caring and Professionalism

To reiterate the point made earlier, nursing subjectivity is an important analytical tool to interrogate the ways in which nurses apprehend their social world and to deconstruct the mainstream theories and concepts built around nursing professional work. This debt is owed to Dorothy Smith's practical approach to epistemology, which offers an alternative way to see nursing professionalism. However, if one spends a lifetime trying to understand and explain what has happened to us without doing anything about it, would lead one, only go around in circles or take a tautological stance. A good understanding of a problematic must undoubtedly stimulate us to put into motion action to change the existing order. An appropriate approach in my view would be to link nursing subjectivity with feminist political economy. The belief being that this approach would increase the potential to develop strategy for proper action in order to move forward, instead of standing still.

Political economy is historical. This means much more than examining change over time. And it means more than focusing on the

material aspects of politics and economics. It assumes that people collectively and individually make their own history, although not under conditions of their own choosing or simply as a result of ideas that spring independently to their minds. People are social, actively formed within particular social locations and relations, rather than pre-existing autonomous individuals. Ideas and discourses are central components of this active formation. Ideas and ways of seeing can serve to reinforce or disrupt the existing order, although the common-sense understanding of the world is strongly influenced by those with economic and political power ... Equally important, these relations are relations of inequality and of ruling" (Armstrong, Armstrong and Coburn 2001: viii).

As seen, in the foregoing section the argument was heavily influenced by Dorothy Smith's feminist perspectives on epistemology and her ruling relations notion, and was engaged at both the theoretical and empirical levels, in order to make the case for nursing professionalism on a different standpoint than the traditional and critical approaches to professions. Through Smith's lenses, one gained an understanding how caring and professionalism paradigms work, and how the practices via objectified knowledge replicated in text/fact, rule or govern the everyday life of nurses, thereby making caring work conceptually invisible. Nevertheless, I contend that there was a need to link it with other approaches for a more exhaustive analysis. Hence what follows is a discussion of the means of this conceptualisation, which is found in the discourses of political economy from a historical materialist approach, with a focus on discontinuities⁶⁶. Historical discontinuities are considered techniques that work for fundamentally

⁶⁶ This concept is controversial and by no means central to the dissertation. It is introduced here only as a technique to deconstruct prevailing ideas/ideology, which appear natural and immutable in nursing's past and current history.

new reasons, because they construct each time new objects as their targets (Foucault 1972). It is recognized that prevailing ideas (ideology) make the arrangements in which we live appear natural and immutable. By focussing on the discontinuities between past and present, we can set ourselves outside that ideology. However, this raises two questions first, what changes must occur in the present and the future for transformation to take place? Second, what role an understanding of the political economy of nursing caring and professionalism can play in the stimulation for strategic changes.

Political economy seeks to locate the movement of society in the forces of change as production and reproduction are transformed. This perspective leads to an understanding of how people or an occupational group have shaped their own lives, under imposed conditions, and what strategies they have used to withstand the changes. Tensions and contradictions within society that produce struggles and resistance to the prevailing order are integral to political economy (Armstrong et al. 1993; Clement 1997). Moreover, a political economy perspective helps to conceive dialectically "objects and subjects of study taken to be fixed or static and unproblematic in the empiricist and positivist traditions of political science and neoclassical economics" (Clement and Vosko 2003:xiii). As a whole, political economy assists us in the understanding of conflicts between structure and nursing action; between nursing relationship with the states and their apparatus; between thoughts and real conditions; between management, nurse executive class and the grass roots, and along with the trend to look at

these features in fragmentation (Armstrong, Armstrong and Coburn 2001).

Viewed in this way, political economy is more relevant to understand not only the complexity of health care policy reform and structure, but also the impact on nursing. Any reform in the health care policy regimes will certainly have a direct or indirect impact on nurses. It reinforced the point made by Björkman et al. (1997:14) on the importance of understanding the political economy of reform processes, without that "generalizations about health policy reforms will remain problematic and policy responses will be correspondingly aberrant." Thus the importance of political economy in any study of nursing issues related to the policy reform processes. Therefore, it is crucial for nurses, who are closely tied to some extent with the social policy regimes of health care provision delivery to understand the political economy of the health care reform processes.

In addition contradictions are part of these processes. Rephrasing Pat Armstrong and Patricia Connelly (1999:1-3) brings to light that nurses "can have it both ways, when they understand the contradictory nature of the world." Nursing is an overwhelmingly female occupational group. As with the gender group to which, the members are connected, they "often experience their world as contradictory, and contradictions are integral to social structure." Nursing caring work was transformed to a paid occupation at the inception of the welfare state policy regime of providing health care to the citizen. Therefore, nurse's work and the labour processes are entrenched in the complex bureaucratic

hierarchy of the health care system, which is also embedded in a gendered class hierarchy. Since then nurses almost always turn to the state for employment, services and protection in their enduring struggle for recognition while blaming at the same time the state for their bad working conditions. The explanation for this occupational group's contradictory experience can be found in the argument put forward by Armstrong and Connelly (1999:2), when they contend that "feminists of all persuasions found themselves looking to the state for employment, services and protection while attacking the same state for reinforcing patriarchy and the unequal relations among women through these same processes." In their view, "it is the state, more than feminist political economy that is contradictory." Certainly, women in general or nursing as an occupational group do obtain "capitalist powers" when they go into the public sector, powers to allocate or to supply nurses and to rule to some extent nursing labour – "but only when it is unlikely that men will be subject to these powers" (Clement and Myles 1994:135). Because, the public sphere of the hospital bureaucratic hierarchy emulates a "form of neo-patriarchy, an economy ruled by senior males in which women may rule women but not men." This explains why in the pinnacle of the administrative chain of command of acute care hospitals, it is difficult to find nurses or women Chief Executive Officer in any of the countries studied in this investigation. Nurses may be found as a senior Vice-President or some similar title. However, they encounter the "glass ceiling" syndrome when trying to reach to the top of "the class pyramid." In other

words, when the senior positioned nurses start to entertain ideas of competing for the chief functions that entail the “exercise of significant authority over men, particularly over senior men” (Clement and Myles (1994:139) they are generally unsuccessful. Building on these premises, and following the same argument, the case can be made for nurses to view the state and all its apparatus and structure through the lenses of the feminist political economists. Adopting that perspective will assist nurses to view the state as not only an “instrument of class rule” (Clement and Myles 1994), and patriarchal reinforcement but also as a “contested terrain” (Armstrong and Connelly 1999) where their fight for recognition can make a difference.

These approaches have the potential to make it less problematic for nurses to accept contradictions as a way of life and move forward than to live in constant dissonance. Moreover, these premises coalescing with the notion of nursing subjectivity as debated earlier in this chapter create a more potent analytical tool for progressive change. However, the position taken in this work is that change should take place not only among the elite or the leadership circle, but also among the grass roots. This goes without saying that the individual nurse has to do some soul searching and hopefully this would bring about some change within. No one can do it better than the nurses themselves, as there is no messiah that will bring nurses to a promised land. The magnitude and the complexity of the issue call for a more sophisticated approach. I contend that wherever nurses are working they can certainly make the difference, providing

they have the means and the will to move forward. To achieve this, a de-socialization will need to take place in order to remove that guilty feeling when nurses individually or collectively are seen as making waves to change the ruling order. De-socializing nurses not to feel guilt or be called “trouble-makers” when they attempt to question orders from the ruling class, which are at odds with their caring work. Likewise creating an environment where nurses can experience their caring work to the best of their knowledge would be a good role for nurse executives in the broader public hospitals sector, if they are really serious about moving the profession forward or understanding their own contradictions.

As seen in the remarks by Armstrong and Connelly, “each aspect of the state can be shaped by women’s [nurse’s] concerns, although victories can become losses or may even simultaneously represent victory and defeat.” For example, after resistance and lobby on the part of nurses related to the deterioration of working conditions brought about as a direct consequence of cost containment of the nineties. In response to the nurses pressure the government of Ontario invested new funds in the hospitals sector for nursing innovation (this can be considered a victory). At the same time hospitals which, were already in deep deficit, were legislated to run a zero deficit budget. One will tend to say in final analysis that the incentive for hospitals to use the extra money to bail out part of their deficit was more than likely appealing, in view of the fact that the problems have not changed nurses still experiencing hardship in

their work environment. In understanding the forces at play, nurses can have a better sense of how to change things, which impact them. With this stand, the Armstrongs and those who are of the same thinking (for instance, Clement and Myles; Connelly; Choiniere etc...) bring another dynamic dimension to the debate. A dimension, which is more action oriented than the solo nursing subjectivity stand.

Drawing on some of the points made in the introduction chapter, it is my contention that a crucial key to understanding the complex field of nursing work and its object of transformation⁶⁷ is to locate it within the context of the past and larger society in order to promote change. Study of the past has a particular significance for 'historical materialism'; it helps reveal the specific nature of the present. This requires examination of the development not only of nursing, the health-care structures and the agencies, but also of the political economy in which they are embedded and the struggles around their development. Lately the political economy approach has to some extent been utilized in health service access and utilization, and has only begun to be applied to the health and health care (Armstrong, Armstrong and Coburn 2001). It is definitively not a major perspective in nursing research. The works of Armstrong (1993)⁶⁸ and Armstrong

⁶⁷ In this we share Clement and Vosko (2003:) notion of transformation as a means to gain understanding in order to promote social change.

⁶⁸ *Vital Signs Nursing in Transition* focuses on nursing work mainly in Canada. Pat Armstrong examines the development not only of health-care structures but also the political economy in which they are embedded and the struggles around their development (Armstrong, 1993:17).

and Armstrong (1996; 2003)⁶⁹ constitute a major breakthrough. In their feminist political economy perspective, the authors study nursing issues within the context of economic resources and cost containment, the tensions between cure and care, and locate them in a broader social picture which goes well beyond the hospital sector to encompass women, household issues and the role of the state. They also address the determinants of health and the deteriorating terms and conditions of employment on the health of care providers or on the health of those they serve and point out greater societal consequences. As opposed to the mainstream functionalist and system adaptation approach, which give the impression that, nurses are passively accepting their state of affairs. The Armstrongs studied nurses in terms of resistance and struggle, force of changes and contradictions and opened up the possibility to develop strategies for action. Moreover, although their work focused on nursing and health care issues mainly in Canada, their approach, opens the way not only for broader analytical perspective in nursing research, but also for cross-national study on nursing caring professionalism issues which are mainly the focus of this dissertation. As acknowledged previously in Chapter One, it is a breakthrough in the sense that their theoretical approach has the potential for improving the point made by Lane (1993:275) that one of the shortcomings of much comparative research has

⁶⁹ *Wasting Away: the Undermining of Canadian Health Care*. The guiding theory is political economy. Armstrong and Armstrong addressed nursing issues within the broader issues of cost cutting tension between cure and care (Pat Armstrong and Hugh Armstrong 1996).

been the problem of developing an "appropriate comparative theory." This makes it difficult to encompass "cross-national differences and universal social trends" within a single framework (Lane, 1993:275). The position adopted in this study is that working with these premises such as, resistance and struggle and, force of changes and contradictions one can attempt to account for variations in time and space of the impact of caring, professionalism and state policy in nursing reproduction in the selected OECD countries. It is hoped that this approach will, improve to some extent the shortcomings identified above by Lane (1993).

Research in nursing history has a tendency to fall into two groups: either a broad-spectrum history of the evolution of nursing as it emerges today, or else an effort to connect the evolution of nursing to related sociological underpinnings, particularly to the notion of professionalism and most recently to patriarchy as a rationalization for nursing ideology (Maggs 1980; Kerr and MacPhail 1988; Reverby 1988; Baumgart and Larsen 1988). While overviews are an important asset in the study of nursing history, they fail to take account of the complexities and intricacies, which define this occupation for women. Maggs (1980:18) emphasizes that, "such overviews, like those which deal with women's history and women's work, ignore, for the sake of generalizations and 'models', the specific population and labour characteristics which existed", and these are done to the detriment of a whole understanding of the distinctiveness of the health care labour market, as well of the population and the health care structures. Just

as the employment, population patterns, and health care delivery of most OECD countries namely, Canada, England, France and Italy were essentially local and regional in nature, so one needs to consider nursing in the same light if the occupation is to be set in its historical and occupational context.

4.3.1 Training and Change in the Mode of Production of Nursing Care

The production of nursing as an occupational group is a response to changing society needs. Modern era of training program for nurses began in England with the creation of Nightingale School of Nursing at St. Thomas's Hospital School in 1860 (Davies 1980; McCloskey 1981). Since that date similar evolution was taking place on both sides of the Atlantic. In Canada, hospitals such as, Mack's General and Marine Hospital in St Catharines, Ontario, and the Montreal General recruited 'Nightingale' nurses from London to administer nursing staff and to set up hospital training schools. In 1874 Mack's General hospital opened the first nursing training program (Kerr and MacPhail, 1988; Growe, 1991; McPherson, 1996). Likewise in France Désiré Magloire Bourneville, a physician reformer and politician led a movement to replace the religious sisters working in the Paris Assistance Publique administration with lay nurses. Acknowledging the fact that the existing lay staff, was not yet prepared to play the supervisory roles of the nuns, Bourneville established in 1878 the country's first public, part-time nurse-training programs at La Salpêtrière and Bicêtre hospitals of Paris Assistance Publique (Timar 1993; Schultheiss 2001; Magnon 2001). After the unification of

Italy, nursing training program was established first in Turin in 1880 at San Giovanni di Torino Hospital, followed by other hospitals in Milan, Florence (Dimonte 1993; Passera 1993; Cosmacini 1994; Signori 2000).

However, the full extent of the modern era of nursing as an occupation and formal state intervention in the coordination of nursing education and work was only started in the early part of the twentieth century in these four countries. Historically, legislations to regulate nursing practice were initiated in 1910 and continue to be amended throughout the twentieth century, till the end of last decade. In Canada, Nova Scotia was the first province to pass legislation regulating nursing. Subsequent enactments took place in Quebec during the 1920, to the conclusion of the process in Ontario in 1922 (OIIQ 1992; Cohen 2000; Kerr-Ross 2003 a). In England this was done with the passing of Nurses' Registration Act of 1919 (Baly 1980; Davies 1980). In France the state established in 1922 a national diploma for nursing along with a set of national guidelines for training (Schultheiss 2001). In Italy regulation coincided with the creation and the legalization of the Regional Nursing Colleges in 1954 ⁷⁰ (IPASVI 1992).

The number of nurses after both world wars increased tremendously and exceeded to a greater extent the number of physicians. Training of nurses in most countries, adopted the model instituted by Florence Nightingale in 1860s in England. Nightingale's primary goals were to eliminate the menial nature of nursing and to increase its professional stature (Kerr and MacPhail, 1988; Baines

⁷⁰ Legal Source: Decreto governativo dell'ottobre 1954.

et al. 1998). An essential feature of the Nightingale reform was that it created a unified nursing structure dedicated to 'cleansing' patients and their environment, both physically and morally. Nightingale's method of nurse education in fact aimed to prepare a strictly disciplined labour force of probationers for hospitals staffing. They would do the task of the hospital both unwearyingly and inexpensively. Nurse education system designed in this manner made political and economic sense in the hospitals (Davies 1980). While medicine sought to 'cure', nursing emphasised care for the patients, hygiene and sanitation, and discipline on the ward. But the subsequent proliferation and expansion of hospitals favoured the institutionalization of medicine's curative model (McKeown, 1965). This led to substantial changes in the content of nursing work and nurses' relations with other health workers. It reproduced the relationship between doctors and nurses the role division seen between husband and wife, father and mother, in the bourgeois family. Just as the home was the province of women, so the hospital ward was the province of 'nurse housekeepers'. The curative model, however, borrowed not from gender relations in the wider society but from the organisation of the factory. Not only did it imply the technical processing of patients' bodies; but it also entailed specialization among doctors and the establishment of a division of labour among other health workers with the doctor as a 'chief-engineer' (Coburn, 1974).

By 1920, as hospitals became the principal employer of nurses, onsite programs for training nurses were initiated. The real training for nurses,

however, took place on the job through a period of apprenticeship with a small stipend (Baines, 1998). This generated a quasi wage-free labour market for hospital, capitalist exploitation at its best. Similarly, the wages after obtaining the diploma or the certificate were also low. At the same time, health care policy and professional regulations were proliferated, further enabling or disabling nursing. Policies or regulations of that kind still pervade and function at various levels: the State, the profession, the organisation, the unit within the organization and the individual nurse (Cheek and Gibson, 1997). The inter-war period in nursing was perhaps fundamental in working out the struggle of the contradiction between the nursing structure and the curative model. As pointed out by Pat Armstrong (1993:19) "developments in health care and in nursing work are located within the context of a changing political economy that continues to segregate and subordinate women's work at the same time as it creates conditions that encourage women to revolt against this segregation and subordination." In the same way acknowledge another paradox that "it is precisely through the economic segregation of women [nurses] into female job ghettos that they are most likely to acquire effective powers over the forces of production" (Clement and Myles 1994:135). These statements can find their application in Canada, France, Italy and England. More detail will be found in Chapter Six and Seven.

4.3.2 Era of New Development Borne out of Contradictions and Tensions

Nursing history also reflects the tensions that developed as nursing educators advocated professionalization as a means to achieve both status and autonomy (Baumgart and Larsen, 1988). Fear of erosion of service commitment became the strongest argument made by the 'traditionalist' nurses as advocates for professionalization surfaced. The ensuing conflict between traditionalists and professionalists was largely played out through different conceptions of nursing education. Proponents of professionalism pushed for an academic program for nursing education centered in the universities. These issues were also part of the International Council of Nurses (ICN) position. As health care became more specialized, the forms and levels of personnel increased and exacerbated the development of a rigid and hierarchical division of labour within nursing (Coburn, 1974). The unionization of nurses has promoted a greater consciousness, and nurses have won the right to have some say in working conditions. However, patterns of unionization are different between nations and jurisdictions. For example in Canada, Quebec and Ontario have their own nurses union; In Italy they belong to public service union, although they are starting to organize themselves by Region. Similarly, the demands that the women's movement placed on the state have both helped nurses challenge authority structures and alter their working conditions (Melosh 1982; Growe 1991; Armstrong et al. 1993). In Canada wages, benefits, hours and job security all improved enormously and seniority was recognized. While this may have helped

ensure jobs for members and eliminate the problem of defining the terms of working conditions, it also opened the way for an intensification of labour. Worst of all, in the last decade the prospect for new graduate nurses to find full-time employment has been very difficult, leaving the nursing system with an aging workforce (RNAO and RPNAO 2000; McKee et al. 2002).

Current developments in nursing work, then, must be viewed within the context of changes in the political economy, changes in other health care work, the premises built into the system, and of nurses' struggle to shape their working conditions. Throughout the 1990s, all health care systems in OECD countries have undergone dramatic change as governments have restructured their health care systems to contain costs. In the Canadian context and elsewhere, health care restructuring and fiscal pressures have reduced the permanent nursing workforce through replacement of full-time nurses with part-time and casual positions (this was highlighted as macro structural issues in Chapter Two and later discussed at length in Chapter Five). Nurses contend that changes in the health care system have made nursing more task-focussed, resulting in lost continuity of care. In many cases, this approach is exacerbated by increasing nursing workloads, resulting from a lack of sufficient resources and having to care for patients who are sicker (Canadian Nurses Association 1997; O'Brien-Pallas 1998). Consequently nurses are working harder, caring for more individuals, and spending less time with each care recipient (to be discussed in Chapter Six). Coupled with these workplace changes, is a diminishing supply of

registered nurses employed in the health system (see Table 3 in Chapter One). Experienced nurses are leaving for work outside nursing; enrolments and graduations have also decreased, because women have other alternatives (O'Brien-Pallas, 1998). As mentioned previously in Chapter Two all four countries are experiencing a nursing shortage except in Italy where there is a Regional difference, shortage exists in the North, but oversupply in the South. Paradoxically, the nurses are not migrating north. Hospital bed closures have wider social implications, patients are staying in hospital for shorter periods of time, and they are discharged home with no community care support, which brings more burdens for caregivers at home mostly women. Registered Nurses responsible for general care in hospitals as well as women in the larger society have found themselves in contradictory situations, imposed on them by the social order of the politics of the new right. They are losing some ground and will probably win some, as the resistance is on to fight this new order.

4.4 Summary

Here the particularity of nursing is illuminated through a focus on its history. Its coherence is understood not in terms of its inner logic but in terms of its structural and practical relationship to the institutional matrix (health care structures, political economy and the struggle around their developments) in which it is embedded, and in which its reproduction is sustained. Both the formation and the transformation of nursing as a profession are understood as

conditioned by broad social and historical forces, which will be explained primarily in terms of the way concrete practices are strategically constructed in the immediate settings in which they are made effective (Brain 1989). The key to understanding the formation of the nursing professional caring work is, therefore, an understanding of the way the practice of nursing is implicated in the historical construction of a self-sustaining social structure with all the inherent contradictions, tensions, struggles and changes. Feminist epistemology focuses on relations of ruling, and feminist political economy open up that possibility. The subsequent chapters will utilize this framework likewise incorporating evidence where applicable in the process.

5.1 Introduction

There is no such thing as analysis without theory. Rational techniques themselves are based on meta-theoretical assumptions about the nature of evidence and logic and every problem definition is laced with political, sociological, and economic theory (Pal 1992: xiii).

This chapter utilizes the theoretical approaches as put forward in Chapter Four to guide the investigation. It examines the overall effect of policy initiatives on the nursing profession. It argues that the state with its various contradictory policy initiatives touches every aspect of nursing practice. In this thesis, policy is viewed as an “objectified” set of procedures mediated by “text” which serves as instruments to operationalize and sustain the ruling order. The problems that nurses confront are similar regardless of the spatial location. However, while the goals for legitimacy and recognition are the same, there are lapses in time and outcomes based on the political economy, and on the cultural and legal institutional arrangements of the different countries and jurisdictions. The chapter begins with the operationalization of the relevance of state policy in nursing. Herein, it proceeds thematically to analyze and compare the effects of policy initiatives, and the transformations that are taking place over time and space making brief references to the individual countries and jurisdictions which are part of the investigation. To accomplish that, the chapter explores the

contradictory nature of the evidence, the tensions and struggle, which result from the contradictions in the areas of: the scope of nursing practice in relationship to physicians and other healthcare workers; the supply and exit problems of a mainly female workforce; the labour process which is embedded in a gendered-class hierarchy, focusing mainly on the transformation of the nursing workforce. It contends that it is crucial for nurses not only to understand the policy process but to also be engaged at all levels if they really want to move forward.

5.2 Relevance of State Policy in Nursing

In the industrialized world and everywhere else including from Canada, England, and France to Italy, which is where this investigation is particularly concerned, the state with its various contradictory policy initiatives touches all aspects of the mode of production and reproduction ⁷¹ of nurses and the overall aspect of the nursing profession. The production and reproduction of qualified nurses are very complex and closely interrelated with issues of supply and demand, retention and the exit from the nursing workforce. The supply of qualified nurses comes from several sources: new nurses entering the

⁷¹ Here the mode of production of nurses is the act or process of producing new influx of nurses for the health care market. This consists of nurses graduated from basic nursing educational programs; nurses who are already credentialed from other jurisdictions or countries, as well as those returning to work after a period of unemployment in nursing. Reproduction here is viewed as the process of retaining nurses in the system, and replacing the nurses that are leaving the market. The notion implies, also daily reproduction or reproductive labour in the feminist tradition, which linked home and workplace. The latter definition would make it possible to look for factors leading to absenteeism and turnover. For instance, a study that focuses on retention would benefit from the combine definitions, which is not the case here.

professional register after completion of the educational and pre-registration requirements; those returning to the labour market after an episode of unemployment or employment in work other than nursing; and nurses from the global healthcare market (Buchan et al. 1997). The demand depends on population needs; on the development of science and technology which, in turn, cause skill scarcities; on cost-control strategies related to global market stagnations or fluctuations affecting, directly or indirectly, the healthcare sector; and alteration of the scope of practice by employers on a large scale. Whereas, exit from the profession can be related to nurses who decide to stay home to raise children; early retirement or retirement; unemployment; or abandonment of the profession altogether as a way of resisting bad working conditions or bad administrative policies in general; and also the presence of more opportunities to work in fields other than nursing. State policy directly or indirectly influences to some extent all the foregoing.

The state's authority is reinforced not only by its status of employer but also by its legislative power which regulates entry to practice; mandatory registration; title right; scope of practice; professional discipline; ascertain standards of practice and monitoring competence; and the accreditation of educational programs (Risk 1992; Feroni and Kober 1995; WHO 1997; Dent 2002). However, there are variations over time and space related to the nation's political economy, cultural practices, institutional structure and agency, the regional and local uneven development that, in turn, create institutional isomorphism and

uneven development regionally and locally in nursing. Nevertheless, the state is not simply a neutral benevolent arbiter of professional claims, as it appears to be. Rather, it acts in its own interests (Armstrong and Armstrong 1990; Johnson 1995; Angus and Bourgeault 1999).

Therefore, state policy or the accompanying legislation, rule or regulation is viewed as “a course of action or inaction chosen by public authorities [the state and its apparatuses] to address a given problem or interrelated set of problems” (Pal 1992: 13). In this, the focus is on policy-makers’ strategies, mainly with regard to the “public [health and health care] problems they define, the goals they pursue, and the instruments they choose.” Problem definition is considered to be a political process.⁷² After all, policy is about process and power; that is to say, which problem definition will be retained or refuted, who influences whom in the making of policy, and how that happens, how it will or not be implemented, and who will benefit or lose. The process also gives rise to “intended and unintended consequences” (Walt 1994:41; West and Scott 2000) as well as tensions and contradictions. As a supplement for the purpose of this investigation, policy is also conceptualized as an “objectified” set of procedures mediated by “text” which serves as apparatuses to operationalize and sustain the ruling order. These text-mediated instruments are found on paper and, more and

⁷² Pal’s interpretation of problem definition is retained as an important one. In that he demystifies some aspects of the political process, this is very crucial especially for nurses who tend to see this as something totally foreign to their work, when in fact the political process in a broader sense of the term, affects all aspect of nursing practice. Nurses do not realize that in their caring work, they are constantly involved in problem definition in order to answer not only to the patients or clients need but also the employer’s request. For more details see Pal (1992:13)

more, in electronic or virtual format under the label of legislation or regulation, or policy and procedures, with contradictions as an integral part of these processes.

In a cross-national study, all the above conceptualizations can find their application in multi levels of governances such as, the Canadian federal system with the provincial governments and the European Union (EU) supra national, national and sub-national. As argued in Chapter Two, while the nation states retain a very powerful and often determinative role in policy development, their influence is increasingly circumscribed and embedded in a dense, complex institutional environment also complicated by an intense political process deeply entrenched in the nation state and their regional government. It is in these instances that one needs to view the healthcare policy process. Given that the nursing profession is a product of health care, one needs to view policy development with respect to nursing in the same angle. Nurses' sources of income or employment are provided by the state. Arguably, any changes in the social policy regime, focusing on strategies to contain cost in the healthcare system, will certainly affect directly or indirectly nurses' production and reproduction.

Equally, nursing is a large, female professional group, like the gender group to which the members are connected they "often experience their world as contradictory, and contradictions are integral to social structure and social relations" (Armstrong and Connelly 1999:1-2). Moreover, as "clients of the state"

when problems arise in the labour market, they lobby for security and remedies. Consequently, the prevalent ideology and nurses' conceptions about themselves are distorted by the ideas and objectified text-mediated relations propagated in state institutions and cultural practices which sustain hospital institutions' structure of control in the paid nursing labour force where the majority of nurses are employed (Armstrong and Armstrong 1990; Clement and Myles 1994). Such legislation and regulation or policy and procedures permeate and operate not only at the supra-national and national, sub-national/provincial or regional jurisdictions through the EU parliament or the various nations/jurisdictions Ministry of Health departments, but also at the local levels through, for example, semi-autonomous⁷³ institutions such as hospitals. These are local policies emanated at the internal administrative level and this type rules in fact the practice setting. They can be enabling at the same impeding nurses autonomy. Cheek and Gibson (1997:668-670) have examined this issue from a critical perspective as part of a study on hospitals' policy documents and found that nursing practice is regulated not only by means of legislation, but also via a top-down "hierarchical system of policy development" emanating from the "enactment" of that rule or legislation. As a result, policy statements proliferate in nursing departments and are placed in binders on each unit/ward.

⁷³ Administratively these institutions are autonomous to manage their internal affairs. However the degrees of autonomy varied over time and space. Usually the Boards of Directors are accountable to the Ministry of Health or the delegate. The Ministry of Health or similar department is responsible to grant privilege to private hospitals to operate and they are subject to the law of the country.

Cheek and Gibson (1997:669) point to the fact that policy is taken for granted as being necessary, and portrayed as being of value and assistance to nursing and nurses. "Consequently the need for, and value of policy is rarely challenge or questioned." In this unqualified statement, there is a matter for contention, although one will tend to accept the taken for grantedness of policy on the part of nurses. However, to say that policy is rarely challenged or questioned is to agree with the presumable subservience and passivity of nurses, as some authors tend to portray it in the sociological literature of the professions. Resistance against policy can take a passive or active form. The mere fact of the proliferation of policy can create policy overload or reader fatigue if the nurses have time to read them, which is less likely given the work intensity. Therefore, as a way of resistance, they can decide to do business as usual without taking into account the new policy. Moreover, one can argue that the nurses to some extent are not totally duped as this seems to imply. They actively resist in the absence of other means by using the same legislation for protection, while blaming it at the same time as seen in this comment:

From a union activist perspective, I find sometimes it is very helpful to use those legislative tools to force non-compliant institutions to comply. Also, I realize that the same legislation, standards of practice, etc., can be used very punitively towards nurses when they have no control as individual practitioners over say for instance, their workload (Interview 7).

Furthermore, Cheek and Gibson (1997:669) comment on to the fact that "nurses are portrayed as autonomous professionals able to assume responsibility

for their own practice, yet . . . the trend in policy development and the various levels of policy implementation seems to contradict such autonomy.” To some extent, the comment has merit; however, there is matter for contention what is missing is the recognition of the contradictory nature of the state policy initiatives, which can empower and disable nurses at the same time. Moreover, the authors fail to see, in this case, that the contradictions are entrenched not only in the supremacy of the text-mediated hospitals’ act and its relation of control over the nursing workforce, but also in the power relation embedded in the institutional matrices of the hospital bureaucratic hierarchy which emulates a neo-patriarchy to keep nurses invisible despite their numbers. This notorious top-down approach is considered to be a real deterrent for nursing progression in hospital environments. In the context of Ontario, one of the participants clearly denounces the Public Hospitals Act and the lack of decision-making power of nurses in the process:

I think one of the big problems that we have right now is most hospital legislations or regulations excluded nurses from the very important decision-making process. For instance, the Public Hospitals Act in Ontario is an antiquated legislation but again so complex. There is not enough room to manoeuvre and it is very complex yet has created major problems for nursing. Again, when you’re depending on the good will of the organization to have you at the decision-making table and that the role of nursing is so important for safe patient care that is a problem, I think (Interview 17).

Nurses are also socialized to view policy as being there to assist them. This attitude reflects the point made earlier by Cheek and Gibson when they

comment on the fact that policy is taken for granted as being necessary, and portrayed as being of value and assistance to nursing and nurses:

I think it's really important to recognize, at the outset, that it's important to have policy, regulatory bodies and rules. It could be really chaotic if there wasn't legislation around the provision of services, around the regulation of professional practice. So, I think from my perspective as a nurse activist within the labour movement we come to recognize the importance of standards of practice, a code of ethics because they can very much be used as tools for pressuring to create kinds of work environments that are necessary for good practice to take place (Interview 7).

Despite the fact that policy affects the nursing practice in general, as well as the day-to-day function and life of the individual nurse, it has only been recently recognized in nursing literature as a critical issue of investigation (Meerabeau 1996; Helms, Anderson and Hanson 1996; Helms and Anderson 1997; Cheek and Gibson 1997; Antrobus 1997; Hewison 1999). This view has an impact on the field and explains, to some extent, the lack of nursing input at the national level on both sides of the Atlantic. In the mid to late nineties, there does, however, seem to be a slight improvement in some countries.

Having no say at the national and provincial or regional levels is an important factor in a culture of top-down approach to policy decision-making. It left the nurses at the care delivery or the local level with no voice at the policy table on top to influence the problem definition process, which will certainly have an impact on their work. It is not surprising that nurses in the industrialized world in general have limited possibility to participate in national decision-

making. Only a few nursing representatives have a permanent position on a national body for health care decision-making as in United Kingdom with a Chief Nurse Officer in all the four territories (England, Northern Ireland, Scotland and Wales). For example, the Chief Nurse in England is a member of the Policy Board in the Department of Health, and Director of Nursing for the National Health Service Executive (Salvage and Heijnen 1997; Chief Nursing Officer Department of Health 1999). In Canada, at the national level, Health Canada established the Office of Nursing Policy (ONP) in 1999 to provide evidence-based nursing perspectives on a wide range of policy issues. The Office contributes also to health policy and program development across the Department. The Executive Director participates in a variety of national committees and working groups, and provides advice and support to the policy work of Health Canada (Canada Office of Nursing Policy 1999). In the same year, a Chief Nursing Officer (CNO) was appointed at the provincial level in Ontario, which became the first jurisdiction in Canada to appoint a CNO. The mandate is to advise the government on health and relevant public policy from a nursing perspective, and foster collaboration between government and nursing stakeholders (Government of Ontario 1999).

In the view of some participants, the fact of not having the nursing voice during different policy-making decisions is detrimental to the professions and for the society-at-large, because nursing perspectives are not reflected in healthcare policy decisions. Rightly so, one would argue especially in the case of Ontario —

that while it is important to have a Chief Nursing Officer to advise the government, if the Public Hospitals Act is not amended to include nurses in the decision-making process at the level of care delivery, then the position will revert to tokenism. Therefore, there is a gap between the policy directions and the policy actions, as in the following statement of ICN that appears to be more an aspiration than reality:

Our mutual efforts assure that the nursing profession is highly valued everywhere, and appropriately utilised, recognised, rewarded, and represented throughout the health care system. Our highest reward is the certain knowledge that our work is shaping a future of healthy people in a healthy world (ICN, 1998:2).

In the vast majority of western European countries for that matter North America nurses are not legally entitled to participate in any form of healthcare decision-making. With the exception of Quebec, the legislation stipulates that every public organization, where at least five nurses are employed, a council of nurses is mandatory. The council is accountable to the Board of Directors and has a sitting representative with voting rights (Government of Quebec 1994). At best, nursing representatives are sometimes asked to advise on specific nursing issues. In some countries, nurses are legally responsible for regulating professional matters, such as licensure and professional ethics. The level of involvement, however, varies widely between and within countries. Nurses from France, Italy and other western European countries report significant difficulties in influencing policy. Gender is also an inhibiting factor (Daune-Richard 1995).

Female nurses experience, to some extent, difficulty in asserting themselves to take part in the decision-making process partly because this is nearly always dominated at the top of the pyramid by male doctors and/or career administrators who naturally assume leadership. Furthermore, socialization and the historical rigid hierarchy within the rank of nursing may teach subordination and passivity (Feroni and Kober 1995; Salvage et al. 1997). In the field, there is some awareness on the part of nurses who participate in interviews on the importance of policy in nursing work life. At the same time, there is an acknowledgement of the apathy or the lack of knowledge on the part of nurses in general of the effects of policy on nursing practice. As the Executive Director of RNAO expressed it in the following quote:

I think we need to enhance, in a huge way, nurses' understanding of the political forces that support them or hinders them in enacting caring practices because, if not, they will continue to live as silent players or silent actors of these terrible dichotomies that they are living day-by-day. And so, they will be kind of pulled apart by a caring framework that is taught to them in schools but because of lacking the understanding of how to deal with this policy, within the organizations an understanding of how to shape their work environment and how to obtain the resources required to enact their practices they will be pulled apart and they will continue to be silent actors where nursing has a huge possibility to change that, if practicing nurses also start to play a role in that (Interview 13).

Some authors are arguing for nurses to be more proficient in politics, in order to influence and improve health policy (Mason, Talbott and Leavitt 1993). There is also agreement in the field that nurses need to be involved:

We have to be much more involved with the political and policy

process and using politics and understand how that affects us. Health care is a political process in every country. Because it is decisions about the allocation of scarce resources and whenever you are in that kind of position, it is a political process. So we cannot remove ourselves from it. Therefore, all educated nurses should view this as part of their role as a health professional and be part of the process (Interview 9).

However, most of these debates in nursing literature do not address the complex nature of the policy process (Hewison 1999). More precisely, the complexity of the links between politics and policy, as previously discussed, are not taken into account very well. Instead, this literature reproduces a “mechanistic” view of both politics and policy (Cheek and Gibson 1997). The understanding of the political structures for policy decision-making has been separated from “substantive” analysis of policy in nursing. “The result is a failure to understand how the environment in which policy is made both mediates and constrains the content of policy” (Helms, Anderson and Hanson 1996:32). Furthermore, not enough attention is given to the proliferation of policies at the institutional level with respect to their effects on the scope of nursing practice and the caring work, as well as the labour process. Such policies sometimes tend to be contradictory like the institutions in which they are generated from. They tend to be based on the goals and problem definition of the institutions in which they are developed not necessarily congruent with nursing goals and problem definition.

5.2.1 Effect on the Scope of Nursing Practice

Policy certainly does affect the scope of nursing practice at the supra national, national, sub-national, institutional or organizational level. All four countries Canada, England, France, Italy, and their respective jurisdictions have incorporated specific regulations for nurses' responsibilities, competences and duties in laws on nursing acts or their equivalents (Risk 1992; Canadian Nurses Association 1993; Salvage and Heijnen 1997). Moreover the state plays a crucial role in the professional goal of aspiring healthcare professions through various negotiations process in order to improve their privilege or their right (Angus and Bourgeault 1999). Therefore, governments at all levels are involved in making decisions and legislations around the kind of healthcare professionals the system will need, what role they are going to play and how they will be compensated. All of these have an impact on nurses' production or reproduction and the role they will end up playing. One of the leaders who participated in the interviews compared nursing with "a piece of dough" as a metaphor to explain some of the ramifications of policy decisions not only on nursing's scope of practice in terms of the fragmentation of the caring work, but also on individual nursing professional practice, in the following quote:

Nursing is like a piece of dough. Other professions have come along and cut it out bit-by-bit. Physiotherapists, occupational therapists, respiratory technologists, etc., they've taken their bits. Nursing ends up being the dough that's left over with all the holes that other people have taken. Moreover, it is difficult for nurses to look at the patient as a whole with all of these people with specialties. And to complicate the matter, there are also the less prepared nursing personnel for

example, aides or nursing assistants or licensed practical nurses. I think it is really hard for nurses to have a professional identity as a result of that. But I still view nursing as the group that prevents patients from falling through the cracks (Interview 6).

The scope of practice of a profession includes the activities for which its members are educated and authorized to perform (Risk 1992). The delineation of the scope of practice, albeit tricky to circumscribe with precision, is considered to be very important given that "it is the base from which governing bodies prepare standards of practice, educational institutions prepare curricula, and employers prepare job descriptions. Consumers, too, need at least a general understanding of scope of practice to know who is qualified to provide different kinds of services" (Canadian Nurses Association 1993: 2). It is within the scope of practice that the concept of caring and professionalism can be materialized. It is also within the scope of practice that one can identify the sources of conflicts and contradictions. There have been lot of factors that contest whether or not nurses work in their full scope of practice. Here, two main issues or sources of tensions and contradictions are identified: the power of employers to restrict or expand nursing's scope of practice and the monopoly of medicine over particular area of practice which are legislated under the transfer of functions or the delegated "medical acts" (Risk 1992; Canadian Nurses Association 1993; Salvage and Heijnen 1997). They are retained not only for their impact on the fragmentation of caring and the labour process, but also for their importance on the overall nursing scope of practice and the individual nurses. The process of contraction or

expansion of the scope of practice and the process of delegation are formatted in “objectified text” of policy and procedures. Ready to be standardized and transformed into functions or job descriptions as required they are developed at institutional level or semi-autonomous organizations, such as hospitals or legal professional associations.

The first important source of tensions is the power of employers to restrict or expand nursing scope of practice. Tensions and contradictions arise between the activities nurses are educated to perform and what they are actually authorized to perform in the work setting or institutions where they are employed. Policies developed at the institutional level have a lot to do with that. In most cases, they contravene with what nurses are legally entitled to do depending on the interest of the institution. For instance, the overall scope of practice for the profession sets, at first glance, the boundaries of practice for all nurses. It is based on national or sub-national laws. However, despite that, the scope of practice of individual nurses is actually influenced by the organizations in which they work, the desires or requests of the employers and the requirements of their patients or clients. Therefore, the actual practice varies from setting to setting. Nurses are usually employed by state institutions or other affiliated organizations such as hospitals, governmental branches or departments that set the parameters of practice, within the general scope of practice determined by the nursing regulatory body. Paradoxically, the scope of practice of the individual nurses can be contracted or expanded by the employers despite

the legislation. Therefore, the problem is not to some extent in the education or in the broader policy/regulations developed at supra national, national, sub-national levels, but in the power entrusted by the state to those semi-autonomous organizations. As illustrated in the following quote provide by a nurse educator from Quebec:

We educate nurses to practice within their scope of practice. That scope of practice, once they are in a field, is often restricted for them. So, I would like to see nurses work within their full scope of practice no matter what setting they're in. My belief is that if we were able to do to that, it would be much more cost-effective to our healthcare system. There would be greater continuity of care for the client and your health outcome would be greatly improved (Interview 2).

Nursing practice is like women's practice very broad, diverse and adaptable. Consequently, however, it is a strength and weakness at the same time. Strength because the scope of nursing practice is resilient, adaptable, offers lot of possibility and has demonstrated that it can evolve over time not only to meet societal needs but also evolve with the progression of science and technology to take different forms. The weakness can be found in the strength in a sense that the scope of nursing practice is so fluid that it leaves the practice of individual nurses wide open to employer alterations and manipulations. This has the potential for nurses to go outside the practice boundaries and expose them to disciplinary measures for illegal practices. Moreover, some employer requirements have the potential to alter the scope of practice to a point that will affect the caring and professional behaviour of individual nurses.

All of these requirements are done in the name of management rights, and are sanctioned by various contradictory policies and procedures to protect the interests of the institutions, at the expense of the individual nurse's standard of practice as stipulated by their regulated bodies. Thus, nurses are placed in difficult position on either contraction or expansion circumstances. This position creates for the nurses not only inner conflicts and a state of identity crisis but also external conflicts with their colleges with respect to the standards and codes of conduct. In addition, it generates a problem of role confusion within the division of labour, as the following quote will illustrate:

It is part of the Cinderella syndrome in nursing. After four o'clock, in the hospital setting when everybody else goes home, nurses suddenly get a brain change: they are changed into a pharmacist, physiotherapist, occupational therapist, etc., because everybody else works from Monday to Friday 9:00 to 5:00. So, it is interesting to note that our practice is always expanding and contracting according to the need of the organization or the practice setting rather than according to what makes sense in terms of patient care. It is fundamentally flawed because managements and nurse leaders in these institutions continue to think about how to make nurses fit the organization instead of what the patients need (Interview 17).

Overlaps between the limits or the parameters of different healthcare disciplines have been of particular concern for the discipline of nursing in text and in reality because the scope of practice "boundaries have historically expanded and contracted based on the supply and demand situation in other disciplines particularly medicine" (Canadian Nurses Association 1993: 21; Salvage and Heijnen 1997). This observation is reflected in the work setting as

seen in the “piece of dough” metaphor (referred to in the previous quote from Interview 6) and also the “Cinderella syndrome” (from Interview 17). Furthermore, the expansion and contraction of nursing practice provoke some reaction and scepticism of the extent of nursing professional autonomy in terms of controlling the scope of practice:

If we really thought about it in terms of what the population or the clients need, working from that premise, we will never entertain to expand or contract nurses’ practice and the scope of practice depending on the organization needs or physician supply. Mainly, if you are a nurse working in downtown Toronto in a teaching hospital, your practice is fairly circumscribed and, if you’re working in the north, I can tell you, you can do all kinds of things and that doesn’t make sense! If we were a profession, we would control what the scope of practice was — no matter where you are geographically. I guess we somehow fail to look at what it is that the clients need and how nurses can meet that need (Interview 15).

This statement, made in the context of Canadian nurses, can find its application in France, England and Italy. This is also true for physicians; however, nurses view themselves more affected by hospital regulations than the physicians.

Indeed, regulated professions (self or central regulation ⁷⁴) are mandated by law through their colleges or similar bodies to control and monitor the scope of practice in the public interest. Nursing illustrations of self-regulated bodies directly related to this investigation are: The College of Nurses of Ontario; The

⁷⁴ In France, nursing is not self-regulated; regulation is done through the Ministry of Health’s central process.

Nursing and Midwifery Council (UK); L'ordre des infirmier/eres du Québec; Collegio IPASVI ⁷⁵ (Italy), which ironically can be considered as an arm or agent of the state. These colleges set the rules or regulations and establish the standards for nursing practice. They represent the legal arm of the profession, are sanctioned by the state and operate in the public interest as part of their mandate, not necessarily to protect nurses ⁷⁶. How the legal mandate of control over the scope of practice is translated into reality is a different story. At first glance, one would be inclined to jump to conclusion and interpret the situations occurring in the field as flagrant contradictions to nursing's claims of professional autonomy in terms of self-regulation. However, it will be too simplistic to accept that without scrutiny. The explanation is more complex than it appears.

For example, MacDonald (1995:134) attributes this to the "mediative" position that the caring professions find themselves, in the sense that nurses' prospects for work are generally in the state-provided healthcare service, which is delivered and governed by semi-autonomous organizations where most nurses

⁷⁵ This acronym means in Italian Collegi delle infermiere professionali, vigilatrici d'infanzia e assistenti sanitarie visitatrici.

⁷⁶ Nonetheless nurses value self-regulated bodies as an element of the status of being professional. Nurses, regardless the nations and jurisdictions, implicitly and explicitly identify regulatory bodies as both a source of power or legitimacy and a source for law and orders, as well as a starting point for effective lobbying. This is understandable because, historically, the granting of a college or similar organization for self-regulation is considered being a privilege an important step toward professionalization. It only comes to reality after lengthy lobbying and internal and external struggle regardless of the nation or jurisdiction. Based on the interviews, to this day, nurses in France are still lobbying to be self-regulated, and with no success. The central government views that move as a source of power for nurses; therefore, placing many obstacles to prevent materialization of this goal. These self-regulated bodies or similar nursing associations have contributed greatly in the improvement of nursing education. For further details, refer to Chapter Six.

are employed. Therefore, the authority of the state over the scope of practice is reinforced by its status of employer. According to him, the “mediative” condition of the caring professions holds back their power. And, this occurs not only in their transactions with other occupational groups, but also places them in a vulnerable position “to attain economic rewards, which leads to the need to take, or to threaten to take industrial action, thus laying them open to the charge of acting ‘unprofessionally’ and jeopardizing their status still further” (MacDonald 1995:134). This is debatable because mediating with a threat of strike can increase the negotiation power. In fact, during the past three decades, nurses in all four countries under investigation have gained the economic rewards and other concessions, which have tremendously improved the scope of practice via this tactic. Although, throughout this period, success sometimes also comes with a loss or, at the same time, may even be a win and a defeat. As the interviewees put it, “in our history, we always move one step forward and one or two steps backwards.” Furthermore, the so-called independent profession members are more and more employed by governments, either on fees for services or as independent consultants relying to some extent on government contracts. Therefore, they also find themselves in a “mediative” situation. One would argue that the problem is not so much in the mediative position, but in the paradoxical gendered nature of the nursing work and in the contradictions that exist in the institutional matrices in which this occupational group is embedded. Moreover, the problem is also located within the relations of ruling that sustain the structure

of control in nursing and provide, at the same time, nurses motive for resistance, change and transformation.

The latter argument is substantiated by feminists and historians who have investigated how various groups within the state mediate “gendered work” relationships. They have discovered that the state has most of the time acted in response to resistances and pressures, political demands and strong lobbying from powerful women and the nurses movement for that matter: for example, through legislation or an influx of additional money within the system for specific programs to improve and identify sets of problems. But jointly, the economic restraint programs introduced by the state to the health sector, for example, have impeded nurses’ progress in putting into action the set policies and in fact achieving their goals (Coburn 1974; Armstrong and Armstrong 1983; Andrew 1984; Smith 1987; Armstrong 1988; Armstrong and Armstrong 1990; Armstrong 1993; Armstrong, Choiniere and Day 1993; Davies 1995; Smith 1999). All of these ideologies and debates, pressures from interest groups, lobbying and negotiations are channelled through the policy process in a non-linear fashion.

Second most important sources of tensions and contradictions is the fact that medicine has protected its monopoly over a particular area of practice and the power of the medical model is the common denominator regardless of its spatial location. As mentioned previously in Chapter Two, there is a symbiotic relationship between these two groups. And, mimetic institutional isomorphism facilitates countries and professional associations to adopt practices from

elsewhere. Therefore, in all four jurisdictions with some variations, legislation provides a clause to delegate certain “medical acts” or to transfer function to other healthcare professionals.

The transfer of function to nurses has, for years, been a major aspect of nursing and medical procedure. Concerns relating to which medical acts can be delegated continue to be an issue for nursing associations in general (Canadian Nurses Association 1993; Feroni and Kober 1995). This approach makes nursing claims of professional autonomy dubious because it implies that nursing does not control its own body of knowledge and scope of practice. However, as previously explained, the issue is not that simple. Its ramification can be found in the gendered contradictory nature of nursing work and in the relations of ruling that sustain the structure of nursing work. “Nursing across much of Europe has great difficulty in translating professional aspirations into practical reality because they are locked into a well-established ‘adjunct’⁷⁷ role to the doctors even more than is the case in Britain or North America” (Dent 2002: 151). This adjunct role to the doctors seems to be the case for France if one judges from the following statement:

From an historical perspective, it was the physicians who created the nursing profession in France. And, till 1965, nurses by law were considered as a medical auxiliary. That is to say, priority was given to accomplish technical acts prescribed by the doctors. In 1979, the government finally recognized nursing as an autonomous role by law, which is placed beside the role dependent of the physicians. This

⁷⁷ A term borrowed from Celia Davies (1995).

removed the nurse from their auxiliary role, because they are now a profession with a proper autonomous role that entitled the right to assess, diagnose, propose care interventions and evaluate (Interview 24).

The French nurses have made a significant step forward toward some autonomy with respect to their scope of practice by the text of law. However, the reality depicts a completely different picture.

What one can observe is that nurses are so busy by the weight of the dependent acts/the prescribed acts that they do not have time to occupy the autonomous part of their role, and they are compelled to delegate it. In fact, if we consider the law, nurses have their independent and dependent roles; but in reality, we remark that they still remain a medical auxiliary because the institutions do not give nurses the possibility to practice to their full scope — due to the lack of adequate staffing which refrains nurses to affirm themselves in their proper roles. In theory, nurses are autonomous and have their proper role, independent of the doctors, but because of the workload, they are not able to practice accordingly and still remain a medical auxiliary (Interview 24).

The obstacle to the change taking place can also be part of the French ethos and the institutional and structural cultural practice which maintain a central control over the paid nursing labour force:

Culturally, in France, we are very traditionalist and have difficulty to push the wall completely. French society tends to be very conservative, so much sometimes that we are on the verge of immobilization. Furthermore, the state is very centralist and uses a top-down approach with little consultation. That is why we have spontaneous labour unrest, which burst like a volcano. It is the central government that defines the scope of nursing practice. There is no special exam to obtain your licence to practice — after your diploma, you are entitled to practice. This is delegated to the general directorate of health and social affairs. All of these have an impact on the scope of nursing practice in France. We have requested to self-

regulate our practice. This was refused because the government thinks this will create an important professional lobby that will bring together a group of professionals which before was divided and united they will be too strong. The government does not want the nurse to be powerful (Interview 24).

In the case of Italy, there is an over supply of doctors which, in general, constricts the scope of nursing practice. Italian nurses have to overcome several obstacles at institutional or legal levels. They have made important efforts in order for the public to understand the role of the nurse. In their strategy, they attempt to establish distinction between the clinical role of the physicians and the clinical role of the nurses. However, well-entrenched cultural practices cannot change overnight:

This is significant in Italy where we have a very high number of doctors, which is higher than any country in the WHO European region. We have a ratio of 5.7 physicians to 3.0 per thousand population. In comparison with EU and G7 countries, Italy has the lowest ratio of nurses, except for Greece with 2.6⁷⁸. It greatly affects the scope of nursing practice. The doctors are actually doing what they should not be doing (Interview 25).

Moreover, a summary of the findings from the interviews reveals that nurses in Italy nationally have to fight a well-entrenched national labour law, which stipulates what nurses can do in a hospital setting — therefore constraining the scope of practice. Even with changes in the National Health System (NHS) and changes in the Ministry of Health laws with respect to nursing, if the labour law

⁷⁸ This statistic can also be found in the European Observatory on Health Care System (refer to reference).

remains the same, nothing will be done nationally. However, nurses in the northern part of Italy tend to be more assertive than those in the other parts of the country. Strategically, they work in two fronts. On one hand, they implement the NHS laws to move forward, yet on the other hand, they unify with the central and the south in the struggle to change the labour law. This gives nurses in the northern region a leading edge in the implementation process:

Labour market laws in Italy are the laws that make huge changes nationally in terms of what you are allowed to do. We have the *mansionerio*⁷⁹ laws which state what nurses are allowed to do. It is a task-based list, which has a huge impact on the scope of practice. It is like you have a policy direction, but if the main law is not amended, you are still where you were before and more frustrated because of the inconsistency. For instance, in the past, nurses were only allowed to do something in hospitals if the doctors were there — but in the community, they can do the same thing without the doctors. However, four years ago, this law was changed fortunately. We have to fight more than twenty years in order for that law to be amended. Now, we can do whatever we have been trained to do. To some extent, the economic constraint has helped. We have national nursing profiles with broad principles. Some nurses are allowed to do quite a lot of things even if the doctors are not there. This resulted in huge changes to the work nurses do (Interview 28).

However, there is a great regional difference in terms of the approach and development of nursing. There is uneven development in the scope of nursing practice contrary to the uneven development in the Regional Italian National Health System, in what is dubbed the north-south divide (European Observatory

⁷⁹ *Mansionerio* is referred to a law that regulated nurses' duties. Nursing work in Italy has been legislated as a task-based occupation. While this law gave nurses jurisdiction over certain functions, it was very limited in terms of professional autonomy (Dent 2002). *Mansionerio* is derived from *mansione* which mean duty, task job or function (Italian Unabridged Dictionary: HarperCollins Sansonni).

on Health Care Systems 2001). In nursing, there seems to exist a north-central-south divide. Based on interviews, the northern region is very advanced with the central less than the north yet more than the south, which is underdeveloped.

This is substantiated by the following quote:

I think there are certainly great national differences in Italy between the northern, central and southern regions. This is also holds true in terms of initiatives. There is also a difference with respect to the types of repartition. The difference in formal knowledge is noticeable as it is quite low, for example in the regions of Naples, Apulia, Sicily, and Calabria. This is a practical example that I give based on my experience dealing with nurses prepared in these regions. I may be wrong but, by experience, that is what I have noticed. I had nurses I can use that word with no hesitation who were really terrible in terms of preparation. At the same time, you can find a lot of well-prepared nurses from the north and the centre. And, it is not a profession that attracts smart young persons unfortunately why should they go in nursing if there is no social recognition? Legislative recognition exists but means nothing because everything revolves around the doctors. There is also a difference between the central and northern regions I think mainly in the approach to problem-solving: in the central it is more intimate, more creative yet the north is more methodical, more integrated, more systematic (Interview 26).

Therefore, the geographical difference matters a lot in Italy. All of this has an impact on the development or contraction of the scope of practice.

In the United Kingdom and equally England, where the majority of nurses are located, there was a task-oriented approach to the nursing scope of practice. The focus was more on the function delegated by medicine to nursing depending on the institutions where the individual nurses work. During the last ten years with the "new nursing" ideology, there has been an emphasis on broader principles with a reference to professional accountability. The delegated medical

act is also a current practice as in Canada and elsewhere. There is also a possibility to have a delegated extended role. The Nursing Midwifery Council (NMC) formerly United Kingdom Central Council for Nursing' Midwifery and Health Visiting (UKCC) was not in favour of the extended role, which is perceived to be too close to the medical model and will lead to more dependence on physicians (Feroni 1995). However, despite the opposition, the extended role is increasing:

Because of budgetary constraint and also as part of managed care, a reform law was introduced in 1993, which forces NHS hospitals to reduce the hours of interns or residents in medicine. All of these strategies put pressure on the nurses to accept a more and more extended role. Moreover, there was dissention among the nurses who were working in intensive care or the hi-technical specialities. They do not share the opinion of the leadership and value much more the status of the extended role (Interview 30).

Canadian nurses also have their share of the contradictory adjunct role expansion and contraction of nursing practice depends very much on whether or not physicians are available. Nursing practice in Quebec and Ontario is also highly circumscribed by the institutions in which the individual nurses are employed. As expressed earlier by a Quebec nurse educator, "we educate nurses to practice within their scope of practice. That scope of practice once they are in a field is often restricted for them" (Interview 2). Quebec and Ontario have legislated scopes of practice that expressly give power to nurses to deliver healthcare services/functions to others. In these cases, the act specifies the types of services/functions that are included, for example, in Ontario the Regulated

Health Professions Act licences acts instead of professions. The Medicine Act contains the entire list of controlled acts, and the Nursing Act includes some controlled acts that nursing is allowed to carry out (Risk 1992; Canadian Nurses Association 1993; Baumgart and Larsen 1993). While some participants from nursing associations praise this move as a step in the right direction, others on the education side deplore it:

One of the things that we generally don't even discuss is the fact that for example in Ontario we have with our Regulated Health Professions Act (RHPA), one of the most constrictive types of regulated professional act that you have across the world, because we are very much defined by our controlled acts, and the controlled acts are medical acts. The controlled acts are almost giving you a status. They're saying if you can do all these extra things, you have a higher status. Nursing, for me, is much broader than that (Interview 1).

For the individual nurses who are working in hospitals, there is no way they will be able to take full advantage of this legislation. The current hospital legal structure represents an impediment to the development of the scope of practice. As seen in the Italian case, if some key structural law remains, it creates difficulty for advancement. It took Italian nurses twenty years of struggling to obtain an amendment on a law which constituted a barrier to their professional autonomy to some extent in the practice setting. Nurses need to know strategically where the impediment is located in order to focus their attention relentlessly on the removal or amendment of this problem. The state gives with one hand and restrains with the other hand. The following quote in the context of Ontario

summarizes the type of dilemma nurses are facing in their struggle to actualize their professional caring work:

Right now we're in a situation in which ostensibly the scope is expanding. We have nurse practitioners and we have extended class nurses who can do additional controlled acts, but the way in which the regulation is conceptualized is so reductionist that sometimes we end up fighting even more battles in different areas. We have had some gains and positive changes around the scope of practice. However, the way in which those changes are implementing, the underlying philosophy of those changes creates more problems (Interview 14).

To sum up, actualization of caring and professionalism are taking place in a very complex institutional and legal relationship. Over the last thirty years, a lot of changes have happened in nursing in all jurisdictions in both Quebec and Ontario with the emergence of more clinical nurse specialists and the re-appearance, on the scene, of the nurse practitioner. Changes in legislation permit nurses to act as surgeons' assistants in Quebec: for example, nurses can now carry out stitching and closing of wounds something traditionally done by the medical residents (CIHI 2001). In England, there is the group of nurse consultants. In France, the nurse liberal practice was developed. Italy is moving in the same direction with the principle of a liberal nurse⁸⁰. However, all these come with their provision of tensions and contradictions. Paradoxically, these changes are happening as part of keeping the cost of health care down. At the

⁸⁰ Is referred to nursing independent practice outside the hospital setting, where nurses can have their own office to provide consultation service or house-call or nursing care prescribed by doctors. They represent 15% of the nursing profession. This service is available only in the metropolitan areas (Com-Ruelle et al. 2000).

same time, nurses responsible for the general care in hospitals are seeing their scope of practice circumscribed depending where they are working. In their struggle for recognition, nursing as a caring occupational group has been lured under imposed circumstances to follow the contradictory path of professionalism to improve their status. There are inherent contradictions in the conditions in which the concepts of caring and professionalism are engendered. In other words, historically there are inherent contradictions between what nursing and medicine valued in their approach to patient or client care.

The former experiences it in terms of wholeness, which means that nurses look not only at the physical care, but also at the psycho-social and spiritual aspects of individuals. This is due partly because nurses spend more continued interaction with patients and families. The latter experiences it in terms of medical objectified facts or engineering model of the body part easy to standardize. This prevailing model constitutes the ruling order for societal health needs and caring is subordinated to it. Thus, put nurses historically in an adjunct role to physicians. Professionalism has served the medical profession outstandingly to the point of governing everyone else in the healthcare workplace. In embracing professionalism as a path for recognition, nursing has started on an unequal footing or asymmetrical circumstances. That legacy still prevails not only in the institutional matrices in which this caring profession is embedded, but also in the relations of ruling that sustain the structure of control in nursing. Nevertheless, they provide at the same time nurses' motive for

resistance, changes and transformation. To reiterate, caring and professionalism are actualized within the scope of practice in a very complex institutional and legal relationship. Indubitably, these intricate ruling relations will have a bearing on the labour process and the fragmentation of caring work. The subsequent sub-section will focus on the labour process transformations that have been taking place in nursing.

5.2.2 Effect on the Labour Processes: The Transformation of the Nursing Workforce

The transformation of the nursing workforce is taking place in a dense, complex institutional legal arrangement, where policy dictates basically every action in the work setting. This is also complicated by an intense political process deeply entrenched in the nation state and their regional government. Therefore, the nurses' caring work and labour processes are entrenched in the complex bureaucratic hierarchy of the healthcare system, which is also embedded in a gendered class ⁸¹ hierarchy. The registered nurses, who constitute the primary focus of this study, are the largest clusters of health professionals in the system and are heterogeneous with different specialties and functions.

However, in the healthcare division of labour of most facilities and countries under the category of nursing, there are, in reality, over and above the

⁸¹ For the purpose of this chapter class is viewed as a stratum or subgroup in the health care organizational hierarchy whose members share certain social, economic, or administrative privileges.

registered nurses, a variety of auxiliary healthcare personnel for example, nursing assistants, aides, and orderlies. McPherson (1996: 260-262) points out that the nursing's traditional affiliation to medicine was established by a class division with the view that doctors were authorized to conceptualize and standardize health service delivery, whereas nurses were expected to execute medical orders. The hierarchical division of labour emulates a form of "neopatriarchy" and was based on gender inequality. On the contrary, nurses' hierarchical relationship with less-trained, patient-care personnel was determined by class and ethnicity rather than gender. Therefore, "positioned between doctors and less-skilled bedside attendants, nurses' relationship to their patients depended on the latter's social status" (McPherson 1996: 260-261).

Changes in the policy regime focusing on strategies to contain cost in the healthcare system,⁸² will certainly decrease the labour market, consequently will affect the nursing labour processes and further partitioned the caring work. Nursing work in Canada, England, France and Italy is varied, broad and changed over time mirroring changing societal needs, health systems, functions, locations and customs. It is not surprising to find, for instance, in Canada as many as 15 categories of nursing personnel with a wide range of preparation (Canadian Nurses Association 1993). Caring is compartmentalized in specialty areas such as

⁸² The healthcare system is by nature labour intensive. Hospitals consume a sizeable portion of the healthcare budget; it is to be expected that they will become the real target for cost containment. Nursing represents a large segment of hospital employment.

maternal and paediatric nursing, mental health and psychiatric nursing, care of the elderly, public health nursing, anaesthesia nursing (in France), emergency and critical care nursing, and rehabilitation reflected medical diseases and, in most instances, medical specialties⁸³ (Canadian Nurses Association 1993; Salvage 1997). These fragmentations create a first set of internal conflicts and divisions between the nurses who tend to identify themselves with the different specialties in which they are working. Tensions arise also with the seniority issues when junior nurses even qualified cannot transfer to other specialties or for that matter cannot have a choice in vacation time and get bumped when hospitals are laying off as cost-cutting measures.

There is a second set of internal conflicts and divisions between the nurses at bedside and the nurse supervisors. This was exacerbated in the seventies with the expansion of unions and nursing militancy, resulting in a widened division between these two classes. The nurse supervisors to some extent associated themselves with the values of hospital administrators and physicians at the expense of what the front-line nurse values when caring for patients. Some participants refer that to a proletariat and deprofessionalization in nursing and deplore the schism between management and front-line nurses, and the stratifications within the profession as seen in the following quotes:

⁸³ The supremacy of the medical model based on body part or diseases and organ functions is incontestably universal regardless of spatial location (e.g., Canada, France, Italy and United Kingdom). What makes it more difficult for nursing is the fact that service delivery is organized under those rubrics caring is adjunct to them. This is an historical legacy, which still prevails.

I have a sense of deprofessionalization. I do have a sense that something was lost in the last three decades. We kind of proletarianized the front-line practitioner and separated them from the nursing leadership because we only unionized the worker and created a barrier between nursing leadership, which was not there before. We are all part of the same profession playing a different role, and then it became management versus the front-line nurse. There was also other thing happening at that time, moving the nursing leadership to a corporate model of vice-president or similar title. The division between the practice and administration became a real abyss and nurses felt that those in administration did not understand what they were doing and vice-versa (Interview 17).

In addition:

The whole profession is stratified from the gender point of view, racially, and in every other way we look at it. We've got lot of internal issues, very divisive. This is typical of any oppressed group. We have a fair bit of work to do just around equality within the professions that's one area which needs to be addressed (Interview 15).

As a result of cost-cutting reform policy, there are also changes in the class power structure. The corporate structure ⁸⁴ introduced in the mid to late eighties has brought a third set of tensions between the new elite classes of senior nurse executives who rose above the nurse managers (where they still exist). The latter are now considered to be middle management. Those nurse executives are part of the ruling elite and answer directly to a new master a male Chief Executive Officer. In some instances, their administrative relationship with the doctors is on an equal footing. In their new role, they are managers disassociated from their

⁸⁴ The corporate structure is borrowed from the private sector. It has evolved and intensified with hospital mergers. In the merging process, all previous entities are incorporated and transformed into a legal corporation. This usually adds more strata to the organizational hierarchy.

nursing background and belong to the new class of hospital executives. For example, in Ontario, as a consequence of hospital restructuring and the implementation of program management, most hospitals removed their directors of nursing in one form or another. Few nurse executives have the title of 'Directors of Nursing' and habitually the Chief Nursing Officer (CNO) does not have line of authority over nursing (Broughton 2001). In the European community for the most part, nurses are in charge of nurses and nursing services. However, the autonomy and status of nurse managers have decreased with the establishment of general management principles and practices. The professional control is also diminished ⁸⁵ (Salvage and Heijnen 1997). The fragmentation of caring work and class division are, to some extent, the effect of policy initiatives, which are more in line with the concept of professionalism than caring. Policy reform based on cost-containment strategies will not only further erode the profession but also will contribute to further exacerbate the compartmentalization of caring.

The change in hospitals, where the majority of nurses are working, is driven for the most part by organizational and fiscal pressure to put a ceiling on public expenditure or to slow down any expansion in this sector (Buchan and O' May 2002). As mentioned in Chapter Two, there are four noticeable trends identified in literature as common to all industrialized countries for that matter to

⁸⁵ This trend also affects the doctors; therefore, both professional groups perceived the managers as a common enemy (refer to Labayle 2002).

Canada, England (UK), France and Italy: the ageing of the populations; the increase in the internationalization of the healthcare workforce; the skill mix and staff substitution; and the need for hospitals to ensure that their staff knowledge keep up at the same pace of the changes (Salvage and Heijnen1997; McKee et al. 2002; Buchan and O' May 2002). Although different countries face different challenges, these trends are considered to be some of the major driving forces transforming the profile of the nursing workforce, as well as the reproduction of nurses.

Firstly, the ageing of the populations for that matter the ageing of the workforce itself. For instance, the Canadian Institute for Health Information (CIHI 2001:49) reported that the average age of nurses in Canada is increasing. In 1999, no more than one in 10 RNs practicing in nursing was under 30. The proportion was one in eight (13%) in 1994. Simultaneously, the number of RNs age 50 to 59 has also increased with almost 53,000 nurses within this age group. It is predicted that many of them will leave the workforce over the next decade. Ontario and Quebec⁸⁶, the two main provinces in terms of population and RN labour force volume, will lose most of their RNs by 2006. In UK, it is reported that in 1991 one in four registered nurses were aged less than 30; and in 1998, it was less than one in seven. At the same time, more than one in eight were aged 55 or over and eligible to retire (Royal College of Nursing 1998:1-2). The same

⁸⁶ Quebec is leading all the provinces, in terms of relative importance of losses with an estimate of 16% of the 2001 workforce (O'Brian-Pallas et al. 2003: iv).

trend is reported in France where the average age of qualified practising nurses shifted from 34 in 1983 to 40 years old in 1998 (DREES 1999; Com-Ruelle et al. 2000:79). The picture is different in Italy with 66% qualified nurses under the age of 35 and 3% between the ages of 55 and 60 ⁸⁷ (IL Sole 24 Ore Sanità 2001).

This has an effect on the labour force at a time when healthcare needs are intensifying and the pool of potential staff is decreasing (this is discussed in Chapter Seven). The nurses who participated in the interviews attribute this to an ad-hoc policy approach to nursing human resource issues, which aim only to balance production needs with management needs for personnel. Moreover, there was also cynicism on their part and a perception that the state treats nurses like any market commodity by mass producing them depending on market fluctuation or haphazardly without any planning. Therefore, there is a call for “an urgent need to bring statistics on nurses into line with people’s need for nursing, rather than institutions’ need for nurses” (Salvage and Heijnen 1997: 70).

The proposition is that planning needs to be done based on evidence:

From a policy perspective, making decisions based only on unplanned organizations’ impulses is fundamentally flawed. We continue to think about how to make nurses fit the organization. I think there has to be a way of doing some future planning and we have to do that based on our demographic needs, based on what we know – there are always going to be outliers that will influence the number you need, but we have not really done that. In my lifetime, I have seen this happening – these ups and downs, we’ve had surpluses and

⁸⁷ This difference to some extent can be attributed to the fact that an Italian nurse spends an average of about ten years in the hospital service, which is relatively less time than the other countries (refer to Salvage et al. 1997: 80). There is also the pension system, which allows people to retire earlier. As noticed, there is no one over sixty years of age .

shortages, and we've had layoffs. This does not make sense. For me, it is a consequence of an ad-hoc policy approach to nursing human resources (Interview1).

At this point, it can be assumed that the problem is not so much in the ageing of the workforce. This view is very static and leaves no room for intervention. For that matter, nurses are not alone. Every profession is confronting the same problems with the babyboom generation coming to retirement age. It can be argued that the problem is more associated with the fact that the labour force is not reproducing itself as fast as it should be. To bring a more dynamic dimension to the debate, ageing can be a symptom of the reproduction problem. The intent is not to downplay the importance of the aging factor, but by all means it needs to be addressed. However, as previously explained in Section 5.2, the production and reproduction of nurses is multifaceted; therefore, the issue cannot be addressed in isolation. In addition, it is crucial to understand how the relations of ruling sustain the structure, which controls the production and reproduction (supply, demand and exit) of the nursing labour force interplay. Likewise, it is crucial to understand how nurses resist or react to the ruling order by refusing to work in nursing. All of these are 'sine qua non' conditions for proper intervention and progressive transformation. This type of thinking, to some extent, is reflected on the field with respect to the impact of prior improper policy decision on the reproduction of nurses:

The issues of the supply and demand, the balance between nursing personnel and the demand for nursing services are going to create some unique tension over the next decades. It is somewhat worrisome, and because of inappropriate policy decisions that have been made, we will end-up not having enough nurses to take care of the population. It takes five years to make a nurse — whether three years of education and 2 years of practice, or 4 years of education and one year of practice. Fundamentally, it takes five years before you get a fully-functioning clinician, knowing that we have to make these decisions on how we're going to meet the demand for nursing services or we risk to make bad policy decisions (Interview 14).

For example, on the reproduction side of the school system in Canada, there was an increase in admissions and in the quotas of seats supply for registered nurses⁸⁸. This increase in admissions was influenced also by what was taking place during that time in other industrial sectors, given the health care is not immune to the trend and variations in the market as seen in this statement:

In my position as a Dean of Health Sciences, I have noticed when there are major layoffs due to bed or hospital closures — it is very interesting to see that in the academic world, there are major drops in applications to nursing. All these nurses were unemployed at the same time hi-tech was really booming. So, our engineering and our software engineering student applications were way up — nursing was way down. This year, the hi-tech is way down because of layoffs and, guess what? nursing is way up! I sincerely think not enough attention is given to these factors (Interview 1).

Paradoxically while the number of seats in nursing education programs

⁸⁸ However the initial lost related to exit via retirement /attrition and lay-offs as part of cost cutting strategies was so severe that it will take some time and many more admissions to replace what was lost. See Canadian Nursing Advisory Committee 2002.

increased ⁸⁹ in all four countries and jurisdictions, the quota is not proportional to cover the projected losses (Canadian Nursing Advisory Committee 2002). For example, in England, the same trend was reported (Buchan et al. 1997: OS144-145) that in the 1990s, the number of students admitted to the traditional apprenticeship hospital nursing schools has decreased due to the gradual transfer to the Project 2000 courses⁹⁰ (community college to be discussed in Chapter Seven). France has difficulty in attracting new nursing students, mainly due to relatively poor status, pay and working conditions:

There is a nursing malaise in France. It became very difficult to retain nurses in these conditions. Nurses are leaving the profession, and there is also the problem of attracting young people to the profession. The work is not valued (Interview 24).

In Italy, the number of students increased considerably and filled the quota as a result of campaigns to enhance the public image by providing more economic incentives and job security. And, the entry to practice at the university level and the prospect to have a job seems more appealing to a certain group of students:

The problem in Italy is that the economic incentive has improved nursing salary, and ironically this has only attracted more people who were not able to find a job and decided to become a nurse. The choice, in that case, is not motivated by wanting to be a nurse. Therefore, when they actually get into the field, the reality is shocking. We have a high turnover in Italy (Interview 26).

⁸⁹ This is in relation to the quotas, not necessarily in terms of predicted needs. In fact, university as entry to practice reduced drastically the number as in the case of Italy when all regional nursing schools were closed in mid 1990.

⁹⁰ While the number of Project 2000 students has risen, it is not, however, at a rate equal to the drop of students of the traditional course load.

Conversely, very little has been done to keep nurses in hospitals and, as mentioned earlier, nurses spend an average of about ten years in hospital service. Causes include the lack of mobility and career possibilities, and burnouts caused by excessive workloads. The nurse turnover is often linked to the lack of organization of the work and improper use of nursing resources (Salvage 1997).

Secondly, the internationalization of the nursing workforce is closely linked to the supply, demand and exit issues. The increase in the internationalization of the healthcare workforce has intensified, with some countries actively recruiting health professionals from other countries. This process is likely to be accentuated by the further expansion of the European Union (McKee et al. 2002). This clearly has many important implications both for the countries that are attracting skilled staff and for those that are losing them. For the countries that are attracting skilled staff, it entails education⁹¹, and in some instances to learning the language. Bonuses, in the form of transportation and lodging, are also part of the package. But to some extent, it is cheaper for the receiving place, since they do not have to pay for the initial education and the experience because most of the time, the newcomers start at the bottom of the scale — regardless of their previous experience. It is a blatant contradiction, considering new qualified nurses in the host country as they are either

⁹¹ There are in England formal educational programs to assist foreign nurses with language capabilities. Quebec, in 1992, initiated in the Cégep du Vieux-Montréal offering educational programs to assist nurses with foreign diplomas or degrees (OIIQ 1992).

unemployed or working in different fields or they have to work at two to three part-time jobs in different settings with no benefits.

Moreover, tensions arise in an already divided workforce with different culture and language barriers; their working colleagues usually treat the newcomers like second-class citizens. And, conflict also arise with patients who are accustomed to their own race or people and have to receive care from somebody that they perceive as being different. For those countries that are losing their nurses, especially those from the third world, it is even more costly — most of the time, they are losing their best professionals who are in search of better conditions or greener pastures. This trend is taking place on both sides of the Atlantic. Nurses in Canada move from the Quebec jurisdiction to the Ontario jurisdiction; there is a lot of commuting in cross-border city from Ontario to the U.S or from Quebec to Ontario; from the UK to Canada and France; France to Quebec; Spain to France; from southern Italy to the north, and lately, Italy has been importing nurses from Spain while nurses in the south are unemployed, because the cost of living in the northern region is shying away nurses from the southern region. The entire process seems to be very confused and has the potential to create more uncertainty in the care delivery process.

Thirdly, there is the tendency to substitute the staff or the professionals utilizing people with different skills, making reference to the importance of “competence” rather than credentials. The trend is to lower the skill and professionalism of bedside caregivers. In addition, there is an increased overlap

of the roles and functions among the various disciplines. As the number of places decreases, competition increases over who can best provide the care to the patient⁹², and who is the most cost-effective caregiver. Nurses and other healthcare workers are all struggling to maintain their positions and patient care roles in an ever-tightening hospital job market (Shamian and Lightstone 1997).

Traditionally, hospitals in Europe, North America and elsewhere have very rigid demarcations as to which can perform which tasks. However, in the 1980s and 1990s, more flexibility in service delivery through staff substitution have been facilitated in Canada, England and, more recently, in France and Italy to some extent by a management scheme of moving away from historical professional delineations towards a competence approach. This is consisted to first define the task and then ask who could perform it most cost-effectively (McKee and Healy 2002). Ironically, professional nursing associations are singing the same credo, not necessarily out of true belief but to control the damage of an impose choice:

At the moment in Italy, we are living a phase of great debate internally within the profession, because this is stimulated by not having a sufficient number of nurses and, at the same time, to the necessity to continue giving positive answers to the Italian citizens. We are strongly discussing what things would be proper interventions or acts for nurses and what things or actions are part of the care process that the nurse can decide to delegate to somebody else under his or her supervision. It is a difficult decision because we are moving

⁹² In England medical interns in the NHS see their hours decreased as cost cutting measurement, and functions are delegated to nurses. For more details see Feroni and Kober (1995); McKee et al. (2002).

away from a long practice of taking care of the person as a whole. We are also in a period of tensions with our country's Minister of Health who would like to solve the problem of nursing shortage by giving others category tasks which are normally being done by nurses; for example, intra-muscular injections or intravenous therapy by other groups who are less prepared. Certainly, we are against this proposition and we are trying to place obstacles to avoid moving in that direction. I am afraid that we will lose and we have to find a way to contain this type of decision (Interview 25).

The danger is that cost-containment strategies have resulted in substitution of more expensive nurses for less expensive care assistants or aides in many countries (Buchan and O' May 2002). These policy strategies are moving nursing away from their wholistic approach to care and further fragmented the caring work as seen in the case of Italy in the above quote. This is substantiated also by the following quote provided by a hospital Chief Nursing Officer in Ontario:

As I sit around different tables, the perception in Ontario of what nurses do are tasks. So, that is simply a matter of dividing those tasks to other types of healthcare workers. And, I think it really again chops up what it is we're all about. So, the division of labour, I think, is probably a slant on how we have been able to articulate what it is we do in terms of work within the healthcare system. We have not articulated that in a language that has been well understood by those making those types of decisions. I think we've been ill-equipped to have the same language that they can understand, to help them realize why it's not appropriate to divide out tasks, that in order to provide holistic care, it means providing holistic care, and what that means (Interview 4).

Associated with the staff substitution issue are the decline in full-time employment and the increase in the part-time and casual RN positions in hospitals, which were introduced as cost-containment reform policy. These were

happening in both Quebec and Ontario. The “virage ambulatoire” or move to community care in Quebec has caused displacement and an increase in casual work related to hospital closures. It was reported that many casual and part-time employees are working in several agencies and are working more than full-time hours (Shamian and Lightstone 1997). Part-time work has also risen progressively in French hospitals ⁹³. At one time, part-time and casuals work were much more common in Britain than in France. However, since the 1990 reforms, short-term employment has intensified in both France and Britain⁹⁴. Hospitals save money by not having to pay benefits to these nurses, but the drawback for the care recipients is the lack of continuity in the care process.

Fourthly is the necessity for hospitals to make certain that their staff can respond to the rapidly changing environment. For example, the College of Nurses of Ontario has made continuing competence and, therefore, life-long learning the fundamental underpinning of quality assurance (College of Nurses of Ontario 1997). Nurses in Italy and England already have to prove their continuing competency if they are to remain registered in order to be able to work as professional nurses (McKee et al. 2002).

⁹³ It was usually attributed to an ageing nursing workforce that older workers and women with families tend to prefer part-time employment. Lately, the work intensification reflecting an average increase in admissions of 50 percent over the previous 10 years (Arrowsmith and Mossé 2000) has been associated with this trend.

⁹⁴ The pool of casuals permits managers to adapt to changing requirements as well as to reduce labour costs (overtime, employee benefits). This has also stimulated the expansion of agency and ‘bank’ nursing to meet peaks in demand for care (Arrowsmith and Mossé 2000). In southern Italy, the nurses who participated in the interviews also reported the growth of agency nursing.

However, in these countries and jurisdictions, despite the fact that continuing education is regulated, funding issues act as an obstacle to accessible continuing education. The resources received by hospitals or professional organizations to administer programs are inadequate. There are problems of lack of staff development educators, and where it exists, lack of release time for the nurses to leave the unit or the ward. Moreover, nurses are hesitant to take study leaves as this increases the workload of colleagues, if there is no replacement to take on the extra load, which in many cases is already high. In addition, there is resentment toward the one who takes a study leave on the part of those who remain on the unit, which created more tensions (OECD 1998). And, in some cases where funds are allocated, management used it to cover deficits:

I think the other thing is that the healthcare system has to acknowledge that it's life-long learning and the education piece and skills maintenance and knowledge expansion cannot be blown off as soon as there is lack of money. In-service education or continuing education is always the area that gets hit first. When there is a budget cut, that's where management look first. To me, that is a travesty of what is seen as a knowledge worker (Interview 7).

The fees or additional costs are not always supported or reimbursed — in some hospitals, the time may be allocated, but not in large scale. It is also the norms for nurses, who have obtained additional qualifications or degrees, not to receive any benefits or promotions. Therefore, the incentives are not there for nurses to take on new educational initiatives on a schedule that is already full. All of these trends certainly have a direct impact on the reproduction of nurses and will erode further the caring work.

5.3 Summary

Labour force changes occur in a multifaceted structure of norms and values as well as within the policies, regulations and traditions, the ruling relations between professions and between employers and employees. The hospital sectors where the majority of nurses work have evolved over the centuries in response to social and political changes, and changes in medical knowledge. Similarly, changes in the population affect not only the demand for care, but also have implications for the type of staff that can be hired (Healy and McKee 2002). Therefore, while these trends are universal, their outcomes or how they play out locally are different from country-to-country, and jurisdiction-to-jurisdiction. The variations are pertinent to the historical path and the political economy of each particular country; likewise, the institutional isomorphism and the cultural practices in their ruling relations assist to maintain control over the paid nursing workforce.

For example, the French nurses with respect to the scope of practice and the labour process, have made an important step forward toward autonomy by the text of law. As part of harmonization with the EU, in 1979 the government finally recognized the role of nursing by law, which removed the nurses from their auxiliary role to the doctors. However, inadequate staffing pattern refrains nurses to affirm themselves in their proper roles. In all the other jurisdictions in

this investigation nursing is self-regulated, except in France where the nurses are regulated centrally. This to some extent places them at a disadvantage when it is time to negotiate or influence their own practice. The impediment to the change can be attributed to the French institutional and structural practice that maintains a central control over the nursing work force. This type of centralization is to some extent, a deterrent not only to creativity and innovation, but also it prevents the nurses to take independent action for progression.

In Italy, there are regional differences. The northern region is very advanced with the central less than the north yet more than the south, which is underdeveloped. At least in these independent regional structures there are opportunities for creativity at regional level, while accommodating for institutional isomorphism. Despite the uneven development, the nurses to some extent have benefited from these structures. Although there is an over supply of doctors which, in general, tends to constrict the scope of nursing practice, Italian nurses have managed to overcome a well-entrenched national labour law, to gain more autonomy over their work. Canadian nurses also have their share of role expansion and contraction of nursing practice. It depends very much on whether or not physician are available. The current hospital legal structure represents an impediment to the development of the scope of practice. There are also variations in the nursing power structure. For example in Ontario, most hospitals removed their directors of nursing in one form or another, whereas, in Quebec there is a provincial law that protect the integrity of nursing structure.

There are noticeable similarities and also nuances in nursing across all the countries and jurisdictions of this study. Regardless, the scope of nursing practice, a variety of issues hamper the effective use of nurses and with that also the caring practice, which is more and more compartmentalized. These factors include keeping out nurses from policy-making and decision-making at all levels of the healthcare system, shortages of well-trained nurses relative to needs, insufficient financial support and asymmetrical treatment of nurses, with its concomitant subordination to medicine. Continuing gender inequity further complicates the situation. Nursing everywhere is women's work and shares the characteristics of other female-dominated occupations: low pay, low status, poor working conditions, few prospects for promotion and poor education (Salvage 1997). The following quote resumes, to some extent, what needs to be done in regards to nursing policy issues. This was provided by a former Provincial Chief Nursing Officer who strongly believes that:

We need to have nurses in senior policy positions in government. It becomes very clear to me through my experiences with the provincial government and the federal government that the nurse's voice was simply not there to inform health policy and it doesn't get there unless you have nurses in these kinds of positions for who have knowledge of how the government works. I hope that we're going to educate nurses to understand basic civics, how government functions and how decisions are made. How politicians and bureaucrats operate. How to inform and influence the policy decision-making process. Again, this is in the public interest. It is not for nurses to be more powerful. It is simply if you don't have nursing input, we get bad policies — the bottom-line policies that are not workable (Interview 17).

In final analysis, one can contend that given the relevance of state policy in

every aspect of the nursing professional caring work, it is crucial for nurses not only to be involved in the political process but also to understand the policy process and be engaged at all levels if they really want to move forward. Health care in every country is a political process. It is decisions about the allocation of scarce resources and whenever you are in that kind of position it becomes a political matter as well as economic. However, the health political process can only find its operationalization in the policy process. Considering nurses' deep embedment in the healthcare system, they cannot afford to ignore how these relations work and how this affects the profession. Overlooking these relationships would result in nurses being left out of the political and policy processes, which will in turn impact the profession as a whole and nursing caring practice.

CHAPTER SIX

THE EFFECT OF POLICY ON THE EVERYDAY PRACTICE OF PROFESSIONAL NURSING

6.1 Introduction

Chapter Six extends the investigation with a focus on the policy initiatives that affect⁹⁵ the everyday practice of professional nursing. In that, the chapter looks at the contradictions within the area of nursing knowledge and actions with reference to the official statement of “nursing is an art and a science”; “nursing is a caring practice.” Subsequently, it examines the nursing work environment, the context of professional activities and how caring is mediated or contested by other factors under the conditions of health care cost-containment. It argues that nursing education policy initiatives throughout the last three decades have, to a certain extent, improved nursing knowledge. However, the healthcare policy reform strategies of cost- containment and the ruling order in the hospital sectors give rise to more impediments than enablers. These prevent nurses from practising their caring work in the way they would like to; therefore, creating a theory and practice gap which makes the work difficult.

⁹⁵ As discussed in Chapter Five in the Relevance of State Policy in Nursing, policy initiatives effects can not only be actual or potential, but also intended or unintended depending on the circumstances and situations. It is all part of the policy process which is non-linear. For instance, hospital restructuring is one of the strategies or initiatives of healthcare policy reform. In this case, the intent of the policy was clearly to cut or contain hospital costs by first reducing the inpatient length of stay and number of beds, and secondly, save money in the contraction of labour costs by reducing the number of RN personnel. The unintended outcomes are the increased work intensity and workloads for those RNs who remain within the system. This, in turn, has the potential to affect the quality of patient care. Therefore, one must keep that in mind when reading the chapter.

Moreover, tensions and contradictions are part of these processes; nurses have to find a way to understand them, for progressive transformation.

6.2 Nursing Knowledge and Actions

The everyday practice of professional nursing cannot adequately be understood without an adequate theory of knowledge and its underpinning notions of subjectivity and objectivity. As such, it is asserted that the knowledge used in nursing practice is both subjective and objective. For this purpose, knowledge is viewed broadly to encompass: facts, feelings or experience known by a person or group of people; it is also the state of knowing; or consciousness gained by learning or experience (Collins 2000). Consciousness⁹⁶ gained by formal learning or the “know-what” (Johnson and Ratner 1997; Smith 2001) is initially learned at hospital schools of nursing, community colleges or universities; and also through research, in-service education and life-long learning and others. The “know-what” or explicit knowledge can be found in the “magisterial” forms of “objectifying discourse” mediated by text in print or electronic format and divulged in scientific books or magazines (Smith 1990b). They can also be found in standardized medical, nursing textbooks or in the rules or procedures guiding the discipline. Ironically the majority of nursing textbooks are labelled under the rubric of medical specialties or diseases, and nursing is

⁹⁶ This concept is viewed as in Marx’s and Smith’s denotation of “social consciousness” and it is used here with the same intent as part of the theoretical approach (refer to Chapter Four).

adjunct to it (for example, paediatric nursing; surgical nursing; diabetic nursing, etc.). The quintessence of what should be the “know-what” (Johnson and Ratner 1997; Smith 2001) for basic nursing education foundation or things nurses ought to formally know is usually decided or adopted by the profession. Needless to say, tensions and contradictions are part of the process.

Whereas, consciousness gained by experience or the “know-how” is learned by the individual nurses’ “refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory” (Benner, 1984:36). The “know-how” or the tacit knowledge where the caring practice is located cannot be found in text, it belongs to the knowers or the subjects. Although some of the activities or the tasks associated with nursing caring practice are tangible and even quantifiable to some extent in workload measurement, it remains that the tacit knowledge is concealed in the mind of the individual nurses. Hence, unlike the explicit, the tacit knowledge is invisible to the external world. In this, experience is inevitably subjective, because it locates the individual nurses within the internal and external worlds and hence defines their subjectivity (Smith 1987; 1990a; 1990b; 1992; 1999). Experience is also unequivocally social and constantly carries its social institution. Likewise, it is “now and hence embedded in an historical path, coming into being dialogically in the discourse of its time” (Smith, 1999:77). Moreover, nurses’ professional experience and caring work is positioned between the external world of discourse, material objects, and the

social relations that draw them together, on the one hand, and the processes of representing one's self in relation to that external world, on the other.

Arguably, the everyday professional practice of individual nurses is located between two zones of tensions — the visible and the invisible. The first zone of tension is the consciousness gained by formal learning, which constitutes the visible or “objectified knowledge” — also closely associated with the notion of professionalism. The ruling order or ruling relations is embedded in the “objectified knowledge” and tends to subordinate other forms of knowledge. Its visibility is translated into texts, formatted on the medical model of a body part and organs, diseases, diagnostics and treatments much easier to objectify or standardize in taxonomy or nomenclature. This, in turn, is translated into tasks ready to be delegated to the nurse at a convenient time. Although the profession is constantly struggling to dissociate itself from the medical model — in times of cost cutting where only the visible matters — the objectified tasks take precedent over anything else, thus pulling nursing closer to medicine.

The second zone of tension is the consciousness gained by experience, which constitutes the invisible, or subjective or tacit knowledge — also closely associated with the notion of caring. This type of knowledge or “know how” is very complex because it internalizes the explicit knowledge and connects it with intuition, as well as refined preconceived notions and theories to constitute a whole. The subject uses the “know how” in the form of judgment to make sense of a case or a concrete situation for proper action. This rich source of knowledge

cannot be found in text — it is part of the subject decision-making process. The individual nurses who leave hospital settings take their valuable skills and experiences with them. The “know how” is embedded in the subject’s or nurse’s actions, depends on particular circumstances surrounding each case of caring intervention and cannot be understood or explained without a context. Therefore, it is invisible to the external world. This is very crucial in times of cost-cutting policy. The wealth of nurses’ tacit knowledge is an invisible line item in hospital budgets. Consequently, the tacit knowledge is vulnerable to policy reform of cost-containment in the hospital sector. However, it is this collective “know how” that makes a difference in the overall quality of hospital care. As Elizabeth Smith (2001:311-312) indicates “when organizations merge, downsize, reorganize, or organizational culture changes, priceless knowledge is lost or buried under new information. Employees who leave take their valuable knowledge, resources, skills and experiences with them. Those who stay may be assigned new jobs and never use their wealth of accumulated knowledge.” In the hospital setting, nursing is at the core of most therapeutic activities and enhancement of the healing process for most patients (White 1997). A drastic depletion or constant reorganization of this pool of priceless invisible knowledge has certainly affected the overall nursing practice and knowledge and, in turn, the quality of care.

During the last three decades, policy initiatives in nursing education have brought about some improvement in the explicit knowledge base of nurses in all

countries and jurisdictions with great variations in time and outcomes — however, not without tensions and controversies. The “know what” is initially obtained at three different levels of institutions and educational programs: hospital nursing schools based on an apprenticeship model, community colleges and university presumably for a more theoretical and scientific approach to nursing knowledge (Davies et al. 2000; Greenwood 2000). The ultimate common goal for the profession is for nurses to obtain their basic knowledge foundation at the university level. The conceptual knowledge history of professional nursing practice for the purpose of this chapter is characterized by two major eras of development and transformation. It began with Nightingale who believed nursing was not a natural ability but a vocation that entails both knowledge and skill. In her commitment to the development of nursing, she envisioned that the knowledge necessary for nursing practice ought to be built on three separate realms: the know-what, which is purely objective and derived from the basic sciences; the rules and procedures that guide the practice and hygiene; and the insights or skills gained through experience (Johnson and Ratner 1997:4-5).

Modern training programs — to actualize this conceptualization of nursing knowledge — began in England with the creation of the apprenticeship hospital schools of nursing (discussed in Chapter Four). In Canada, parallel to hospital schools, there were some university schools of nursing starting after the post first world war in 1919 in British Columbia which expanded to both Quebec (McGill University) and Ontario (University of Toronto) thus giving few nurses the elite

opportunity to higher education (Coburn 1974; Kerr-Ross 2003).

Throughout this period, nurses initiated to bunch together and formed nurses associations with the goal to become a profession. Registration ⁹⁷ was a critical step in establishing the skilled nature of nursing and clearly intended to improve nurse's explicit knowledge, at the same time excluding other uneducated women caregivers (Coburn 1974). The struggle for registration started in the late nineteen century and coincided with the formation of the International Council of Nurses⁹⁸ July 1899 (Bullough and Bullough 1964). One of the principal mandates of ICN was to assist nursing worldwide in the setting of minimal standards for nursing education with the principle that each nation's nursing program must be developed in congruence with the customs of individual nations (Bullough and Bullough 1964). This international association has played an important role in the nursing evolution worldwide, although nursing history does not to some extent emphasize this fact.⁹⁹ Therefore, nursing

⁹⁷ Refer to Chapter Four

⁹⁸ International Council of Nurses (ICN) is composed of memberships from nurses associations of one hundred and twenty countries. ICN purposes were: to encourage self-government of nurses through their associations, to improve nursing educational standards, to establish a professional ethics, and to increase the public usefulness of its members (Bullough and Bullough 1964).

⁹⁹ Historical ICN allows nurses to cooperate with international bodies, for instance, the World Health Organization (WHO), the United Nations Education, Scientific and Cultural Organization (UNESCO) and the International Labour Organization (ILO) (Bullough and Bullough 1964). The collaboration function provides opportunities to influence and promote nursing agendas and perspectives to these bodies, in which their governments are signatory. Strategically, therefore, what nurses cannot obtain directly from their national government, they manage to obtain indirectly via these organizations and, in return, press their government to honour their signature. ICN policy statements and positions reflect new development and changes in the health system, which will have an impact on nurses. These policy statements and positions are channelled through the different associations for actions and carry their own load of tensions and

associations with their effective lobbies have played, to some extent, an important role in the propagation of formal nursing education programs. Hospital schools of nursing have survived for more than a century-and-a-half with great variations in their times of closure among nations and jurisdictions. There are also great variations in both nursing knowledge and scope of practice.

Although evolution is on a continuum, the second era of major overall development in nursing knowledge and practice actually initiated after the World War II. This was in conjunction with the increasing progress in science and medical technology along with the complexity of the care requirements, major developments in the healthcare system of industrialized countries. Similarly, hospitals have expanded and increased in complexity to meet the care needs of the population. Science and technology became and continued to be the prevailing discourses in the healthcare system. These developments have great ramifications on the nursing discipline due to the fact that formal knowledge of nurses has to adjust in order to meet the challenges of the change in the practice setting. During that time, nurses' pursuit for professional legitimacy has also amplified. Starting in North America, nurse academicians, "in an attempt to portray nursing as a legitimate discipline rightly placed within institutions of higher learning, began to minimize the importance of the technical and

contradictions in their effort to keep up with the pressure of changes. When translated at the national level, how the implementation and outcomes play out depend very much on the political economy and institutional arrangements of each country and jurisdictions. Therefore, there are enormous variations in the outcomes. ICN has a fundamental importance in the development of nursing worldwide, although not enough emphasis is given to this aspect of development of the profession in nursing history.

experiential aspects of nursing" (Johnson and Ratner, 1997: 6).

In the late 1950s, the word nursing science started to make its way into literature. Paradoxically, by the mid-1960s, many nursing theorists upheld the position that educated professions and technical works are not compatible (Johnson and Ratner 1997). Therefore, they have promoted the idea that nursing practice requires only scientific knowledge, and other kinds of knowledge were dismissed (Carper 1978; Donaldson 1995; Johnson and Ratner 1997). This stand is problematic. One will tend to ask: what kind of scientific knowledge, what is the purpose of the existence of nursing in society and what kind of nursing practice they are talking about.

Since that, there has been a growing importance — concerning the creation of a body of empirical knowledge exclusive to nursing — to the point that "there seems to be a self-conscious reluctance to extend the term knowledge to include those aspects of knowing in nursing that are not the result of empirical investigation" (Carper 1978:16). Simultaneously, there was the continuing debate about the meaning of nursing. Authors such as Bishop and Scudder (1997: 82), observe that nurses for the most part have uncritically accepted the claim that nursing is an art and a science, and are convinced that this label will assure academic and professional recognition and respectability. In their views, the claim that nursing is an art or a science "leads nursing scholars away from the issues of the day, such as applied science versus human science, and from seeking the identity of nursing in the practice itself . . . Nursing is a practice in

that it seeks to foster healing and wellness through communally developed ways of being with patients that sometime involve applying science and other times artistic, creative care" (Bishop et al. 1997: 85). The notion of applied science can be viewed in this case as a nursing practice that will attempt to apply scientific findings to the solution of patient care problems identified by the individual nurses. However, it is more an abstraction than reality. The extent to which the nurse's use of various scientific interpretations and techniques in their caring work, such as observation, etc., to provide care and facilitate the healing process is not sufficient to call nursing an applied science.

This struggle regarding the meaning of nursing itself is being challenged on two fronts. On one hand, there are those who consider that the meaning and direction of nursing should come from applied science¹⁰⁰ (Rogers 1961; Walker 1971), and on the other, those who believe that nursing is a caring practice that can be best articulated and developed with explanation from the human sciences (Benner and Wrubel 1989; Donaldson 1995; Benner and Gordon 1996; Bishop and Scudder 1997). This schism has and continued to create tensions amongst the scholars, and nursing leaders. Donaldson (1995: 3) reminds nurses "the primary purpose for developing the discipline and the science of nursing is not self-aggrandizement for the profession of nursing. The knowledge of the discipline must ultimately support service to clients and the health of society." This is

¹⁰⁰ With no concrete proposition, there is matter for contention, what kind of applied sciences, and whose science.

significant not only in terms of the orientation and the underlying philosophy that will guide the curriculum development or objectives of a school of nursing; the core and optional courses or what can be eliminated is decided on these premises — including what the formal knowledge of nurses will be and which educational institutions are best suited for nursing education.

These tensions that started in North America (United States and Canada) more than four decades ago are still strong and have now — to some extent — filtered through in all jurisdictions with variations and uneven development. The contradictions in the fields between nurse leaders who participated in this investigation from the academics to the professional associations are evident. There are disagreements in the meaning of nursing which reflect the tensions in literature. Questions raised are not only with respect to the notions of caring practice and nursing being an art and a science, but also vis-à-vis the asymmetry that exists in the claims in terms of the emphasis placed on one notion to the detriment of the other. The struggle and inconsistency are evident in the following quotes expressed by various academic leaders with two different views:

It's very interesting that we use the caring practice language now because if I take myself back 43 years, we called it the "art and the science of nursing" — basically both were integrated. I can't be a really caring professional. I'll take myself back in the paediatric world where I did some research as part of my previous academic mandate — my caring will be very limited if I don't understand that child's condition. If I don't understand that because he has leukemia and because he's got radiotherapy going on right now or a certain

chemotherapy medication package coming in, if I don't understand the implications for all of this on him physically, cognitively, emotionally, and his family — if I don't understand the science of that, I am going to be limited in my caring, and my caring is what that child and that family need. For me, nursing is an art and a science (Interview 1).

There is also tension between nurse academics in the claim that nursing is an art.

Some are not convinced that enough formal knowledge is provided to nurses with respect to the art component to assist them in their practice:

We have paid much attention (and I am not critical of that) to the empirical knowledge, the scientific knowledge required to provide sound nursing care, but less attention to the knowledge and skills required to provide the art of nursing. Although we have magnificent nursing theories that speak about that, we've not always been teaching the concrete skills required to enacting these processes (Interview 11).

The following reflect the same critique but from a nurse's association leader perception:

Nurses think and write about caring being central to nursing practice and yet I believe that we haven't paid sufficient explicit attention to the knowledge and skills required to enact caring practices (Interview 13).

All of these have implications in the practice setting “workers [nurses] who lack adequate education and training, or explicit knowledge, struggle to keep up” (Smith 2001:311) when there is pressure in the work setting. They are ill equipped to properly activate the caring practice, and other more visible priorities, such as

the “objectified” medical tasks that take precedent.

The philosophical debate of the “know what” in nursing had an ongoing domino effect on the way nursing education is delivered and has exacerbated the growing dissatisfaction with the Nightingale apprenticeship model. Hospital nursing schools’ hegemony was gradually coming to an end, starting in the late ‘60s until 2000 in all the jurisdictions, which were part of this investigation. Changes started to occur with variations in time and outcomes. For example, in 1964, the Ryerson Polytechnical Institute in Toronto, Ontario can claim to be the first nursing diploma program in Canada to be delivered in an educational institution (McPherson 1996; Kerr-Ross 2003). Similar movement was taking place in Québec in 1967 with a pilot project in three Collèges d’enseignement général et professionnel or CEGEPs (Cohen 2000). By 1972, the apprentice-type educational system in hospital settings were replaced by community colleges¹⁰¹ and the number of university nursing schools was also increased (Lalancette 1993; McPherson 1996; Cohen 2000; Kerr-Ross 2003). Collaborative efforts are underway in Ontario for mandatory university degree as entry-to-practice by year 2005. The same process is taking place in Quebec with no set date as yet. A

¹⁰¹ In Québec, three programs were designated in 1967 to a pilot project for transfer to the Collège d’enseignement général et professionnel (CEGEP), and others followed through till 1972 — the year when the last School of Nursing annexed to hospitals in Québec was closed. Similarly in 1964, the Ryerson Polytechnical Institute in Toronto, Ontario can claim to be the first nursing diploma program in Canada to be delivered in an educational institution due the effective lobbying on the part of the Registered Nurses Association of Ontario (RNAO). By 1972, all the schools were transferred to the colleges of applied arts and technology (CAATs) by order of the Ontario government.

nurse academic from Quebec offers an answer to the delay¹⁰² in the following quote:

There are two types of nursing in Quebec with one very progressive located in Montreal, Quebec City and Sherbrooke where the big universities are annexed to hospitals. Nurses in these locations are more assertive in advancing nursing education and practice. There are also more RNs with degrees working in these university health centres. However, in the Outaouais region and in other parts of the province, it's a totally different story. This dissonance creates a problem when it's time to reach a consensus — we are not speaking the same language. The progress that is taking place in Montreal, etc., is not the reality province-wide. In my opinion, as far as nursing is concerned, there are two realities in Quebec — one very progressive and one regressive (Interview 8).

In England, the transfer was initiated with the adoption of "Project 2000"¹⁰³ in 1989 and completed in 2000. Some university programs were established in 1960 and progressing — there are more university-prepared nurses than thirty years ago (UKCC 1986; Feroni and Kober 1995; Fulbrook et al. 2000). Similarly, nurses associations continue to lobby for higher education as entry to practice nursing in England and the UK:

I think becoming a degree-based professional group has been a big driver for the last 10 or 15 years. In England and elsewhere in UK, that is a political debate that has been going on . . . we've had publicity around why the nurses need to have degrees. Because of bad publicity

¹⁰² This can be attributed also to the fact that "l'Ordre des Infirmières et infirmiers du Québec", and the union are under the same umbrella with different mandate. There is potential for conflict of interest with the different stakeholders.

¹⁰³ One of the major policy changes behind Project 2000 was that student nurses should have supernumerary status and not be viewed as apprentices. They would be under the educational system control. Their introduction to the practice areas would also be spread over a period of time and clinical placements would be shorter. See Fulbrook et al. (2000) for more details.

in a lot of hospitals around the quality of care, people are saying why do nurses need to be degree-based? People don't understand the complexity of nursing and we need to articulate the impact of having degree-based nurses in the healthcare system; however, I don't always think the institutions are ready to embrace that. And that's where the organizational culture needs to shift to actually accept these bright, more articulate, more challenging, and more questioning nurses. So when they come in, they can use their intelligence and they feel valued (Interview 34).

In Italy, there was a direct transfer from regional hospital schools of nursing to university¹⁰⁴ initiated in 1992 and ended in 1997 (IPASVI 1992; Il Sole 24 Ore Sanità 2001). It was reported — during the interview process — that prior to the transfer, there were 540 schools throughout Italy, which were funded and controlled by the Regional National Health Services. Most of the Italian nursing schools were annexed to hospitals and nurses were in charge of those schools. The acceptance for entry to practice at the university level was due to the relentless lobbying on the part of the nurses associations (Federation regional and national). It was a strategic move — the Italian nurse leaders used the EU law and the Alma Alta declaration¹⁰⁵ to make their case for higher education. Paradoxically, this was facilitated also by the fact the government wanted to find more employment for their oversupply of doctors, who were also glad to take

¹⁰⁴ It is important to note that the direct transfer was facilitated because in Italy the university is the only system of higher education. Unlike Canada and England there is no network of polytechnics, no *écoles des hautes études*, as in France (Krause 1996).

¹⁰⁵ Is related to a shift to primary care signed in 1978 by nation members of the World Health Organization with emphasis on prevention, health promotion and determinants of health. The focus is also on community health a shift from the approach of relying only on cure and disease or disability. The complementary skills and knowledge that nurses will require to guide people, to deal with family and community health can only be acquired at a higher education institution.

back nursing education.

In France, there was a different evolution and outcome related not only to the omnipotent central role of the state in the education system but also to the lack of cohesiveness and strong professional nurses associations — unlike the other jurisdictions where serious philosophical debates involving nursing academics and associations were taking place to effectively lobby and propose or influence policy on explicit nurses knowledge. French nurses were to some extent passive observers in the transformation of nursing education. Improvement and changes in the know what or objective knowledge in France is much more a result of coercive isomorphism of the European Union law — thus, to some extent, nurses indirectly benefited from what was taking place in England and elsewhere, but with different outcomes. In 1995, the Nursing Education Institute¹⁰⁶ replaced the initial traditional schools of nursing. These institutes are mainly annexed to public hospitals and placed under the aegis of regional representatives from the French Minister of Social Affairs. The change was done to comply with the European Union law; however, not to the satisfaction of the president of one the professional associations:

The EU standard is respected quantitatively, not qualitatively. The criteria for admission was improved, the aspiring student must have a baccalauréat¹⁰⁷. One must have 4,600 hours of theory and clinical

¹⁰⁶ Here, institute is not equated with higher education.

¹⁰⁷ For this term, there is a distinction between countries. In France or countries/institutions, which adopt the French school system, in order to meet the requirements of having completed secondary school, one has to pass two successful nation-wide baccalauréat exams in two different

practice or three years of study. This is very important to facilitate the free movement between the 15 countries. Therefore, France was compelled to apply these standards. Actually, in France, nursing education is not at a university level. There was a good opportunity to do a real reform . . . It did not turn out that way (Interview 21).

However, the transfer to more theory and increasing the academic knowledge of nurses was not without controversy and contradiction built into the process. Opinions differ, particularly between nurses in the service sector and those in education. Greenwood (2000:17) observes that nurses in the clinical setting criticize that new graduates (of either diploma or degree courses) are insufficiently equipped for clinical practice in that they are lacking in certain skills. Nurse educators complain that the expectations of nurses in the clinical service are unworkable given the objectives of modern-day nursing education. This is true in England and the UK (Greenwood 2000), and in both Quebec (Lambert 1993) and Ontario (Ross-Kerr 2003). In Italy, there was an added dimension with the transfer to universities — the curriculum was changed to reflect a heavy component of bio-medical courses to the detriment of nursing topics (Sansoni 1998). This was substantiated by a nurse educator:

The new curriculum, in my view, is designed to prepare a “medical nurse”, if I can use that term — a program where 70% of the topics focus on anatomy, physiology, and where there is more biology, less on humanity, and less and less on the development of the nursing

terms. Whereas in Canada — Quebec (premier cycle) and Ontario — it is a post-secondary degree obtained from a university. This is similar in Italy; however, it is called a laurea di primo livello in infermieristica, which is the equivalent to the baccalaureate in Canada and in England (in terms of face value) but contents varied from university-to-university and from country-to-country. In France, it would be a license ès (noted that nurses who have university degrees in France obtained them from other disciplines and not in nursing).

discipline — is not aimed to prepare nurses. In the weekly schedule, as you can see, all the medical courses are in the morning when the mind is fresh. The nursing topics are always late in the afternoon or evening. This is absurd; the curriculum is done not in function of the preparation of the nurse but in function of who is teaching. The education is oriented more towards curing than caring — this is the problem (Interview 26).

The clinical practice, although drastically decreased, was improved to some extent in 2001 after a period of adjustment by a joint-appointment arrangement or part-time teacher between hospitals and universities. In France, the increased theoretical component has also resulted in a decrease in the clinical; although it did not translate to a crisis because the Nursing Education Institute still remains under the same aegis. However, due to the workload, it is reported that nurses in clinical areas have no time to assist or to act as a role model for students. The concerns are also related to an imbalance in the clinical practice of nursing students, as evidenced in this quote:

The piece that still concerns me a bit in the current environment is — how are we going to make sure that nurses are not only academically competent but also clinically competent? I think here our colleagues in medicine have an excellent model that we need to look at very carefully because they have been able to develop a way by pulling together academic learning and practical learning in a nice way, that when people graduated they have competency in both. We have to strike a balance between being competent academically and clinically (Interview 11)

Ironically nurses always try to distance themselves from medicine, but they constantly refer to it as an ideal model to follow.

One of the strengths medicine has is that they pretty well know what doctor knows and what the role is — and I think that's one of the

things that we should be looking for in nursing (Interview 9).

Portraits of progress depicted in traditional nursing history do not speak of the struggle and rising dissatisfaction, and the cynicism in nursing with respect to the unequal treatment within the education system. Extensive debates continued about the quality of instruction and the opportunities for nursing students in contrast to those of other students in the post-secondary education system. Comments like this, in the Canadian context, illustrate the frustration on the part of some of the leaders who took part in the interviews:

Policy is Baccalaureate as entry to practice — affects nurses' knowledge and skills. It's a key instrument in ensuring that nurses have the knowledge and skill level required in today's practice setting. And, it's always amazing that we have to discuss this even because occupational therapists and physiotherapists are routing towards a Master's as entry to practice and there are no questions about this right now; however, it is coming. Audiologists are indicating that they want to be like psychologists and have a PhD as entry to practice. Nurses are with clients 24 hours a day. There are some studies that have been done on the number of minutes surgeons spend at bedside with their patient if they're not doing surgery, and it's less than an hour. So what happens for the other 23 hours of the patient's cycle? There are a number of multidisciplinary people affected, but it's the nurse who is there. You will want that person to be at that level of understanding of a patient's condition and implications of the interventions and alternatives, and how to problem-solve — I think we have been very poor at marketing exactly what nurses do and the responsibilities that they have. So, from a policy perspective with a Baccalaureate as entry to practice, it's really one step in the right direction here (Interview 1).

Nonetheless, during the last three to four decades, all jurisdictions have seen major positive transformations in nursing education with great variations and

uneven development in time and space. These policy initiatives have brought, to some extent, an improvement to nursing formal knowledge, although not necessarily to everyone's satisfaction and contradictions are inherent to the process. There are more baccalaureate-prepared nurses not only in nursing but also in other associated disciplines in the humanity, arts or social sciences than there were 30-40 years ago, likewise more graduate nurses at Master's and Doctoral levels. However, it took nursing basically all its existence to convince society with some degree of success and failure that the profession requires higher education in order to practice. How both types of subjective and objective knowledge play in the day-to-day professional practice of nurses under policy reform of cost-containment, and how caring is mediated or contested by other factors in the practice setting under such condition will be the topic of subsequent sections.

6.2.1 Nursing Professional Practice

Since the first nursing school, training was established more than a century ago where nurses have gathered in enormous pools of explicit and tacit or invisible knowledge acquired by means of consciousness gained from learning or experience. Here, it is contended that nurses in their caring work use various scientific interpretations and techniques as well as artistic means to provide the care and facilitate the healing process. For example, proper intervention requires on the part of the individual nurses a certain amount of observation, induction

and deduction based on known facts about particular cases. In addition, excellent care constitutes a whole and entails not only intuition and experience, but also an amount of creativity and sensitivity. However, the application of science and art methods in nursing care does not imply that nursing itself is either an art or a science. For that matter, neither nursing nor medicine can make such claim. Arguably, professional caring or nursing work or actions is positioned in a complex relationship to scientific knowledge where “formal knowledge is put alongside other knowledges, leaving a considerable place for adjustment, negotiation and connecting in the light of a carefully acquired and detailed understanding of persons and situations” (Davies, 1995:22). Intuition, emotions, experience and commitment are recognized as part-and-parcel of the process of effective caring work.

Therefore, nursing skills or actions are very complex and heterogeneous. Individual nurses, who constitute the nursing practice as a whole, varied in their degree of competence or expertise. To illustrate nursing actions and the policy impact, Benner’s (1984) classic work “From Novice to Expert” will be utilized. Her work is remarkable in explaining the complexity of nursing knowledge and how individual nurses applied their knowledge to carry out their caring work. Unlike the proponents who believe that the direction of nursing should come from applied science with no real substance, Benner (1984:3) believes that “the knowledge embedded in this clinical expertise is central to the advancement of nursing practice and the development of nursing science.” In addition, she

asserts that the knowledge necessary for nursing practice is embedded in the judgments or decisions made by professional nurses in their day-to-day practices, and not all of this knowledge can be described or identified in theoretical propositions — hence contends that the course of action for an expert judgment in clinical practice is not based entirely on objective knowledge, but on the intuitive decisions-making process of the nurse.

This view is congruent with the notion of invisibility of the subjective knowledge discussed earlier. Because the subjective knowledge is hidden to the exterior world, its importance in the overall patient quality of care is often overlooked in times of cost-containment pressures. It is within this line of thought that nursing skills or actions can best be explained in an attempt to unveil some of the concealed aspect involved in the nursing care delivery process. Benner (1984: 13-36) posits that individual nurses during an uninterrupted caring practice passed through five¹⁰⁸ levels of proficiency: novice, advanced beginner, competent, proficient, and expert. Taken as a whole, the everyday nursing practice or actions constitutes a complex continuing process involving the different stages of tacit or invisible knowledge in order to make the difference in the patient quality of care. Here, it is argued that the ruling order of policy reform initiatives based on cost-cutting strategies can affect the different stages and, therefore, deplete the vast reservoirs of invisible knowledge that the

¹⁰⁸ However, there is a caveat. In reality Benner's five stages do not fit in a clear-cut fashion. There are some overlaps between the stages. In a period of uncertainty of merger or beds closure where nurses are moving from unit to unit, the different transfers blur their levels of competency.

nursing profession has accumulated over time. This, in turn, will have an impact not only on the everyday nursing professional practice as a whole, but also on the quality of patient care.

For instance, in stage one, novice nurses are considered to be beginners as they have had no experience in the work or situations in which they are expected to partake in. They rely on the rules and procedures to guide their performance. However, the rules are not able to inform them of the most appropriate tasks to carry out in the real situation (Benner 1984: 20-21). They need the pointing of the clinical leader in order to connect the rules and procedures with the real situation. However, in the current climate as a result of downsizing and restructuring, there is a vacuum of nursing clinical leadership in hospital settings and where they still exist, the functions are more managerial than clinical (Aiken et al. 2001; Labayle 2002); therefore, leaves the novice nurses with no effective guidance for a smooth developmental stage. Moreover, casualization and part-time employment — where nurses have no choice than to work in two or three different settings — kept them in the stage of constant novice. This is true, to some extent, for all the jurisdictions because, as a measure of cost-saving casualization and part-time, jobs have increased (Arrowsmith and Mossé 2000; Aiken et al. 2001) everywhere with some variations depending on regional differences, the care requirements, the specialities and skill scarcities. For example:

In Ontario, young nurses are trying to piece together three or four

casual jobs. They never got to be expert in anything; and they had very little mentoring because there were very few senior people to mentor them — and, the nurses who were there, were so busy . . . But again, in a way, it's a disservice to our young health professionals, nurses — because if you look at the different stages, they are always novices because they are moving from floor to floor, unit to unit; it is hard for them to get up to the expert level because they haven't had any sort of solid base. That is the sense I get from the perspective of new grads (Interview 10).

The above quote, provided by an Ontario participant, can find its application elsewhere in Canada, France, Italy and the UK. The novice notion is applied not only to the new graduates, but also to any experienced individual nurses entering for the first time in a clinical setting where they have no previous knowledge with the patient population. The performance is affected and downgraded to the novice level (Benner, 1984:21). When hospitals are restructuring or downsizing by merger or bed closures, the nursing staff is laid-off with no consideration being given to the tacit knowledge, which is moving away with them — thus creating a precarious situation for the patient care. This, in turn, activates the bumping process with a chain reaction where nurses with several years of work experience in a particular unit or specialty will often be bumped to a completely new area and place the practice at risk:

Where I get most concerned is with seniority and bumping. If I have a nurse who has been a specialist in Obstetrics for 25 years and they close the Obstetrics Unit in the hospital and she now has seniority and she's going to be bumped because of her seniority into the Emergency Room, but I have an Emergency nurse who has done her Master's degree in emergency nursing and has five years of experience, while this other nurse has had 25 years in OBS and because of her seniority she gets into the Emergency Room — is this good practice? There is

where we're looking at the contradiction because it's again getting back to that belief that a nurse is a nurse is a nurse and not realizing that if the doctor has to specialize — you wouldn't want an obstetrician fixing your leg in orthopaedics, of course — and we haven't come to that. If there's a body of knowledge that you really have to deal with the population of patients and the nurse is the one that's going to be there all the time, she's the one that's going to have to identify the risks, appropriate intervention (Interview 1).

While this example is related to local hospitals in Ontario during the 1990s, beds were closing and hospital mergers were happening in Quebec, in all regions in Italy, in France and England (Healy and McKee 1999; Aiken et al.; 2001; CIHI 2001; Labayle 2002). Therefore, nurses everywhere — depending on the respective countries and jurisdictions labour relations law or collective bargaining — were going more or less through to the same process.

In stage two, the advanced beginners are able to display a slightly satisfactory performance — they have handled or are being pointed by mentor-sufficient actual cases to infer on a recurring situation. In what Benner (1984:22) dubbed “aspects of the situation”, she sustains that the advanced beginners need support in the clinical practice setting. Their assessment of patient care requires some help from nurses who have reached at least the competent level of ability and functioning, to make certain that important patient needs do not go unmet because the advanced beginner cannot yet prioritize what is most crucial. They need the guidance of a mentor or a role model. However, with an already heavy workload, the experienced nurses have difficulties effectively assisting the beginners. The pool of experienced nurses is depleted by attrition, early

retirement or other forms of exit. Again, in this stage, the advanced beginners will experience the difficulty of benefiting from the guidance or the pointing of the mentors who are already under pressure with increasing work intensities. In this case, the quality of care is affected because important patient needs go unmet — not by negligence on the part of the nurses, but by lack of experience and guidance.

In stage three, however, the competent nurses are epitomized — have been for two to three years on the same position or similar situations, they begin to see or to think and intervene in terms of long-range goals or plans of which they knowingly activated. The competent nurses are not as fast and flexible as the proficient nurses but possess sufficient skill to deal and manage unforeseen events or emergencies in clinical situation (Benner 1984: 25-26). The same can be said for this group. With no full-time employment, the nurse can be working in fields for more than two to three years, but are never in the same position. It is also true for the full-time nurses, who can move twice or more from ward to ward during the bumping process related to mergers, restructuring or downsizing. Moreover, restructuring and mergers contribute to organizational culture change and create a high level of uncertainty. Therefore, competent nurses do not have the opportunity to think or intervene strategically.

In stage four, proficient nurses are characterized, as performers who observe situations as “wholes rather than in terms of aspects, and performance is guided by maxims” (Benner 1984: 27). They learn from experience and foresee what will

happen in a given situation and how the course of actions could be modified to suit the conditions at hand. This holistic understanding improves the proficient nurse's judgment and decision-making process. Proficient nurses have usually worked for approximately three to five years with similar patient populations. They will regress to an analytic, competent level when placed in a situation where procedural account is required (Benner 27-31). Most hospital organizations introduced by management have been intended to imitate industrial models of productivity (Aiken et al. 2001; Labayle 2002; Dunleavy et al. 2003) thus introduce new sets of ruling order totally foreign to the explicit knowledge of the nurses. When forced into the accounted conditions of new procedures, which do not necessarily fit into the work process, the proficient nurses regress to a competent level, which inhibits their practice and affects the quality of care. Moreover, these new sets of ruling relations "had limited success in terms of retaining nurses or improving patient outcomes and have been demonstrated in some cases to yield negative outcomes (Aiken et al. 2001:51).

Finally, in stage five, the expert nurses (Benner 1984: 32-36), with their vast background and experience, understand intuitively and rapidly each situation and focus on the precise cause of the problem without entertaining a wide range of options prior to reaching conclusions and solutions. Nurses, who have handled many situations and look after many people, get a strong foundation on understanding new situations, but this complex knowledge, in which the expert nurses constantly refer to activate their nursing practice, "cannot really be put

into abstract principles or even explicit guidelines" Benner (1984: 36). The performance of the expert nurses will deteriorate, if they are forced to observe rule or formal model. Restructuring has brought more rules and regulations, which are foreign to the nurse's approach; therefore, impede their ability to care. The following quote provided in the French nurses' context illustrates, to some extent, that the problems are universal:

In France, since the accreditation process was introduced with the restructuring of French hospitals, there are more and more regulations and procedures. This new philosophy of care and associated regulations is adopted from the Anglo-Saxon managed care model. There is a big gap between these norms and philosophy and what they give to the nurses as a mean for the implementation. The nurses are prepared to care for patients, based on their initial learning or continuing education and experience accumulated during their practice life. What we have now noticed is that these expert professionals are caught between the norms and regulations on one hand, and the knowledge of the real need of the patients on the other hand. Moreover, they are faced with a staffing issue, which has not been revised since ten years. While the needs have increased, so the patient's complexities, as well as the healthcare need and expectations, yet the staffing patterns remain the same. Therefore, the nurses have to make ethical choices in their activities because they know, even if they identified patient X or Y will need some interaction say psychological, which is one of the caring foundations, they will not be able to do it because there are not enough nurses on the unit (Interview 24).

All of these are the effects of the policy reform strategies of cost-containment. They indubitably have an impact on the continuity and the overall quality of patient care as evidence by the erosion of the "consumers' trust in hospitals" (Aiken et al. 2001:8). In all industrialized world nursing, professional caring

practice, as a whole, is under attack. Here professional caring practice is viewed as one, which fosters an environment that is conducive to both caring for and caring about. If the nurses are exposed to situations where they can only fulfill partially their mandate, this is considered as an attack to the professional integrity. Professional caring practice in this case, is actualized in the hospital's setting, where the nurses can provide services to a group of patients or a group of clients. It is argued that the ruling order of policy initiatives affects all five stages of nursing knowledge and actions; thus impeding nurses to activate the caring practice the way they would like to do — therefore, creating a theory and practice gap. As it is, the “contemporary downsizing of nursing staff and their collective skill level is much more alarming than the downsizing of facilities” (White, 1997: OS9). Invaluable tacit knowledge, resources, observational skills and strategies went with the nurses who leave. Those who remain are trying to cope with an ever-increasing patient acuity and workload, which jeopardizes their ability to practice fully and the big loser, in that kind of working environment, is the caring practice and ultimately the patient. The objective knowledge expressed mainly in curing taxonomy and standardized into task is taking precedent over the subjective knowledge, which finds its expression in the caring practice, thus creating asymmetry in nursing professional practice — individually and as a whole.

6.2.2 Context of Professional Activities: Caring Under Siege

In the 1980s, hospitals were faced with the challenges of policy of cost-containment, doing more with less at the same time providing high quality care to the population with an increasing need and uncertain era (Sochalski et al. 1997; Aiken et al. 2001). The processes used to control the cost varied from merger, downsizing, restructuring to complete closure and qualify staff substitution by less prepared health care workers. During the 1990s, hospitals in Canada (Sochalski et al., 1997:OS15-OS16), England, France and Italy have reduced their average length of stay from over 16 days in the 1970s to seven and eight days (Healy and Mckee, 1999: 3-4). Given the majority of qualified nurses workforce is concentrated in the acute care hospital sectors, the effect of the policy reform initiatives on the nursing profession in all jurisdictions was very disturbing and the consequences remain to this day. The number of nurses was reduced drastically (OECD Health Data 2003) while the work intensity has increased significantly (Aiken et al. 2001; Dunleavy et al. 2003).

In all four countries and jurisdictions, there are fewer inpatients than 10 to 15 years ago — those remaining are sicker and require more intensive nursing care. Moreover, decreases in the length of stay intensify the work in terms of more admissions and discharges. Thus, the increased employment of RNs in 1999 for France, England and Italy was probably more than counterbalanced by the increased acuity of the inpatients. Although in Canada more RNs were hired, there was no net gain in caregiver capacity (Shamian and Lightstone 1997: OS66).

What complicates the matter is the difficulty to come up with a fair assessment of the real impact since nobody knows if the number of nurses per capita was the right number to begin with, while all these changes were taking place in all healthcare systems during the 1980s and 1990s. The current means and tools used in the health system to assign nurses to population or to measure workload are inadequate to capture the magnitude of nursing caring work. For instance, the available indicators of patient-to-nursing ratios can be misleading since they do not take into consideration the severity or intensity of cases. The common workload measurement tool is task based and does not necessarily reflect the total dimension of the caring work, which is not only providing the care, but also caring about.

The heavy workload of nurses, the ageing of the workforce, the bad working conditions, the lack of recognition and the depletion of the nursing workforce have been discussed at length in both the media and the literature across all jurisdictions. From expression such as “squeezed like a lemon” to the last drop, which is a good illustration on how the nurses union in Quebec describes the working conditions with the current environment in the practice setting (FIIQ 1999:1; Skene 2001). They are echoed by their Ontario colleagues “there simply aren’t nurses available to pick up the slack, resulting in horrendous working conditions for those who remain” (Wahl 2001:4). In England, the picture was similar to the other locations. The overall mass of the qualified nursing workforce did remain stagnant, while activity rates reduced patient length of hospital stay,

and increased patient acuity continued to grow. There were also changes in the workforce composition. The reduction in work hours of medical interns had led to new roles for nursing staff thus increased an already heavy workload (Buchan et al. 1997: OS145). As evidenced in the following:

Workload is number one issue — I mean it is totally unrealistic in most cases. For the amount of work that we expect nurses to do, we don't give them enough support staff — I mean we get plenty of data in UK how during the fiscal tightening in the '90s nurses' workload went up and support staff went down, and we assume that because the hospitals come to a hold. Nurses have to take on many of the functions in addition to their patient loads. So, we hear that right across the whole country, nurses — no matter where they're practicing — they feel like a 'hamster' on a wheel just trying to keep up with the task (Interview 34).

Work intensity, lack of time to provide the care the way nurses would like to do so and faulty work design were also reported as a major issues, in the mega international study conducted in five industrialized countries (including Ontario and England) with a sample of more than 43,000 nurses practising in more than 700 hospitals (Aiken et al. 2001). The study found that “fundamental problems in the design of work are widespread in hospitals in Europe and North America” (Aiken et al. 2001: 44).

Also the Italian nurses feel that the increase in the workload aggravated a condition that was already precarious because the ratio of nurses per thousand populations is lower in comparison to the other jurisdictions (Masi 2002). As reported in this quote by a clinical nurse manager:

I think today, unfortunately, the role is very oriented toward cure of

disease and mainly the physical care, not enough importance given to the psychosocial aspect of the care. This is aggravated by the lack of sufficient number of nurses in Italy. This is very crucial as nurses are doing 10 hours per shift and have tried to cope with no sign of relief because the staffing patterns have not changed (Interview 26).

For example, from French perspectives, the reduction in the average length of stay in a surgical unit to three to four days have intensified the workload in two ways: on one hand, patients are kept during their acute phase, which requires more care and monitoring; and on the other hand, the number of admissions and discharges are intensified which, in turn, increases the administrative work. Midy (2003:7) observes that on a 20/25 beds unit with three days length of stay, a nurse looked after 30/35 patients a day in France:

We cannot continue to do more with less. We are in the situation, in France, where they are constantly asking for more with less. They are asking more and more and giving less and less. This is no longer possible, we are at a dead-end. Nurses have done their best during the last five years. They greatly played their role to support this, which was not the case for the other paramedical profession. The problem is we are now at the limit of the system (Interview 21).

The foregoing factors and accounts speak clearly about the effect of the working environment on nurses and nursing practice, and to some extent the deterioration of the quality of care. However, what is not discussed explicitly in literature is how caring is mediated or contested under cost-containment. This question, among others, was specifically asked throughout the interview process to each of the 38 leaders who took part in this investigation across four nations. The aim was to get their perception on this particular issue in order to fill the gap

in literature.

The assumption was that the provision of holistic care entails both caring for and caring about. Caring for or providing care indicates a set of behaviours during therapeutic interventions. Caring about suggests an attitude or intrinsic value which must accompany behaviours. Therefore, it is contended that caring for, without caring about, to some extent disables the caring process, because a component is missing. For instance, in abstraction or intuitively, under normal circumstances, the individual nurses are aware of the importance of holistic care (caring for and caring about) to the healing process. However, in reality, they can still be exceptional by having the right behaviours in providing the care. But if they are pressured by the priority of the workloads, their interactions with the individual patients will suffer, because there is a potential for the nurse not to display the proper attitude and value, which respects the integrity of that human being. In this case, an important part is absent in the therapeutic relationship. Therefore, both the caregivers and the care recipients will be in a state of dissatisfaction. The former is dissatisfied — due to the feeling that the caring process is, to some extent, incomplete, although not done deliberately nor by negligence. The latter is dissatisfied for feeling that something was lacking in the behaviour of that nurse. The dilemma is how to measure or reconcile the impact of the missing component in this equation.

The process consists of finding what themes will be best to convey the issue at stake, that is to say, the mediation or contestation of caring under cost-

containment. Most importantly, what are the conceptual ramifications with the internal contradictions inherent not only with the concept of professionalism, but also with the caring concept. How did reality contrast with the rhetoric? The initial strategy was to strike a balance between the investigation purpose that was set a priority by the question and the statement of the participants themselves, which often spoke in themes outside the original research purpose. To achieve this, a working title¹⁰⁹ was retained to guide the reading of comments. This was very useful for not only the conceptual ramifications, but also to operationalize the term mediated and the term contested. This was facilitated by the guidelines used for the interviews with the participants. All 38 answers were clustered under each title.

For this specific question, computer-assisted, qualitative research methods were utilized to identify common themes¹¹⁰. Some quotes were also identified by jurisdiction during the process. A full list of themes was created. From that list, a coding template for analysis of the data was done. The analysis was extended through a careful reading of the data that had been collected under each code. The variety of responses within single codes was documented in order to identify themes and sub-themes. To validate it, the frequency of similar responses within the codes, themes and sub-themes were calculated. The analysis finds 15 themes

¹⁰⁹ Expressed as: The value and the invisibility of caring in nursing work.

¹¹⁰ QSR NUD.IST distributed by SCOLARI to help organize, analyze within the theoretical framework and track the frequency of themes and sub-themes in the transcription. For more details see NUD.IST Qualitative Data Analysis Software for Research Professionals.

and 40 sub-themes. In the final analysis, the working title was used again. Five main themes were retained for their ramifications. The participants perceived that: nursing is lost; the practice setting is disabling caring; the invisibility of caring suffers from the bottom line approach to care; caring is outweighed by priority of treatments; and there is a lack of value attached to caring. It is worthwhile to mention that the themes are all interconnected.

First, the perception that nursing is lost. Nursing is the reason why the profession exists. If nurses cannot fully actualize the caring work, then there is a sense of something missing. The leaders who shared this belief feel that caring was certainly not at the top of the list. They related it to the fact that most encounters in acute care settings is the medical referral — which means as long as people have their medical treatments carried out and nurses perform that support function — then that was all it required for safe outcome. In reality it is more complicated than that. With respect to the periods for the same theme, they perceived that during the '90s there was a significant change in terms of the focus on getting the task done. Therefore, the speeding up of work was incredible and, still is, because the acuity and complexity of patients became greater, as did the complexity of the treatment and technology involved in the care process. In many cases, the patient load didn't changed nurses just have to go faster and faster to get the work done — "we kind of lost nursing." The lost feeling is summarized in the following quote provided by a Quebec participant:

We became so focused on carrying out the medical plan of care

because this is what is valued by the organization that you get the medication and the treatment done. The psychosocial aspect of care is now considered to be a frill and pressure is placed to ignore these needs (Interview 3).

Second, practice settings are disabling caring. Work settings, such as hospitals, provide nurses with locations to practice their profession. If the work environment is not conducive for nurses to do both — caring for and caring about — it disables, in this case, an important component of nursing. Moreover, if there are no mechanisms in place for personal development, nurses will get discouraged and this will eventually deteriorate nursing care. For the most part, the leaders, who shared this perception, think that the work environment needs to be conducive to enable caring to occur. And from their perspectives, the current situation is to some extent universal. Unhealthy work environments that have been created over the years are impacting on nurses' competence to activate their caring practice, and to work to their full potential within their role as a nurse. This implies not to put the individual nurses in a situation to be just task focused but to definitely be holistic in their approach. In their view, unfortunately, work designed with a difficult workload to handle in a given day, in some areas, created an environment that is not nurse friendly. Even from a scheduling perspective, how nurses are scheduled is often perceived that they're just a number in the system as opposed to a person with a real work/life balance need. The lack of professional development support is another issue. No financial remuneration for nurses who go on for additional preparation, which is the

whole context of the work environment. They definitely think all these hinder nurses to be able to fully evolve within their caring profession.

This is the case in all the jurisdictions. Nurses are frequently said to abandon their workplace because of inadequate support for continuing education (RNAO/RPNP 2000). This is one of the main reasons why nurses in Canada are lured to the US, which offers education as a bonus to attract migration of Canadian nurses down south of the border. This is one of the leading issues on the agenda of all nursing professional associations, including nurses unions. They set aside their differences to take a common front. For that matter, nurse union leaders have vehemently denounced the problem of nursing continuing education as in the following statement:

This is a paradox when you think apprentices in trades, like plumbers, pipe fitters. They have the ability to return to school if they reach different levels of their apprenticeship, and have support through payment of unemployment insurance for their education. So it's something we've been trying to address with the Minister of Human Resources Development. I think it must be acknowledged that this issue is really important and not accepted it as something, which needs to be addressed, as insane (Interview 6).

Questions are raised with respect to the double standard and asymmetrical treatment when applied to nurses because of the gender they represent. Given the unique set of skills and knowledge which need to be kept up to date with the evolution of science and technology, nurses unions cannot digest the fact that this privilege is afforded to a predominantly male group in the private sector and cannot be afforded to a knowledge worker, in what has been seen as a

traditionally public sector and traditionally a women's work area.

Third, the invisibility of caring suffers from the bottom-line approach to care. Caring is part of the "know how" and belongs to the subject or individual nurses. Like the "know how", it is invisible in the line budget of hospitals — therefore, vulnerable to cost-cutting. The invisibility of caring actions is constantly mentioned in the comments. The participants seem to think that nobody really believes that it has an impact:

It is also one of those things that you can't measure and when administrators really have a sense that money is tight, what they do? They focus on the bottom line thing, in terms of what can be measured. Therefore, other dimensions of nursing just get put on the shelves (Interview 26).

Unfortunately, the bottom line — the concern to achieve a balanced hospital budget or keeping the healthcare system in the black — have moved away from the holistic framework of delivering care. So, it's the physical things that have to be done. And, of course, those needs are necessary and have to be met, but it's to the detriment of the caring parts. Moreover, with the corporate style, management is based on managed care where productivity is the bottom line. Nursing is seen as a drain or liability on the resource. Therefore, it's a loss for nurses because it's the caring, although invisible, that makes the difference in the quality of care.

Fourth, caring is outweighed by the priority of treatments. Hospital care delivery service is organized to reflect body part or disease and organ function —

caring is adjunct to that. Therefore, caring is placed on a subordinate position or unequal footing. The nurse leaders, who expressed this view, think there are other constraints in the way institutions have actually designed their care delivery. Nurses cannot do their caring work fully, if the entire shift is related to getting a whole bunch of tasks done. Someone from Ontario provided the following example:

If you give me a whole bunch of patients and I have to really make sure that they get their meds on time, that their IVs are running OK, that very specialized care is provided whatever those specialized interventions may be, then I'm going to be very busy and I'm going to be very focused on getting that done for that large number — it may mean that I haven't got time to sit with the patient and say, "Mrs. Jones, how do you feel right now? Has anyone really explained to you how you're going to feel and what we can I do to help you after you have your breast removed?" (Interview 1)

Regardless of the jurisdictions, the concerns that caring is outweighed by the treatments were real. Everyone perceived that the problem is worse in his/her particular location. In the view of the participants, nurses have to constantly prioritize and caring is left behind not because individual nurses willingly ignore that component of their work, but because the circumstances force them to act differently — as evidenced by this example extracted from a French clinical leader:

For example, in my service, I have never had more than two nurses for 23 patients with very intense and heavy technical chemotherapy care. They are constantly making a choice. The nurse chooses to do the treatment because she has five or six more treatments to finish. This means she has to choose — for example, patient X said to her, while she is doing the treatment, that since the last admission, he is not feeling well and had difficulty coping with the treatment because he

cannot accept the loss of autonomy. In this case, the nurse has the knowledge and the competence to assist the patient with this request, but she is forced to leave this important request for later or not even answer to that need which is very much the proper role of the nurse because she knows, that the others six patients who are waiting for their chemotherapy will not be having it on time. I must say, it is worse in France (Interview 24).

In a nutshell, there was an underlying agreement that caring was under siege whether or not they agree to the centrality of the concept in nursing. This perception was true regardless of the functions and jurisdictions, and regardless of how they interpret or translate the concept culturally in French or Italian into the meaning of nursing. They also recognized that, in order to mediate or compensate, nurses give up their lunches, work late, and don't take care of themselves in order for that care can be there.

I know nurses who will miss their coffee to spend a little time with someone who is upset or to explain a process or procedure to the individual or their family, or to facilitate the discharge, etc., because they've spent the rest of their time running from patient to patient to patient providing the physical kinds of care (Interview 7).

This view was validated by Dunleavy et al. (2003: 25) in a study done in Ontario indicating that "nurses are missing breaks and working anywhere from 15 minutes to a full hour of overtime to get their work done." It is also reported that nurses in Italy are working ten hours. The cross-national study of five countries (which includes England and Ontario) done by Aiken et al. (2001: 46) finds that many nurses across these countries were experiencing considerable job-related

strain. The burnout rate, which is an expression of overwork, was also a concern for leaders:

I think the kinds of things that have been happening in health care, particularly in acute care, make it very difficult for people to care. I think that the burnout rates, which are essentially the shutting off of caring, are symptoms of the sort of self-protection that nurses almost have to put into place because they're working in such difficult circumstances and to come back tomorrow, you may have to turn off. And, I think that is really unfortunate (Interview 6).

A leader from England provides the following quote:

I suspect that what happens is nurses in England become so frustrated in their inability to practice within their full scope, they either leave or they build up strategies against the anxiety associated with this situation. So, they become defensive, lose their motivation, they stop caring as much because they don't feel valued, and that is what I call horizontal oppression. If you are down, you kick the next person close to you (Interview 31).

Fifth, the perception that there is a lack of value attached to caring. Caring cannot be explained without a context, whereas the treatments can be quantified in tasks. In a milieu of what is counted is what one can see — caring is for the most part lost under the heavy weight of the priority of the treatments. From this point of view, many of the participants feel that caring is undervalued in the healthcare sector. This is translated also in the role descriptions of nurses, which are defined by tasks and productivity. That notion of sitting at a bedside to explain or teach a procedure to a patient to facilitate the healing process and the interpersonal relationships are not defined in role descriptions. And, they believe

if things as fundamental as this are not recognized that means it is not valued and counted as part of the care process. As a follow-up question, the interviewees were asked to give a numeric percentage of the value placed on curing versus caring. When calculated, the overall average from their perception was that 80 percent of value is placed on curing and 20 percent on caring. This high value on curing seems to be related as follows:

In the current acute setting, patients come in, you fix them and they are out as soon as possible. It is based on the interventions that you can quickly put in place. Caring is another phenomena altogether and because it is poorly understood, there is very little value in that. I would say that there is very little value, especially around senior management tables (Interview 4).

The perception of the leaders has validated to some extent the findings from the studies of Aiken et al. (2001) and Dunleavy et al. (2003) concerning the problems that nurses were confronting in the practice setting. Being in leadership positions, they are leaving with their own contradictions and suffering when constrained in their functions to make contradictory decisions that the ruling orders impose on them. Sometimes in trying to make the best of a bad situation, it inevitably translates into a bad situation in the practice setting. However, this approach has its limitation because it is the perception of the leaders not the nurses in the practice setting per se. The choice was dictated by practical reason, which is discussed in the Methodology in Appendix One. Nevertheless, the findings reveal that the leaders who participated in this

investigation are not so distant. They are aware of what the front line nurses are enduring in the practice setting. As evidenced in this chapter, it is not so much nurses or the leaders who are contradictory, but the institutional arrangement in which they are embedded that is contradictory. The same holds true for the relations of ruling that sustain the structure of control in nursing and, at the same time, provide nurses motive for resistance, changes and transformation.

6.3 Summary

In summary, there is evidence of tensions and contradictions in the operationalization of both objective and subjective knowledges of nursing reinforcing and being reinforced by the conceptual ramifications of the concepts of professionalism and caring. It is not surprising that these concepts carried with them their load of tensions and contradictions not only in nursing practice settings but also in the educational settings.

There was a common goal to build a caring profession. One of the main objectives is to improve nursing knowledge through higher education. It turns out to be a difficult path with endless struggle — it takes more than a century to achieve this goal with some degree of successes and failures. In certain cases, the success was also a failure. While the different jurisdictions have the same purpose, there are great variations in the milestones in terms of time and outcomes. There is no doubt that policy initiatives in nursing education in the 1990s on one hand have enabled nurses to some extent in the explicit knowledge

and in the expansion of the scope of practice as seen in Chapter Five. Moreover, the goal of university as entry-to practice has materialized for some or is in the process for others — and, not even in the horizon in France at the time of this investigation. Nurses are more knowledgeable than ever and the profession has accumulated a vast reservoir of explicit and tacit knowledge. However, the impediments outweigh by far the so-called enablers. After the basic explicit knowledge when entering in fields unlike other professions, the means for nursing professional development and continuing education are lacking. Nurses at bedside are more frustrated now than ever before. The same policy initiatives and their associated ruling order are holding them back in the practice setting preventing nurses to practice to their full potential. Nursing leaders, who participated in the interviews, are clearly dissatisfied with the current situation. Regardless of their position, they candidly expressed their frustration with what is taking place in the practice setting. One gets a sense that they are also overwhelmed, because they are constantly reacting to make the best out of a bad situation.

The task-oriented milieus create asymmetry in nursing practice. If the trend continues, the ruling order of the objectified knowledge will continue to take precedent over the subjective knowledge; therefore, nursing will be more and more medicalized — unless nursing, as a profession with research, manages to demonstrate the importance of caring in the healing process. However, even this will not be sufficient, if society continues to attach more value to the curing

process, hence, undervalue the caring one. Indubitably nursing, as a profession, will still exist as long as people continue to be sick — but will be dependant on the transformation of the societal need for health care and the transformation of the political economy of different nations and jurisdictions. Similarly, nursing will transform with it. Tensions and contradictions within society that produce the struggle and the prevailing order are integral parts of all these processes. In one way or another, there will be some imposed choice. However, if as a profession, nurses accept that tensions and contradictions are an inherent part of transformation and understand how all these come into play, they will be more astute and strategically prepared for progressive transformation. This should not be the role of the leaders only. Wherever nurses are working, they can certainly make the difference.

CHAPTER SEVEN

SUMMARY AND CONCLUSION

7.1 Summary

This study has examined the political economy of nursing in four nations of the industrialized world. Specifically it has focused on the impacts of caring, professionalism and state policy on the profession and the everyday practice of nurses in Canada, France, England and Italy, under a policy reform strategy of cost containment. Herein it has argued that tensions and contradictions exist, not only in the institutional matrices in which this occupational group is embedded, but also in the relations of ruling that sustain the structure of control in nursing and provide at the same time nurses motive for resistance, change and transformation.

First, at the conceptual level this thesis set out to demonstrate that there were inherent contradictions built into the different assumptions of the concepts of caring and mainstream professionalism, as well as in the conditions in which both concepts were engendered. These at the same time have created tensions within which they make it difficult for individual nurses to practice fully their caring work. The findings revealed that there were internal contradictions inherent not only with the caring concept, but also with the concept of professionalism. On one hand, the study has shown that the notions of wholeness and subjectivity were internal to caring. However, the subjectivity which is inner to caring has contributed to some extent to its invisibility. On the

other hand, internal to professionalism, there was a presumption of speciality and objectivity. Unlike in the caring subjectivity, the objectivity of the concept of professionalism has made it more visible. These internal contradictions, in turn have created tensions within the profession; and for the nurses especially when they are trying to express or understand themselves through the lenses of abstraction. Conceptually caring was found to be a challenge for nurses wherever they were located. There was the perception that nurses think and write about caring being central to nursing practice and yet some believe that there was not sufficient attention paid explicitly to the knowledge and skills required to enact the caring practice.

The study has also shown, that there were linguistic and cultural difference with the caring concept which was viewed differently from country to country. Thus has created cross-national tensions among the participants in their interpretation and acceptance of the concept.

The problem was not so much with the concept of professionalism, which tends to be visible and more standardized with its endless list of attributes. Despite the fact that the trait tenet was contested, and displaced in social sciences it still prevails in the field. It was found that historically nursing occupational strategies and beliefs are themselves often based implicitly or explicitly on a trait tenet of what a profession is (Abbott and Wallace 1990; Porter 1992). Empirically the views of the nurses who participated in the interviews regardless of their jurisdictions or countries of origin accepted the functionalist orthodoxy as the

right path to follow. The taking for granted of this tenet as a generally accepted professional goal to pursue was unequivocal. However the study revealed also that the underpinning philosophy of professionalism was not at synch with the philosophy of caring. This explains the notion of the dual contradictions in nursing.

Second, at the theoretical level the thesis has shown that feminist theory has offered to some extent a way of exploring the inherent contradictions of nursing caring and professionalism issues within the context of health care institutional arrangement. It has also demonstrated that although the feminist theory of nursing subjectivity was very helpful in explaining the epistemic dilemma of nursing within the context of a specific institutional ruling order, yet relying only on this notion of the knowing subject was not sufficient to test the whole reality of nursing's collective knowledge/experience. Moreover, it was inadequate to assist in the development of strategies for progressive change. Thus the proposition to link feminist theory of nursing subjectivity focuses on relations of ruling with political economy. This link has been demonstrated to be a dynamic analytical tool in the understanding of the formation and transformation of the nursing professional caring work. Similarly, this tool has demonstrated its usefulness in the understanding of the way the practice of nursing was implicated in the historical construction of a self-sustaining social structure with all the inherent contradictions, tensions, struggles and changes that are part of these processes.

Third, at the operational level the thesis has demonstrated that the state policy initiatives have an effect on the profession, from the scope of practice, to the labour process. Furthermore, state power has influenced the everyday practice of nurses, starting from nurses' knowledge and action, to the professional practice and the context of professional activities. In this thesis, policy was viewed as an "objectified" set of procedures mediated by "text" which serves as apparatuses to operationalize and sustain the ruling order. This objectified set of procedures have a direct or indirect control over the individual nurses' practice, and they are developed at supranational, national, regional and institutional or organizational levels. However, there were variations in their development process and outcomes over time and space related to the political economy, the cultural and legal institutional arrangements of individual state and jurisdiction.

The analysis of the evidence gathered from the literature, government documents and the interviews have shown that caring and professionalism were actualized within the scope of nursing practice in a very complex institutional and legal relationship. All four countries and their respective jurisdictions have incorporated specific regulations for nurses' responsibilities, competences and duties in laws on nursing acts or their equivalents (Risk 1992; Canadian Nurses Association 1993; Salvage and Heijnen 1997). These policy initiatives are loaded with tensions and contradictions.

In fact, there have been lot of factors that contest whether or not nurses work

in their full scope of practice. However the study has retained two main sources of conflicts and contradictions because of their importance in the compartmentalization of caring. One important source of tensions was the power of employers to restrict or expand nursing scope of practice. Tensions and contradictions arise between the activities nurses were educated to perform and what they were actually authorized to perform in the work setting or institutions where they are employed. Policies developed at the institutional level have a lot to do with that. In most cases, these policies have contravened with what nurses are legally entitled to do depending on the interest of the institution. Their impacts have intended or unintended consequences on the individual nurses' standard of practice as stipulated by their regulatory bodies.

Paradoxically, the scope of practice of the individual nurses can be contracted or expanded by the employers despite the legislation. Therefore, the problem was not to some extent in the education or in the broader policy/regulations developed at supra national, national, sub-national levels, but in the power entrusted by the state to those semi-autonomous organizations. As a result, nurses are placed in a difficult position on either contraction or expansion circumstances. This situation has created for the nurses not only inner conflicts and a state of identity crisis but also external conflicts with their colleges or similar body with respect to the standards and codes of conduct. In addition, it has generated a problem of role confusion within the division of labour.

The other most important source of tensions and contradictions was the fact

that medicine has protected its monopoly over a particular area of practice and the power of the medical model is the common denominator regardless of its spatial location. The transfer of function to nurses has, for years, been a major aspect of nursing and medical procedure. Concerns relating to which medical acts can be delegated continued to be an issue for nursing associations in general (Risk 1992; Canadian Nurses Association 1993; Feroni and Kober 1995; Salvage and Heijnen 1997). However, there was uneven development in the scope of practice between country-to-country, and jurisdiction-to-jurisdiction. These variations in the outcomes were related not only to the cultural, legal and institutional arrangements, but also to the supply of doctors. Indubitably, these intricate ruling relations have a bearing on the labour process and the fragmentation of caring work.

The transformation of the nursing workforce was taking place also in a dense, complex institutional legal arrangement, where policy dictates basically every action in the work setting. This was also complicated by an intense political process deeply entrenched in the nation state and their regional government. Changes in the policy regime focusing on strategies to contain cost in the healthcare system, has certainly decreased the labour market, and consequently has affected the nursing labour processes and further partitioned nurses' work.

The investigation has shown that caring was already compartmentalized in specialty. The further fragmentation of caring work and class division are, to some extent, the effect of policy initiatives, which were more in line with the

concept of professionalism than caring. Policy reform based on cost-containment strategies has not only further eroded the profession but also has contributed to further exacerbate the compartmentalization of caring. There were enormous variations in nursing across all the countries and jurisdictions of this study. Regardless, the scope of nursing practice, a variety of issues hamper the effective use of nurses and with that also the caring practice. These factors include keeping out nurses from policy-making and decision-making at all levels of the healthcare system, shortages of well-trained nurses relative to needs, insufficient financial support and asymmetrical treatment of nurses, with its concomitant subordination to medicine. Continuing gender inequity further complicates the situation. Nursing everywhere is women's work and shares the characteristics of other female-dominated occupations: low pay, low status, poor working conditions, few prospects for promotion and poor education (Salvage 1997).

The study has also demonstrated that the everyday professional practice of individual nurses was located between two zones of tensions — the visible and the invisible. The first zone of tension was the consciousness gained by formal learning, the "know what" which constitutes the visible or "objectified knowledge" also closely associated with the notion of professionalism. The ruling order or ruling relations is embedded in the "objectified knowledge" and tends to subordinate other forms of knowledge. Its visibility was translated into texts, formatted on the medical model of a body part and organs, diseases, diagnostics and treatments much easier to objectify or standardize in taxonomy

or nomenclature.

The second zone of tension was the consciousness gained by experience, which constitutes the invisible, or subjective or tacit knowledge, also closely associated with the notion of caring. This type of knowledge or “know how” is very complex because it internalizes the explicit knowledge and connects it with intuition, as well as refined preconceive notions and theories to constitute a whole. The subject used the “know how” in the form of judgment to make sense of a case or a concrete situation for proper action. This rich source of knowledge cannot be found in texts — it is part of the subject decision-making process. Therefore, it is invisible to the external world. The wealth of nurses’ tacit knowledge is an invisible line item in hospital budgets. Consequently, the tacit knowledge was vulnerable to policy reform of cost-containment in the hospital sector.

Nonetheless, during the reform period of the last two decades, all jurisdictions have seen major positive transformations in nursing education with great variations and uneven development in time and space. These policy initiatives have brought, to some extent, an improvement to nursing formal knowledge, although not necessarily to everyone’s satisfaction and contradictions are inherent to the process. There are more baccalaureate-prepared nurses not only in nursing but also in other associated disciplines in the humanity arts or social sciences than there were 30-40 years ago, likewise more graduate nurses at Master’s and Doctoral levels. However, it took nursing

basically all its existence to convince society with some degree of success and failure that the profession requires higher education in order to practice.

The study has also demonstrated that when hospitals were restructuring or downsizing by merger or bed closures, the nursing staff was laid off with no consideration being given to the tacit knowledge, which was moving away with them — thus creating a precarious situation for the patient care. Invaluable tacit knowledge, resources, observational skills and strategies went with the nurses who leave. Those who remained were trying to cope with an ever-increasing patient acuity and workload, which jeopardizes their ability to practice fully and the big loser, in that kind of working environment, was the caring practice (more specifically the caring about) and ultimately the patient. The objective knowledge expressed mainly in curing taxonomy and standardized into tasks was taking precedence over the subjective knowledge, which finds its expression in the caring practice, thus creating asymmetry in nursing professional practice — individually and as a whole.

In the context of professional activities, the analysis of the data has also shown that the increase in the workload has a direct impact on caring in all the jurisdictions to the extent that the nurses who have participated in the study have perceived that nursing was lost. Because nursing is the reason why the profession exists, if nurses cannot fully actualize the caring work, then there was a sense of something missing. The leaders who shared this belief feel that caring was certainly not at the top of the list. They also perceived that during the '90s there

was a significant change in terms of the focus on getting the task done. Therefore, the speeding up of work was incredible and, still is, because the acuity and complexity of patients became greater, as did the complexity of the treatment and technology involved in the care process. In many cases, the patient load didn't change, nurses just have to go faster and faster to get the work done — "we kind of lost nursing."

In the jurisdictions under study there was evidence that the practice settings were disabling caring. Work settings, such as hospitals, provide nurses with locations to practice their profession. If the work environment is not conducive for nurses to do both — caring for and caring about — it disables, in this case, an important component of nursing. Moreover, the unhealthy work environments that have been created over the years are impacting on nurses' competence to activate their caring practice, and to work to their full potential within their role as a nurse. Work designed with a difficult workload to handle in a given day, in some areas, created an environment that was not nurse friendly. This was the case in all the jurisdictions.

Furthermore, the invisibility of caring has suffered from the bottom-line approach to care. Caring is part of the "know how" and belongs to the subject or individual nurses. Like the "know how", it is invisible in the line budget of hospitals — therefore, vulnerable to cost cutting. The bottom line approach and the concern to achieve a balanced hospital budget or keeping the healthcare system in the black — have moved away from the holistic framework of

delivering care. Nursing was seen as a drain or liability on the resource. Therefore, it's a loss for nurses because it's the caring, although invisible, that makes the difference in the quality of care. Caring was also outweighed by the priority of treatments. Hospital care delivery service is organized to reflect body part or disease and organ function — caring is adjunct to that. Therefore, caring was placed on a subordinate position or unequal footing.

Regardless of the jurisdictions, the concerns that caring was outweighed by the treatments were real. Everyone perceived that the problem was worse in his/her particular location. In the view of the participants, nurses have to constantly prioritize and caring was left behind not because individual nurses willingly ignore that component of their work, but because the circumstances force them to act differently. In a nutshell, there was an underlying agreement that caring was under siege whether or not they agree to the centrality of the concept in nursing. This perception was true regardless of the functions and jurisdictions, and regardless of how they interpret or translate the concept culturally in French or Italian into the meaning of nursing.

The perception is that there was a lack of value attached to caring. Caring cannot be explained without a context, whereas the treatments can be quantified in tasks. In a milieu of what was counted is what one can see — caring is for the most part lost under the heavy weight of the priority of the treatments. From this point of view, many of the participants feel that caring was undervalued in the healthcare sector.

The findings revealed also that the leaders who participated in this investigation were not so distant from the problems that nurses are confronting in the practice setting. On the contrary, being in leadership positions, they were leaving with their own contradictions and suffering when constrained in their functions to make contradictory decisions that the ruling orders impose on them. Sometimes in trying to make the best of a bad situation, it was inevitably translated into a bad situation in the practice setting.

7.2 Theoretical and Methodological Implications

This thesis has made the case for a feminist theory of nursing subjectivity in order to develop part of the theoretical framework. It borrowed from Dorothy Smith's practical approach to epistemology and her ruling relations tenet to interrogate empirically and theoretically the ways in which nurses/subjects apprehend their social world. In this the study set out to relocate nursing professionalism on a different standpoint than the traditional and critical approaches to professions. In addition, it has argued that there was a need to link the feminist theory with other approaches to stimulate the debate toward progressive action for change, which found its expression in the discourses of political economy from a historical materialist approach. Here, it was contended that a crucial key to understanding the complex field of nursing work and its object of transformation was to locate it within the context of the past and larger society in order to promote change. The study of the past has a particular

significance for 'historical materialism'. It helps reveal the specific nature of the present. This has required us to examine the development of nursing, the healthcare structures and the agencies but also the political economy in which they are embedded and the struggles around their development, likewise the pressure of changes and contradictions (Armstrong and Armstrong 1996; 2003).

The link between feminist theory and political economy has facilitated the process and improved the point made by Lane (1993:275) that one of the shortcomings of much comparative research has been the problem of developing an "appropriate comparative theory." This makes it difficult to encompass "cross-national differences and universal social trends" within a single framework (Lane, 1993:275). With this analytical tool, such as pressure of changes and contradictions, resistance and struggle, the study was able to account for variations in time and space of the impact of caring, professionalism and state policy in nursing reproduction and everyday practice of nurses in the selected countries and their respected jurisdictions. Thus, improving, to certain extent, the shortcomings identified above by Lane (1993).

At the comparative level, the study took the form of a cross-national study. The theoretical framework was utilized to analyze and compare: firstly, the nursing scope of practice and the labour process transformation under the conditions of cost-containment in this sector along with the impacts on the production and reproduction of nurses; and secondly, nurses' skills and knowledge, including the link and contradictions between knowledge and

actions. Countries and jurisdictions, such as France, Italy (Lombardi, Lazio, Apulia) and England, were compared under each theme more in breadth than in depth. It was expected to find, on one hand, a trend toward convergence in the intent of nurses' training and on the other hand, great variations and dissimilarities in the implementation process over time and space, related to the political economy of different countries/jurisdictions. Moreover, given the nature of hospital bureaucracy and the predominance of the medical model, it was assumed that there are, to some extent, similarities in the labour process (which is embedded in a gendered and classed hierarchy) that make the operationalization of nursing caring work problematic. The findings have validated both assumptions.

The investigation was processed throughout thematically. The countries were compared in breadth within this parameter with the view that approach provides a broader discussion on the topics, as do the conceptual and the methodological ramifications. However, there were some limitations with this approach. While the study makes it possible to understand a broad range of issues common to nurses in the selected countries and jurisdictions, and to account for variations over time and space, it did not focus in depth on a specific country to give a detailed account on each of them. Nevertheless, this fits well with the intent of the study, which aims to look at nursing issues with a broader and not fragmented scope for a better understanding of what is at stake. The suggestion for future research could be to focus in depth on a specific issue. For

example, compare the scope of nursing practice, or the labour process between different institutions within a jurisdiction; or between the different jurisdictions within a specific country. This can be done using the same framework for analysis. The thesis represents a significant departure from the way nursing issues was approached. The merit is in the demonstration that such analysis can be done.

7.3 Conclusion

To reiterate, contrary to ICN' policy statement:

Our mutual efforts assure that the nursing profession is highly valued everywhere, and appropriately utilised, recognised, rewarded, and represented throughout the health care system. Our highest reward is the certain knowledge that our work is shaping a future of healthy people in a healthy world (ICN, 1998:2).

One can only conclude that the reality seems completely different than what nurses have strived for and envisioned in their work. The problem of explaining the complexity of nursing to policy makers and the public persists. Because nursing is a profession that provides patients with so many different services, functions, and activities simultaneously, in their daily practice nurses were often doing more than one thing at once. As seen in the evidence, unlike medical knowledge, nursing knowledge is relatively permeable. It has a distinct core but also shares knowledge with the expert medical, diagnostic, and other specialty domains of many occupations.

Society is ever changing. Changes in the power structure, tensions and

contradictions within society, that produce struggles and resistance to the prevailing order are integral to political economy. Similarly the actualization of caring and professionalism were taking place in a very complex institutional and legal relationship. Over the last thirty years, a lot of changes have happened in terms of expansion and contraction of nursing scope of practice in all jurisdictions. For example, in Ontario there were, not only more clinical nurse specialists, but also the nurse practitioners have re-appeared on the scene. In Quebec changes in the legislation have permitted nurses to act as surgeons' assistants. In England there are the nurse consultants. In France the nurse liberal practice was developed. Italy is moving in the same directions with more nurse specialists. Paradoxically, these changes were happening as part of keeping the cost of health care down. At the same time, nurses responsible for the general care in hospitals are seeing their scope of practice circumscribed depending where they are working. In their struggle for recognition, nursing as a caring occupational group has been lured under imposed circumstances to follow the contradictory path of professionalism to improve their status. This move has proved to be very difficult because historically there were inherent contradictions between what nursing and medicine valued in their approach to patient or client care.

In embracing professionalism as a path for recognition, nursing has started on an unequal footing or asymmetrical circumstances. That legacy still prevails not only in the institutional matrices in which this caring profession is

embedded, but also in the relations of ruling that sustain the structure of control in nursing. Nevertheless, they have provided at the same time nurses' motive for resistance, changes and transformation. There was evidence of tensions and contradictions in the operationalization of both objective and subjective knowledges of nursing mimicking the conceptual ramifications of the concepts of professionalism and caring.

These concepts carried with them their load of tensions and contradictions not only in nursing practice settings but also in the educational settings. There was a common goal to build a caring profession. One of the main objectives was to improve nursing knowledge through higher education. It turns out to be a difficult path with endless struggle — it takes more than a century to achieve this goal with some degree of successes and failures. In certain cases, the success was also a failure. While the different jurisdictions have the same purpose, there are great variations in the milestones in terms of time and outcomes.

There was no doubt that policy initiatives in nursing education in the 1990s on one hand have enabled nurses to some extent in the explicit knowledge and in the expansion of the scope of practice. Moreover, the goal of university as entry-to practice has materialized for some or is in the process for others — and, not even in the horizon in France at the time of this investigation. Nurses are more knowledgeable than ever and the profession has accumulated a vast reservoir of explicit and tacit knowledge. However, the impediments outweigh by far the so-called enablers. Nurses at bedside are more frustrated now than

ever before. The same policy initiatives and their associated ruling order are holding them back in the practice setting preventing nurses to work to their full potential. Nursing leaders who participated in the interviews are clearly dissatisfied with the current situation. Regardless of their position, they candidly expressed their frustration with what was taking place in the practice setting. One gets a sense that they are also overwhelmed, because they are constantly reacting to make the best out of a bad situation. The task-oriented milieus have created asymmetry in nursing practice.

In the final analysis, one can contend that given the relevance of state policy in every aspect of the nursing professional caring work, it is crucial for nurses not only to be involved in the political process but also to understand the policy process and be engaged at all levels if they really want to move forward. Health care in every country is a political process. It is decisions about the allocation of scarce resources and whenever you are in that kind of position it becomes a political matter as well as economic. However, the health political process can only find its operationalization in the policy process. Considering nurses' deep embedment in the healthcare system, they cannot afford to ignore how these relations work and how this affects the profession. At least this is an evident issue identified as one, which will necessitate further study in terms of policy research agenda for nurses. Overlooking these relationships would result in nurses being left out of the political and policy processes, which will in turn impact the profession as a whole and nursing caring practice.

Appendix One: Methodology

This work employs a variety of methodological procedures to gather evidence and establish relations. In this appendix I briefly report on the research process, not only to make clear the methods used in this study, but also to discuss some of the implications. It includes discussion on the units of analysis; the sampling procedure and sample; how the data are analyzed; the study 's limitations and ethical considerations.

First of all, when I started the Ph.D. program, I had already the topic that I wanted to investigate. I seized the opportunity of the doctoral seminar to write a preliminary proposal as part of the course requirement. This was my roadmap to fill the knowledge gap at both theoretical and methodological levels. The study started with an overview chapter, which set the stage for the comparative study, with the view that it was important to understand the macro policy process of health care. Similarly, I examined the reforms that were taking place in order to understand the relevance of state policy in nursing (discussed in Chapter Five). It was judged also important to know the different health care systems and their method of financing in order to locate nursing as well. This chapter was part of a previous work done for one of the comprehensive exams as a context to assist in the mapping of macro structural issues that have a direct or indirect impact on nursing caring and professionalism. It was also useful to identify if there are

similar problems, convergence and divergence in selected OECD countries: European Union, Canada, U.S.

In retrospect this overview chapter done prior to writing the final proposal was very useful in terms of not only the selection of the units of analysis but also as a device to help decide strategically what was feasible or not. Moreover having a priori some knowledge about the health care systems, their organizations, financing and delivery and terminology used in each countries put one on a leading edge in terms of knowing what kind of reforms were taking place, and in addition what gaps need to be fill and how that affect nurses in Canada (as the departure point), England, France and Italy. My actual nursing experience and facility to speak the three languages were also a great asset. Therefore all of these facilitated the process and allowed me to concentrate strategically on other sources of evidence, which were not available in Canada, at the same time, validated what was already collected.

Units of Analysis

Canada was the departure point; I have opted for the Provinces of Ontario and Quebec where a great number of nurses is located, this represents a cross-jurisdictional section of the French and English Canada. Although nursing in Quebec and other provinces in Canada are to some extent influenced by the U.S. there are cultural and linguistic differences between the two jurisdictions. I also selected France, (although divided into departments, the decision making for

health care is more centralized); Italy (Lombardy, Lazio and Puglia, a cross regional section of the northern, central and southern part); and the United Kingdom (English Region) as cases for analysis and comparison. All of these countries have adopted the Nightingale model of nursing originated in England. It was of interest to see how it was applied in practice, and the transformation over time and space. The selection of France was related to the historical link with the French nursing order that funded the first Canadian hospital, in Quebec City, in 1639 (Baines, 1998). Nurses from France tend to look at Quebec for innovation. Moreover, the four cases are chosen because of personal interest and particular intellectual attraction. There is no comparative study in nursing which selects these particular countries and jurisdictions as units of analysis. The choice was also dictated by the familiarity with the three languages (French, English and Italian). More importantly, because I believe that the study has the potential to bring a broader understanding on nursing issues that I considered very complex, and countries can learn from each other.

At the time of the proposal for this study, a select sample of documents on health care policy issues and regulations related to nursing caring and professionalism between 1970's and late 1990's in these four countries was analyzed. The rationale for this selection was threefold: First, it did provide elements for a feminist political economy analysis of the impact of caring, professionalism, health care agencies and the state in the reproduction of nursing. Second, during this period nations were faced with increasing economic

problems involving the oil price shock of the early 1970s, increasing international competition and stagflation. Virtually every country in the Organization for Economic Cooperation and Development (those in Europe, North America, and the south Pacific) has proposed or launched major reforms of its health care system. Concerns over cost escalation are said to be central to motivating all these reforms, even though these countries have very different levels of expenditure on health care (this constituted the topic of Chapter Two). It was assumed that the selection of samples at a period of time marked off by three decades would make it possible to look at changes in the labour process, the scope or content of care, manpower and implications for nurses and related issues in Canada, France, England and Italy as a critical test to produce relevant evidence, in time scope and space.

However, I discovered that I had to go beyond that. The issues of nursing caring and professionalism are part of a remote and a recent history. From a historical materialism perspective the past really matters in nursing, it helps reveal the specific nature of the present. To make it more manageable, I divided into two eras, the Nightingale and the post war period, mainly World War II. This period coincided with the expansion of the hospital sector worldwide and the progress in science and technology. Also throughout the twentieth century, there were different changes that were taking place in nursing, from regulation and education to the scope of practice and the labour process in the different

countries and jurisdictions. Moreover the uneven development required a wider span to account for variations in time and space.

Sampling Procedure and Sample

The study is based mainly on primary and secondary source documents. If the documents do not provide sufficient information, semi-structured interviews were conducted with key informants who are in the forefront of the policy formulation and implementation to fill the gap. There are four main sources:

- 1) The schools of nursing archives are very important because it was assumed that nursing schools perpetuate the caring culture and the historical values of this occupation in their curriculum. Their research and ideological boundary setting bring some insight on the socialization of nurses in these countries (for example in Canada I used University of Ottawa and Université du Quebec and Montreal for better accessibility, and University of Toronto on-line; In Italy La Sapienza University degli Studi (Rome); University degli Studi (Milan). In addition, they produce or supply nurses for the health care labour market and adjust the number according to demand. Moreover these documents are accessible and are identified via CD-ROM or On-line searches on MEDLINE, CINAHL, HSTAR and governments and institution web site. For the purpose of this dissertation a wide range of interdisciplinary literature was found in Canada at the University of Ottawa, Carleton University, or inter-library loan, Canadian Institute for Scientific and Technological Information (CISTI) and Health and

Welfare and the European Union library; in France, Assistance Publique Library of Pitié Salpêtrière (Paris), the library François Mitterand (Paris), OECD (Paris); In Geneva, the International Labour Organization (ILO) library. Likewise, some access to free on-line material is provided by the International Council of Nursing (ICN) and National Nursing Associations and regulatory bodies in France, England Italy and Canada. These documents provide valuable evidence on nursing knowledge and skills, level of preparation, changes in the curriculum as well as exogenous factors that motivates the changes. The argument was that convergence toward higher education in nursing training seems to be responding both to the developing dynamics of science and technology, on the one hand, and to a variety of exogenous factors associated with resource levels, patterns of morbidity, demography, or other.

2) Government legislation, policy documents and reports related to the health care sector were crucial to understand the role and the impact of state interventions. They give information on the health care systems and assumptions, the social, political and economical context behind a policy and what are the implications for health care agency structures. In addition evidence is gathered on the internal characteristics of health care agencies (nurses' work places) on how external forces, structural influences such as the business cycle or state policy, condition the entire labour process.

3) Newspapers clips and newsletters from nurses' unions and organizational correspondence used in contrast with hospitals management

journals and documents help establish the link and contradictions between knowledge and actions. Interestingly, unions also have their own contradictions and can be distant from the actual labour process. These documents provide evidence of transformation in the labour process, on how the resistance and struggles alter the organization, social interactions and nurses themselves. It was assumed that under the conditions of cost containment there is a serious and growing divergence between how nurses want to practice nursing, based on their share values, norms and knowledge, how they feel the care should be delivered, and how the hospital management and the state see nursing deliver the care. This implies that if there are labour process changes in the hospital, then there will be a change in the nurses themselves in both their attitudes and their relationship to work.

4) Journals and related research on nursing issues are also used with the above documents. Through a preliminary content analysis of these documents, I identified individuals who were able to clarify gaps or discrepancies in the documentary data. These people were able to provide in depth perspectives on what was concealed in the documents. I also found other people who were recommended (by snow balling effect). Initial contact was established by phone followed by E-mail in the respective language of all the informants. In Europe the phone contact and fax was more effective in terms of speed to set an appointment for the interviews.

5) Semi-structured interviews were conducted with the: Deans/Directors and Professors of schools of nursing; hospital's Nursing Directors; Ministries of Health Chief Nursing Officers; key leaders of the International Council of Nurses; Professional Leaders of National Nursing Associations, Colleges and Unions; and where accessible hospitals CEOs or delegates. The rationale for choosing were two-fold. First, a lot has been documented about the changes and the problems of Registered Nurses working in hospital settings as a consequence of policy reform under the constraint of cost containment in the health care sector. It was important to have the views of the nurses in the leadership who make decisions in terms of education/knowledge, regulatory bodies, professionals associations, management and unions which have a direct impact on the nurses at bedside. I wanted to see how they are experiencing the current situation themselves and with the RNs, how they are living with the contradictions although from different line of work and perspectives. Second, there was the time factor and limited resources for a PhD project. Strategic decision in the data collection had to take place. It was much easier to contact the leaders than doing interviews or observe RNs in their work setting, because this would entail not only to obtain Ethics clearance in term of the different hospital Ethic boards if there is no reciprocity with the Carleton University, but also far more financial cost associated with this comparative study of four countries: Canada (2 jurisdictions); France; Italy (3 jurisdictions) and England.

The Semi-structured interviews were focused on the following themes:

caring, professionalism, training/certification (skill and knowledge), the labour process and the policy process. The purpose was to examine the experiences and views of key informants who would accept voluntarily to participate in the interview process. This has the advantage of filling the gaps in the documents, as well as to look at the impacts. The guideline was not provided in advance; because I wanted people to talk candidly about the issues regardless of their function (see guideline annexed with the appendix). It is understood that the interviews have provided flexibility for follow-up on the subjects' answers and seeks new information about and new angles on the topic. Questions related to: the difficulties encountered in establishing credibility for activities around these themes, as well as their research activities; their perceptions of the operationalization of caring and professionalism in the practice setting; the factors that promote or hinder nurses practice; and their perceptions on the evident change and transformation in the nursing profession and potential effects on patients and nurses; what kind of change they would like to see or propose.

The study includes past and present representatives and informants from nursing organizations and policy makers wherever it was possible. All the informants who were contacted accepted to take part in the process. Thirty eight interviews were conducted: Seventeen in Canada (Quebec and Ontario); twelve in Italy; two in Geneva; four in France; three in England. Most of the interviews were done individually with one by phone and a focus group of five in Southern Italy. The interviews were processed in the language of the participants (English,

French and Italian) to facilitate free expression. The guideline was not provided in advance to the participants, because I wanted people to speak candidly about the issue regardless of their function. Some participants even asked to decide after the interview, whether or not they wish to remain anonymous, because their comments can be in contradiction with what their organizations are promoting or wanting people to believe. This process was effectuated during the months of May 2002 till early December 2002. Three months were spent in Europe from September to December, crossing back and forth from Geneva, Milan, Rome, Paris, London and Foggia. In Europe, the Chief Executive Officer of the International Council of Nurses facilitated the initial contact. All interviews were taped and verbatim transcribed for analysis. The French and Italian interviews were translated and transcribed directly in English by myself. The key for success was good plan of action, time management, and flexibility. This was also facilitated because the participants were interested in the study.

2.4 Data Analysis

One disadvantage to this complex research process was the difficulty in deciding which issues to prioritize. With some useful advice from my committee members I have developed a framework for the study, and organized the data by chapter. The analysis takes several forms and involved an iterative process of moving back and forth between the information obtained in the documents and in the empirical material from the interviews. This also entailed an examination of the

data not only at the conceptual and theoretical level, but also to look at the methodological implications. The data were organized under three broad areas. One of these was related to major aspects of the concepts of caring and the theoretical ramifications. The second was related to different policy initiatives and their effects actual, intended and unintended. The third was around nursing life (skills and knowledge), the context of professional activities, and more directly professional matters including the scope of practice or content of care, manpower, the labour process and related issues. This helps to identify gaps for both nurses and other health care providers directly involved in the labour transformation process. Documentary and interview data were coded or categorized according to these broad headings and comparative material was collated. Following this a chronology of events was developed as well as an account of the transformations and the implications.

Limitations

Criteria for reporting national statistics vary substantially, and small changes in definition can have large analytic implications (Klein 1991). As noted above the data were gathered from primary official sources and complemented by unofficial findings via interviews and others. While the data are dependable as much as possible, it is impractical to warrant that they are totally accurate for several reasons. These include limitations in finances and infrastructures involve

in data collection, there is also the time element if one wants to bring the PhD project to completion. Furthermore, terminology differs widely, especially when dealing with three different languages (English, French and Italian). One need not only to stay very close to the text to reflect on its meaning, but also to look at the functions behind the terminology. For instance, the term for the nursing regulatory bodies in Ontario is called College of Nurses of Ontario, in UK there is a Royal College of Nursing, which has a different function, the equivalent for Ontario regulatory body is The Nursing and Midwifery Council. In Italy Colleggio, bears to some extent the same meaning that exists in Ontario. But the nurses are lobbying to be called “Ordine”, it is perceived to be different in term of prestige, because in Italy, doctor’s regulatory body is called Ordine, which bears the same meaning as the College of Physicians and Surgeons in Ontario. The same problem of translation can be illustrated in the case of Quebec, where the terminology “L’ Ordre des infirmiers and infirmières du Quebec” is used as parallel to College, when one translates the word “Ordre” into Italian it bears the meaning of Ordine.

Comparisons are difficult to make and differences difficult to assess when viewed out of context. Another issue is the comparability of the OECD statistics. Therefore it is important to acknowledge how the data were collected and the purpose. One also needs to go beyond the written reports and texts to the empirical interviews and other primary research and confront them back and forth. It is important to know about another country in order to see the nuances

and meaningfully interpret differences between nurses' social relationships to labour process, as well as trying to understand the expectations of nurses from the state. To make the matter more complicated, the contemporary social order and the health systems are in continuous evolution in all the countries under investigation and beyond, the data in some files may very well change by the time this project come to an end, although all the efforts were made to bring the latest information.

Further, any attempt to describe the caring work, functions, education and knowledge, organization and administration et cetera, of more than 1 million nurses between Canada, England, France and Italy in a political economy as historically, culturally, geographically diverse as the European Community and Canada, must have limitations and pitfalls. All of these nuances contribute to difficulty of cross-national study. Therefore, this work should be read with all these difficulties in mind. Nevertheless, the data should be accepted as rational for the intentions for which they were gathered; and their magnitude and quality are in general adequately strong and responsive, for the purposes of the analysis despite some gaps. After all, it is the challenges which makes the work gratifying.

Ethical Considerations

Consent was obtained from the key informants who in certain case are identified in the study by their position and organization. The questions for the interview are in the public domain they are not intimate in nature. The actual interviews took place after all procedures had received ethics clearance from the Carleton University Ethics Committee.

Guidelines for Conducting Interview

The questions will focus on:

- I. Nurses education and regulation and licensing body
- II. The labour process and the actualization of caring in hospitals setting

First, general background information about you

1. Kind of position/relationship with nursing?
2. Where, what kind of organization, jurisdiction/state?
3. For how long?

Second, What are your views on nurses' professionalism and caring work?

4. Definition of nursing?
5. Role of caring in nursing?
6. Definition of professionalism?
7. Vision of nursing professionalism?
8. Models of nursing professionalism, promotion or implementation?
9. How is caring mediated or contested by other factors under the condition of health care cost containment?
10. What are the implications for the labour division?
11. Are there changes in the labour process?
12. Others?

Third, What are your views on nurses' training on the one hand and the labour process on the other?

13. Processes for changing curriculum?
14. Triggers of changes in the curriculum?
15. Value place on caring versus curing?

16. Trends toward standardization/convergence in nursing training?
17. Similarities and dissimilarities?
18. Links and contradictions between knowledge and actions?
19. Factors that promote or hinder hospital nurses practices?
20. Others?

Fourth, in your point of view what are the effects of the policy initiatives on nursing professional practice?

21. Nursing knowledge and skills?
22. Nurses working environment/context of professional activities?
23. The theory and practice gap?
24. What are the potential effects on patients and nurses?
25. Research activities?
26. What kind of changes that you would like to see or propose?

Fifth, in your opinion what are the effects of the policy initiatives on the nursing profession in general?

27. The policy process?
28. The scope of nursing practice?
29. Licensing and Regulating body with respect to certification?
30. Hospital regulations?
31. Nursing professional associations and regulatory bodies?
32. What are the changes and transformations in the nursing profession and in the division of labour?
33. What kind of changes that you would like to see or propose?

Finally, are there any questions that you would like to ask that I have omitted?

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