‘Nursing Hours’ or ‘Nursing’ Hours: a discourse analysis

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Sydney Nursing School
The University of Sydney

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<th>Full Title</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACCC</td>
<td>Australian Competition and Consumer Commission</td>
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<tr>
<td>ACHS</td>
<td>Australian Council of Healthcare Standards</td>
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<tr>
<td>AHC</td>
<td>After-Hours Coordinator</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AIRC</td>
<td>Australian Industrial Relations Commission</td>
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<tr>
<td>ALOS</td>
<td>Average length of stay</td>
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<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<tr>
<td>ANCI</td>
<td>Australian Nursing Council Incorporated</td>
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<tr>
<td>ANF</td>
<td>Australian Nursing Federation</td>
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<tr>
<td>ANMC</td>
<td>Australian Nursing and Midwifery Council</td>
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<tr>
<td>ANMAC</td>
<td>Australian Nursing and Midwifery Accreditation Council</td>
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<tr>
<td>APHA</td>
<td>Australian Private Hospitals Association</td>
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<tr>
<td>AUSTL</td>
<td>Australia</td>
</tr>
<tr>
<td>BSL</td>
<td>Blood Sugar Level</td>
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<tr>
<td>CCU</td>
<td>Critical Care Unit</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CN</td>
<td>Clinical Nurse</td>
</tr>
<tr>
<td>CPM</td>
<td>Continuous Passive Movement</td>
</tr>
<tr>
<td>CTH</td>
<td>Commonwealth of Australia</td>
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<tr>
<td>CVA</td>
<td>Cerebrovascular accident or ‘stroke’</td>
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<tr>
<td>DDA</td>
<td>Dangerous Drugs of Addiction</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>DoHA</td>
<td>Australian Government Department of Health and Ageing</td>
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<tr>
<td>DRG</td>
<td>Diagnosis Related Group</td>
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<td>EBA</td>
<td>Enterprise Bargaining Agreement</td>
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<td>EN</td>
<td>Enrolled Nurse</td>
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<td>EQuIP</td>
<td>Evaluation and Quality Improvement Program</td>
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<tr>
<td>FTE</td>
<td>Full-time equivalent</td>
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<td>FWA</td>
<td>Fair Work Australia</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>HTU</td>
<td>High Therapy Unit</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<tr>
<td>ICD-10-AM</td>
<td>International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification</td>
</tr>
<tr>
<td>ICN</td>
<td>International Council of Nurses</td>
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<tr>
<td>ICNP®</td>
<td>International Classification Nursing Practice</td>
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<tr>
<td>IFC</td>
<td>Informed financial consent</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<td>ISO</td>
<td>International Standards Organisation</td>
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<tr>
<td>LHC</td>
<td>Lifetime Health Cover</td>
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<tr>
<td>LW</td>
<td>Labour Ward</td>
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<tr>
<td>NANDA</td>
<td>North American Nursing Diagnosis Association</td>
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<tr>
<td>NHPPD</td>
<td>Nursing hours per patient day</td>
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<tr>
<td>NIC</td>
<td>Nursing Interventions Classification</td>
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<tr>
<td>NOC</td>
<td>Nursing Outcomes Classification</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>NUM</td>
<td>Nurse Unit Manager</td>
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<tr>
<td>OBS</td>
<td>Observations</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PBS</td>
<td>Pharmaceuticals Benefits Scheme</td>
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<tr>
<td>PHIAC</td>
<td>Private Health Insurance Administration Council</td>
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<tr>
<td>PHIO</td>
<td>Private Health Industry Ombudsman</td>
</tr>
<tr>
<td>PHIIS</td>
<td>Private Health Insurance Incentives Scheme</td>
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<tr>
<td>RCN</td>
<td>Royal College of Nursing</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SaO₂</td>
<td>Arterial Oxygen Saturation Level</td>
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<tr>
<td>SIS</td>
<td>Standard Information Statements</td>
</tr>
<tr>
<td>TL</td>
<td>Team Leader</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>USA</td>
<td>United States of America</td>
</tr>
<tr>
<td>WHO-FIC</td>
<td>World Health Organization Family of International Classifications</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<tr>
<td><strong>GLOSSARY</strong></td>
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<td>-----------------------------------------------</td>
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<tr>
<td><strong>Accreditation</strong></td>
<td>The status obtained by an organisation after a successful third party external evaluation by a recognised body to assess whether an organisation meets applicable predetermined and published standards (ACHS, 2011).</td>
</tr>
<tr>
<td><strong>Acute care hospitals</strong></td>
<td>Public and private hospitals that provide services mainly to admitted patients with acute conditions. The average length of stay is usually short (AIHW, 2010a, p. 504).</td>
</tr>
<tr>
<td><strong>Admitted patient</strong></td>
<td>A patient who undergoes a hospital’s formal admission process.</td>
</tr>
<tr>
<td><strong>Allied health professional</strong></td>
<td>Professionals working in dietetics and nutrition, hospital pharmacy, occupational therapy, orthoptics, orthotics and prosthetics, physiotherapy, podiatry, radiology, speech pathology and social work (AIHW, 2010a, p. 504).</td>
</tr>
<tr>
<td><strong>Australian Industrial Relations Commission (AIRC)</strong></td>
<td>Dating back to 1904 the AIRC was Australia’s independent, national industrial tribunal. Its functions included assisting employer and employees in resolving industrial disputes, handling certain termination of employment claims and dealing with applications about industrial action. As of 1 July 2009, <em>Fair Work Australia</em> became the new national workplace relations tribunal and assumed AIRC functions (FWA, 2011a).</td>
</tr>
<tr>
<td><strong>Available beds</strong></td>
<td>Beds immediately available for use by admitted patients.</td>
</tr>
</tbody>
</table>
Average length of stay (ALOS)

The average of the length of stay for admitted patient episodes. (AIHW, 2010a, p. 505).

Award

An award is an enforceable document containing minimum terms and conditions of employment. Awards prescribe the minimum enforceable wage rate and employment conditions. Generally, an award applies to employees in a particular industry or occupation and is used as the benchmark for assessing enterprise agreements before approval. Fair Work Australia has responsibility for making and varying awards in the national workplace relations system (FWA, 2011a).

Benchmark

A standard or point of reference for measuring quality or performance (AIHW, 2010a, p. 506).

Benchmarking

A continuous process of measuring quality or performance against the highest standards of a specific indicator (AIHW, 2010a, p. 506).

Casemix

The range and types of patients (the mix of cases) treated by a hospital or other health service. This provides a way of describing and comparing hospitals and other services for planning and managing healthcare. Casemix classifications put patients into manageable numbers of groups with similar conditions that use similar healthcare resources, so that the activity and cost-efficiency of different hospitals can be compared (AIHW, 2010a, p. 507).

Clinical Nurse

Is a registered nurse and/or midwife with advanced nursing skills, usually with a minimum of 3 years post-
registration experience. The role is predominantly clinical in nature.

Diagnosis related groups (DRGs)
A widely used type of casemix classification system. In Australian acute hospitals, AR-DRGs (Australian Refined Diagnosis Related Groups) classify admissions into groups with similar clinical conditions (related diagnoses) and similar resource usage. This allows the activity and performance of hospitals to be compared on a common basis (AIHW, 2010a).

Enrolled nurse
Second level nurses that provide nursing care under the direct or indirect supervision of a registered nurse. They must hold enrolled nursing registration with the national registration board.

Enterprise bargaining
A process of negotiation that occurs between an employer and their employees (or their union) in an organisation. The bargaining process and outcome may occur through guidelines established by Fair Work Australia and/or independently from this. Unions are not necessarily involved as employee representatives in negotiations.

Free-standing day hospital facility
A private hospital where only minor operations and other procedures not requiring overnight stay are performed. The facility does not form part of any private hospital providing overnight care (AIHW, 2010a, p. 511).

Full-time equivalent (FTE) workforce or workload
A standard measure of the size of the workforce that takes into account both the number of workers and the hours that each works (AIHW, 2010a, p. 511).
Functional flexibility

Relates to the nature and degree of flexibility in the utilisation of labour in an enterprise. It refers to managements’ capacity to adjust the work practices and skills of its employees (Sutcliffe & Callus, 1994).

Gap

The difference between the total costs incurred by individuals for healthcare services over and above any refund from Medicare and private health fund and the cost of treatment. It is also referred to as ‘out-of-pocket costs’ (AIHW, 2010a).

Hospital Cover

A form of health insurance that covers the costs of hospital treatment, such as accommodation or medical fees for in-hospital services.

Informed financial consent (IFC)

Provision of cost information to patients, including notification of likely out-of-pocket expenses (gaps), by all relevant service providers, preferably in writing, prior to admission to hospital or treatment (DoHA, 2011b)

Intensification

Heightened demands by employers for workers to produce more in a given period than has traditionally been the case (Sutcliffe & Callus, 1994).

International Classification of Diseases

International Statistical Classification of Diseases and Related Health Problems. The World Health Organization’s internationally accepted classification of death and disease. (WHO, 2007). The 10th Revision (ICD-10) is currently in use. ICD-10-AM is the Australian modification of ICD-10, used for diagnoses and procedures recorded for patients admitted to hospitals (AIHW, 2010a, p. 513).

Glossary
<table>
<thead>
<tr>
<th>Glossary</th>
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<tbody>
<tr>
<td><strong>International Classification for Nursing Practice (ICNP)®</strong></td>
</tr>
<tr>
<td>The international nursing taxonomy developed by the International Council of Nurses.</td>
</tr>
<tr>
<td><strong>Lifetime Health Cover</strong></td>
</tr>
<tr>
<td>An Australian Government initiative under which people who take out hospital cover with a registered health fund earlier in life pay lower premiums than those joining at an older age.</td>
</tr>
<tr>
<td><strong>Length of stay</strong></td>
</tr>
<tr>
<td>Duration of hospital stay, calculated by subtracting the date the patient is admitted from the day of separation. All leave days, including the day the patient went on leave, are excluded. A same-day patient is allocated a length of stay of one day (AIHW, 2010a).</td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
</tr>
<tr>
<td>Australia’s national healthcare system, introduced in 1984. It subsidises the cost of medical services for all Australians. It is financed through income taxation revenue, which includes a Medicare Levy of 1.5 percent based on a person’s taxable income.</td>
</tr>
<tr>
<td><strong>Medicare levy surcharge</strong></td>
</tr>
<tr>
<td>An additional surcharge on the taxable income of high income earners who are eligible for Medicare and who do not have an appropriate level of hospital insurance with a registered health fund.</td>
</tr>
<tr>
<td><strong>No gap/known gap</strong></td>
</tr>
<tr>
<td>Arrangements by which a health fund covers the entire gap, or requires its members to contribute towards the gap but informs members in advance of the amount that they will need to pay.</td>
</tr>
<tr>
<td><strong>Numerical flexibility</strong></td>
</tr>
<tr>
<td>Relates to the ability of the enterprise to regulate the number of workers it requires dependent upon changes in</td>
</tr>
</tbody>
</table>
the level of demand for products or services (Sutcliffe & Callus, 1994).

**North American Nursing Diagnosis Association (NANDA) taxonomy**
Developed to refine and promote terminology that reflects nurses’ clinical judgements or diagnosis.

**Nursing Intervention Classification (NIC)**
A standardised classification of interventions that nurses perform. Developed by the Center for Nursing Classification and Clinical Effectiveness at the University of Iowa, it is used in the development of nursing standards, care plans, competency evaluation, and nursing information systems.

**Nursing Outcome Classification (NOC) is**
A standardised classification of patient/client outcomes developed to evaluate the effects of nursing interventions.

**Patient days**
The number of full or partial days of stay for patients who were admitted for an episode of care and who underwent separation during the reporting period. A patient who is admitted and separated on the same day is allocated one patient day (AIHW, 2010a, p. 517).

**Pharmaceutical Benefits Scheme (PBS)**
A national, government-funded scheme that subsidises the cost of a wide range of pharmaceutical drugs for all Australians to help them afford standard medications (AIHW, 2010a, p. 517).

**Private hospital**
A privately owned and operated institution, where patients are treated by a doctor of their own choice. Patients are charged fees for accommodation and other
services provided by the hospital and relevant medical and allied health practitioners. This also includes private *free-standing day hospital facilities* (AIHW, 2010a, p. 518).

**Private patient**
A person admitted to a private hospital, or admitted to a public hospital who decides to choose the doctor(s) who will treat them and/or to have private ward accommodation. They will be charged for medical services and accommodation (AIHW, 2010a, p. 519).

**Productivity**
A measure of the output (services produced) per unit of input (labour). It is used to measure the efficiency with which services are produced. There is an emphasis on productivity as a target of industrial relations negotiations (Sutcliffe & Callus, 1994).

**Public hospital**
A hospital controlled by a state or territory health authority. In Australia public hospitals offer free diagnostic services, treatment, care and accommodation to all that require them (AIHW, 2010a, p. 519).

**Public patient**
A patient admitted to a public hospital who has agreed to be treated by a doctor(s) of the hospital’s choice and to accept shared ward accommodation. The patient is not charged (AIHW, 2010a, p. 519).

**Quality**
Relates to the characteristics by which clients or stakeholders judge an organisation, product or service. Assessment of quality involves use of information gathered from interested parties to identify the difference between users’ expectations and experiences.

**Risk management**
Designing and implementing a program of activities to identify and avoid or minimise risks to patients,
employees, visitors and the institution; to minimise financial losses (including legal liability) that might arise as a result and to transfer risk to others through payment of premiums (insurance).

**Registered Nurse**
Includes persons with a minimum three-year training certificate and nurses holding post-graduate qualifications. They must be registered with the state/territory registration board (AIHW, 2010c, p.2698).

**Separation**
The formal process by which a hospital records the completion of an episode of treatment and/or care for an admitted patient (AIHW, 2010a, p. 520).
CANDIDATE STATEMENT

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed: 

Date:
ACKNOWLEDGEMENTS

My thanks go to the many people whose encouragement, friendship and intellectual generosity have made this thesis possible. My grateful thanks go to:

The nurses who participated in the study and to the hospital executive for bravely welcoming me into their world at a time of significant business sensitivity;

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Julie Henderson for reading and commenting on drafts of chapters;

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The PhD group for your invaluable support and kind hospitality;

To my family: my mother Angela; Dario, Antoinette, Danielle, Nicholas; and my late father Marco, who would have been proud.

Finally, thank you to Holly, Roland and Suu Kyi.
ABSTRACT

This thesis is about the business of nursing; the making and remaking of nurses’ work in the context of private healthcare. Nurses in Australia, as in other countries around the world, have experienced considerable workplace changes over the past 15 years due to governments and public and private healthcare organisations seeking to reform healthcare service delivery. These reforms have significantly changed not only how private hospitals manage care, but the nursing role in practice.

This ethnographic study explores the impact of these reforms on nurses’ work in one Australian acute care private hospital. It critically examines nurses’ organising practices in light of the workload measurement method used to staff the hospital, unit and ward with minimum staffing. Using Foucault’s (1972) archaeological approach and drawing upon governmentality theory as the analytical framework, I will argue that within the political rationality of neo-liberalism, ‘care’ in nursing is a technology of governance. As such, nurses’ ‘care’ transforms contemporary healthcare policy, in particular policy pertaining to private healthcare, from a macro to the micro level of everyday practice. Care is the means of producing a ‘business savvy’ nurse; someone who is not only an expert clinician with transferable skills but who knows the private health market and is able to work within a competitive business environment.

Analysis reveals the contradictions and tensions that exist for nurses between the clinical and economic foci, and the economics and business of health as the nursing role is played out within the organisational imperatives of their work.
This study illustrates the shifting boundaries of nurses’ work in relation to the ascendancy of business concerns in healthcare delivery. While methods of workload measurement may well represent what counts as the nursing hours in healthcare organisations, the nurses in this study spoke at length of the strategies they used to make the nursing hours ‘work’. Findings indicate that nurses employ specific discursive strategies when talking about ‘nursing hours’. When addressing their workloads, their discourses centred on the business of care delivery, of nurse-to-patient ‘allocations’ and ‘handover’, or the many instances of ‘handing over’ their work. The study challenges nurses’ professional discourses about what nursing is, what nurses actually do and the sophistication with which this is accomplished at work. Conceiving of nurses’ work in terms of ‘nursing’ hours rather than patients in the business of health service delivery provides a different way of thinking about nursing workforce issues at a time when healthcare organisations and systems worldwide grapple with the question of how many nurses and what kind of nurses they need.
The research question for this thesis stems from practice. I began my doctoral study at a time when healthcare reform was high on the political agenda here in Australia – and it continues to be so – for both the public and private healthcare sectors. I was concerned with the impact of these reforms, not only for myself as a practising nurse, but for my colleagues and the care extended to patients within private health.

In Australia, a prominent private healthcare system exists alongside the public system (Duckett, 2005). Briefly, by way of background, the funding environment for private hospitals changed significantly in 1995 with the passage through the Australian Commonwealth Parliament of the ‘Lawrence reforms’; reforms attributed to then Health Minister Carmen Lawrence. These reforms paved the way for the use of contracts between private health insurance funds, private hospitals and doctors (Access Economics, 2002; Lawrence, 1995). This, and later conservative Liberal/National Coalition Government (1996–2007) reforms such as the Private Health Insurance Incentives Act 1998 (Cth), National Health Amendment (Lifetime Health Cover) Act 1999 (Cth), and Health Legislation Amendment (Gap Cover Schemes) Act 2000 (Cth), influenced how private hospitals were enrolled in ‘managed care’ 1.

As a registered nurse and After-Hours Coordinator/Nurse Manager who continued to work on the wards during this time, I became increasingly aware of how nurses spoke of

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1 At its simplest, managed care is a term used to describe a health care delivery system that manages access, cost and quality of health care by monitoring how and in what manner services are provided. It originated in the United States of America in the 1980s (Stack, 2005). In managed care, a health care organisation assumes responsibility for delivery of health care for an individual in exchange for a fixed payment (Duckett, 1996).
their work at a clinical level – as ‘nursing hours’. There was a shift from nursing hours being the singular domain of hospital administrators and managers to a spread of that domain to the talk of nurses on the wards. How nurses’ ‘nursing hours’ were thought about, managed, worked and accounted for permeated their talk. It seemed to me that nurses no longer spoke of nursing patients – although of course they did – but that nurses on the wards, across all levels, were speaking more about the calculation of nursing hours in relation to their work on the wards. In recognition of this change in nurses’ talk and its implications for practice, I visualised a reshaping of nurses’ work. My initial impetus for embarking on this endeavour was related to my professional practice and understanding this change at work. This thesis considers how changes at the macro level of governance play out at the micro level of the ward; the evidence of contradictions and tensions between the spheres of business management and nursing; and the situation for nurses in private health because these organisations produce a certain type of care within a competitive business environment.

**Writing up the thesis**

All work that is not my own is referenced in the text and all sources have been listed in the Reference List at the end of the thesis. Approval for the study was granted from both the relevant Human Research Ethics Committee of the study site hospital and Flinders University.

Fieldnote entries appear in italics and are indented from the left. Interview extracts are in normal font and indented from the left. All tape-recorded material and documents are verbatim transcripts. Long quotes from other literary sources appear in block style text, indented from both the left and the right. I have used footnotes to provide additional
information and to indicate where I have cited directly from data in-text to make reading easier. Data has been edited to preserve anonymity. All names of people are pseudonyms.

Where reference is made in footnotes to the hospital website as a source of data, the URL has not been included to preserve the hospital’s privacy and anonymity.

The Appendices appear as in the original or, where the original was not in scanning condition, as replicas. Therefore, they have not been formatted in the same way as the rest of the thesis.

Some of the material contained in this thesis has appeared elsewhere in different forms; as a refereed journal article and in conference papers whose abstracts were peer reviewed.


Chapter 4 draws upon material presented in a conference paper, ‘It’s a business, not,


Chapter 8 includes material presented in a conference paper, ‘Nurses’ working time: ‘nursing’ the hours’. Paper presented at the 3rd Annual Joint ULMS and Keele
University Institute for Public Policy and Management Symposium on Current Developments in Ethnographic Research in the Social and Management Sciences, University of Liverpool, United Kingdom, 2–4 September 2007.

An initial review of the workload literature was presented at the ‘In Sickness and in Health Conference’, Ethics, Power, Practice, held in Melbourne, Australia, 16–17 July 2002, where I presented a paper entitled Toffoli L. ‘Accounting for nurses’ work’.

Ms Margaret Bowden provided professional editorial assistance, which was limited to Standards D (language and illustrations) and E (completeness and consistency) of the Australian Standards for Editing Practice (Council of Australian Societies of Editors) in line with University of Sydney policy.
CHAPTER ONE
INTRODUCTION

A critique does not consist in saying that things aren’t good the way they are. It consists in seeing on what type of assumptions, of familiar notions, of established, unexamined ways of thinking the accepted practices are based. (Foucault, 2002, p. 456)

This thesis is a critique of the organisation of nurses’ work. It examines some of the assumptions and ways of thinking about the nursing workforce and its problems, and how representations of these problems, for instance as a workforce in ‘shortage’, are understood. It also considers how these problems are characterised and shaped through discourse, where discourse is understood as a certain way of thinking and talking. The concept of discourse is difficult because it means different things in different analytic traditions (Bacchi, 2009). I draw upon Foucault’s notion of discourse, where discourse “form[s] a practice which is articulated upon the other practices” (Foucault, 1978, 24). A further analytic framework from Foucault is his notion of ‘government’ as being:

The broad sense of techniques and procedures for directing human behaviour. Government of children, government of souls and consciences, government of a household, of a state, or of oneself. (Foucault, 2000a, p. 81)

In this thesis, I argue that the neo-liberal political rationalities of healthcare lead to nursing ‘care’ becoming a technology employed in the government of private health. The thesis considers how the business of private healthcare governs nurses’ souls (Rose, 1999a). It explores the problems of nursing within the private healthcare arena; how some of these problems are thought about, and how they in turn inform governing
practices (how nurses’ organise their work). Understanding how government occurs is an aim of the thesis, which considers how the various techniques and procedures located in the webs of documentation (Cheek & Rudge, 1994), such as legislation and government and hospital policy, accomplish this.

This study uses ethnography in conjunction with Foucault’s archaeology, where archaeology is a descriptive enterprise that goes beyond studying the conditions of possibility to that of the conditions of existence of practices (Dreyfus & Rabinow, 1983). Ethnographic methods of participant observation, interviews, keeping detailed fieldnotes and document analysis are used to explore how nurses within a private hospital do their job. These methods are used to examine the kind of thinking or the mentalities that govern nurses’ work.

In this chapter, I survey the influences on nurses’ thinking/mentalities through a discussion of governmentality theory, describing the programmatic and technological aspects of this concept. The chapter proceeds by providing a rationale for using ethnography as a research approach to study the everyday work of nurses; an approach where participant observation, conversational interviewing, and the close reading and analysis of documents are key investigative methods (van der Waal, 2009). I conclude by focusing on Foucault’s (1972) archaeology as providing the methodological framework for analysing the discursive construction of nurses’ work.

**Talking about the nursing workforce**

Healthcare reform and industrial change impact on the health workforce in a number of ways. The structure of the workforce and the number of people employed are often the
subject of government action and policy. Industrial issues are ultimately about payment and employment arrangements (Duckett, 2005). Nurses’ employment arrangements have been at the forefront of policy and nursing research for many years, particularly with the emergence of nursing being identified as a workforce in shortage (Productivity Commission, 2005; Senate Community Affairs Reference Committee Secretariat, 2002; World Health Organization, 2006). This identification construes the nursing workforce as a problem; something to be explained, understood and, importantly, to be resolved (Miller & Rose, 1990). Australia and other Organisation for Economic Cooperation and Development (OECD) countries are experiencing nursing shortages (Aiken & Cheung, 2008; Buchan & Calman, 2005; KPMG, 2009; O’Brien-Pallas & Baumann, 2000; Simoens, Villeneuve, & Hurst 2005). The nursing shortage problem has seen much attention focused on why nurses enter and leave the profession and their employing hospitals (Buchanan & Considine, 2002; Dockery & Barns, 2005; Duffield & O’Brien-Pallas, 2003; Goodin, 2003; Hayes et al., 2006; Weinberg, 2003; Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2010; Zeytinoglu et al., 2007), and the impact of the shortages on patient care (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Buerhaus et al., 2007; Doherty, 2009; Duffield et al., 2007; Rafferty et al., 2007; Schuldham, Parkin, Firouzi, Roughton, & Lau-Walker, 2009).

The initial idea for the study, introduced in the preface, was to understand how a change in nurses’ talk governed how nurses thought about their work at the micro level of a ward. What I saw as the redrawing (figuratively speaking) of organisational boundaries was the impetus for the thesis. Despite years of reforms to healthcare delivery in Australia under large conceptual rubrics such as privatisation, corporatisation, globalisation, economic rationalism and managerialism, also referred to as ‘New Public
Management’, there was a need, on my part, to understand how changes to healthcare policy and legislation governed nursing – and, therefore, my practice. This thesis draws on Foucault’s (1979) notion of governmentality, and what Miller and Rose (1990) call the “programmatic character” of this concept. Programmatic, as used here, refers to the way government reports and papers from industry/business, unions, and academics propose solutions for dealing with problems. The use of programmatic here is also characterised by an eternal optimism; an optimism that a domain, such as ‘health’ or ‘nursing’, can be administered better or more effectively, and an idea that reality is, in some way or other, programmable (Miller & Rose, 1990). While some of this thinking can be understood and seen as (re)worked at the level of policy and organisations, what of the nurses? How do they (re)program their work? What kinds of thinking or mentalities do nurses draw upon when thinking about their work?

Considerable literature emphasises the impact of healthcare reforms within the public healthcare sector as neo-liberal market principles and managerial rationalities or managerialisms were introduced into the sector both in Australia and overseas (Allan 1998a; Beynon, Grimshaw, Rubery, & Ward, 2002; Doolin, 2002; Germov, 2005; Leicht, Walter, Sainsaulieu, & Davies, 2009; Rankin & Campbell, 2006; Traynor, 1999; White & Bray, 2005). However, there is limited research into the impact of reforms on Australia’s private healthcare system.

Australia has long had a mixed health system, with roles for both public and private sectors in the financing and provision of healthcare (Access Economics, 2002). Here in Australia, private medical and allied healthcare is available through private health insurance, privately owned hospitals and charitable organisations. The private
healthcare sector plays an important role operating alongside the public sector, as will be discussed in some detail in the following chapter and Chapter 4. Approximately 44.8 percent of Australians had private health insurance at September 2010, which covered the cost of private hospital care, and 51.8 percent had some form of cover for allied health services such as chiropractic, dental, physiotherapy, and optical (PHIAC, 2010b).

**Governmentality as a theoretical framework**

This thesis addresses the way in which understandings about business or enterprise shape how nurses act in private health. While both public and private healthcare sectors may experience similar problems with nurse recruitment and retention, with an onus on increased throughput of patients and tight budgets, I argue that a different mentality governs the work of nurses in private health.

Governmentality is used as the theoretical framework for analysing the manner in which nurses within a private hospital conduct their work. Here, government refers to the relationship linking the state and non-state forms of governance. It does not refer to the political government of a nation-state such as the Commonwealth Government of Australia, be it at federal or state level – although that is not to say that the state is dismissed from an analysis. Foucault’s (1979) notion of governance is understood as “the conduct of conduct” (Gordon, 1991, p. 2) or, in Foucault’s (1994, p. 237) own words, “conduire des conduits”, not only of ourselves but of others. Dean (2006, p. 20) puts it succinctly, saying that government is “broadly, the deliberate shaping of the way we act”.

Governmentality is about the “art of government” (Foucault, 2007a, p. 364); the ways of
thinking or the ‘rationalities’ about governance. Gordon (1991, p. 3) explains governmental rationality as:

... a way of … thinking about the nature of the practice of government (who can govern; what governing is; what or who is governed), capable of making some form of that activity thinkable and practicable both to its practitioners and to those upon whom it is practiced.

This is the discursive field in which “the proper ends and means of government are articulated” (Miller & Rose, 1990, p. 5). It is where particular kinds of knowledges or discourses about objects such as economy, health, and in this thesis, nursing, “are rendered in a particular conceptual form and made amenable to intervention and regulation” (Miller & Rose, 1990, p. 5), or what these authors, drawing upon Foucault (1979), describe as a “mentality” of rule.

Michel Foucault (1926–1984) first coined the term ‘governmentality’ during a series of lectures delivered at the College de France in the late 1970s, entitled Society must be defended (Foucault, 2003), Security, Territory, Population (Foucault, 2007a) and The birth of biopolitics (Foucault, 2007b). Investigating political power, it was Foucault’s contention that there was a “shift of emphasis” (Foucault, 2007a, p. 363) in the thinking that informed government toward the end of the eighteenth century, in which “political knowledge … put the notion of population and the mechanisms for ensuring its regulation at the centre of its concern” (Foucault, 2007a, p. 363).

Foucault interpreted the emergence of the concept of ‘raison d’état’, or reason of state, in the first half of the eighteenth century as a transformation from the earlier art of government or governing to:
... an art of governing that finds the principles of its rationality and the specific domain of its application in the state. “Raison d’état” … is the new matrix of rationality. (Foucault, 2007a, pp. 364–365)

The earlier art of government was based on principles “derived from the traditional virtues (wisdom, justice, liberality, respect for divine laws and human customs) or from common skills (prudence, reflected decisions, care in surrounding oneself with best advisors)” (Foucault, 2007a, pp. 364–365). Rose, O’Malley and Valverde (2006) explain that reason of state resulted in an art of governing that assigned priority to all that could strengthen the state and its powers by intervening in, and managing, the habits and activities of the state and activities of subjects to achieve that end. Dean (2006) states that, for Foucault, this transformation in the art of government re-poses the question of power, where the power of the state is exercised in a governmental way rather than exercised on behalf of a sovereign; “the idea that ultimate power was located in a determinate body – the crown, the people” (Gunn, 2006, p. 709). Foucault (1980) does not see power as being about “repression” or “silence”; it is far finer and more “insidious” than that. It “doesn’t weigh on us as a force that says no, but it traverses and produces things”, and therefore “it induces pleasure, forms of knowledge, produces discourse” (Foucault, 1980, p. 119). Simons (1995) writes that power enables the development of discourses and the knowledge implicit within them, while at the same time repressing other possible discourses and other forms of knowledge(s). Power is needed for the production of knowledge and knowledge is needed for the exercise of power – “power/knowledge is a knot that is not meant to be unravelled” (Simons, 1995, p. 27). Thus, for Foucault (1980), power is something that “circulates”; it is productive rather than possessed:

Power must be analysed as something which circulates ... It is never
localised here or there, never in anybody’s hands, never appropriated as commodity or a piece of wealth ... individuals are the vehicles of power, not its point of application. (Foucault, 1980, p. 98)

If power is productive rather than possessed, an analysis resides “in its effects rather than its sources and at the margins rather than at the centre” (Gunn, 2006; p. 709). Therefore, an analysis of government focuses on the operations of power on nurses’ practices, strategies and technologies by which ruling occurs:

The exercise of power consists in guiding the possibility of conduct and putting in order the possible outcome. Basically power is less a confrontation between two adversaries or the linking of one to the other than a question of government. This word must be allowed the very broad meaning which it had in the sixteenth century. “Government” did not refer only to political structures or to the management of states; rather it designated the way which conduct of individuals or of groups might be directed: the government of children, of souls, of communities, of families, of the sick. It did not only cover the legitimately constituted forms of political or economic subjection, but also modes of action, more or less considered and calculated, which were destined to act upon the possibilities of action of other people. To govern, in this sense, is to structure the possible field of action of others. (Foucault, 1983, p. 221)

This thesis considers the structuring of the field of action of nurses in private healthcare within the political rationality of neo-liberalism.

**Political rationalities of neo-liberalism and nursing**

Miller and Rose (2008) see the political rationalities such as liberalism and neo-liberalism as having particular moral and epistemological dimensions, and being “articulated in a distinctive *idiom*” (Miller & Rose, 2008, p. 59). The moral dimension
“elaborates upon the fitting powers and duties for authorities” (Miller & Rose, 2008; p. 58) through allocation of responsibilities and duties, or, put more simply, who has the right to rule. The epistemological dimension is one where political rationalities are “articulated in relation to some conception of the nature of the objects governed – the nation, the population, the economy” (Miller & Rose, 2008, p. 58). In other words, this is about particular understandings of objects to determine if something should be subjected to governance, and finally, the way in which these understandings and justifications are “made thinkable through language” (Miller & Rose, 2008, p. 59).

Language, in this context, is understood as a set of intellectual techniques for rendering reality thinkable and practicable, constituting domains that are amenable or not amenable to intervention (Rose, 1996).

In this thesis, the moral and epistemological dimension for nursing is concerned with a raft of governmental programmes and technologies described in the many jurisdictional reports and studies of the healthcare workforce. Changes to healthcare legislation and policies that privilege patient ‘choice’ for health services and the promotion of private health as a means of taking pressure off the public healthcare system are among these programmes and technologies (Abbott, 2006; Elliot 2006; White & Collyer, 1998). Changes to the healthcare workforce legislation and policies include the recent establishment of a single national registration and accreditation board for health professional education and training (COAG, 2008a), which will:

… help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce. (COAG, 2008b, p. 5)
Understandings about nursing and the work that nurses do, their professional knowledge(s) and traditions, and relationships between healthcare professionals, workforce mobility/flexibility, and education are examples of some of the different knowledge(s) or epistemological dimensions of nursing rationalities that are a focus for governing and government. The distinctive idiom that renders the reality of nursing work thinkable, which I illustrate in the following chapters, includes discourses of nursing as an ageing workforce in shortage, with problematic employment participation rates. These problems are also thought to be compounded by nursing’s (in)visibility in the language of supply and demand, and in nurses’ working time, as well as by discourses of enterprise or business management.

Miller and Rose (2008) identify that political rationalities, as (government)ality, are translated and realised in programmes of government in designs put forward by a range of authorities such as economists, government reports, and committees of inquiry in the:

... proposals and counter-proposals by organizations of business, labour, finance, charities and professionals that seek to configure specific locales and relations in ways thought desirable. (Miller & Rose, 2008, p. 61)

If government is understood as “a problematizing activity” (Miller & Rose, 2008, p. 61), nursing programmes of government include particular problematizing of the nurse workforce that needs to be addressed, for example workforce participation rates, what constitutes nurses’ working time, and education. In outlining the ‘problem’ of nursing in a reformed health system, governance programmes such as nursing workforce research determine what aspects of research are considered to be important, what will attract research funding, and where and how this research will occur. This activity translates the political rationalities of nursing into ‘real’ facts; it makes for actual measures for
government and governance. While programmes lie at the macro level of government, mechanisms that connect the “aspirations of authorities and the activities of individuals and groups” (Miller & Rose, 2008, p. 63) are required to bring these programmes into the realm of the everyday. Techniques of government lie in the “humble and mundane mechanisms” (Miller & Rose, 2008, p. 63) found in:

... techniques of notation, computation and calculation; procedures of examination and assessment; the invention of devices such as surveys, and presentational forms such as tables; … the inauguration of professional specialisms and vocabularies; building designs and architectural forms. (Miller & Rose, 2008, p. 63)

This is the point where technologies of government, political rationalities, and the programmes of government articulate, intersect, and are deployed (Miller & Rose, 2008). Thus, in the case of nursing, the jottings nurses write into their ‘handover sheets’, the nursing notes in patient medical records, calculations to determine/ensure ‘appropriate’ nurse staffing, professional regulation and policies, and the vocabularies found in workload measurement and classifications systems for nursing, as well as in protocols and research are some of the technologies deployed in nursing/health policy.

**Using ethnographic method**

Ethnography as an approach to research becomes particularly useful in identifying what some of these technologies are and how they operate in programmes of government.

Van Maanen (1988, p. 1) writes that “ethnography is written representation of a culture or selected aspects of that culture”. Hammersley and Atkinson (2003) see ethnography as referring to a method, or set of methods, that characteristically involves the ethnographer participating in people’s daily lives for an extended period of time; a
research approach that “requires immersion” (Cunliffe, 2010, p. 227). Immersion allows the researcher to experience directly both the ordinary routines and conditions with which people conduct their lives, and the constraints and pressures to which they are subject (Emerson, Fretz, & Shaw, 1995). In the case of this research, immersion entailed a year of fieldwork, collecting data primarily through writing fieldnotes on participant observation, interviews, and collection of documents for analysis. Documents comprised a range of organisational texts, such as hospital policies, mission statements, marketing material, minutes of meetings and fieldnotes about nurses’ interactions with each other, meetings, nurses’ formal and informal conversations, stories, what they were gossiping about, and their routines and work practices. Organisational symbols, such as dress, logos, and the décor of the hospital and wards were also described in fieldnotes. All of these are considered part of the ‘textwork’ (Van Maanen, 1996) for analysis.

The usefulness of ethnography as a qualitative research approach becomes clear as I analyse some of the technologies of government, which are found in what some would consider rather mundane organisational texts, to illustrate how they are used to translate nursing care into neo-liberal forms of enterprise governance. The analysis also illustrates where market relationships and values govern nurses’ work as they make their ‘nursing hours’ work. Texts include the hospital’s ‘Annual Review’, organisational chart(s), nurses job descriptions, nurses’ handover sheets, and their scrappy bits of paper used to record their organising strategies.

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2 Report to the public that details an organisation’s financial and operational activities over the past year.
Discourse and texts

Discourse analysis was used to analyse the texts. Foucault’s (1972) notion of discourse is different from other forms of discourse, such as those concerned with the detailed analysis of speech events or text as discussed in socio-linguistics (Lemke, 1995). Foucault is not concerned with the semantics of statements (what is said) or what ‘things’ mean, or with discovering speakers’ supposed ‘hidden’ intentions. Foucault (1972, p. 108) defines discourse as “the group of statements that belong to a single system of formation”. A system of elements and relations enables statements to come into existence; a discourse is a group of statements that share the same formative system. This focuses discourse analysis at the formative level – just before something is said – at the level that enables something to be said and illustrates ‘what’ is forming (Topp, 2000).

Foucault (1972) sees statements as representing a single unit of a discursive formation surrounding an object of knowledge. He looks to boundaries/limits that permit something, and not other things, to be said; what is permissible to say at any one moment in time. How this comes to be understood is only in terms of the historical conditions that gave rise to it, and from which certain theoretical choices were made over others that could have been made at the time (Foucault, 1972). Foucault uses existing texts as “starting-point[s]” (Foucault, 1972, p. 26) from which to look for a point of attack for analysis of discourse. A focus on text is required to understand or analyse the production of discourse. According to Lemke (1995):

> Texts record the meaning we make in words, pictures and deeds. Politics chronicles our use of power in shaping social relationships large or small … in all this language plays a critical role. (Lemke, 1995, p. 5)
Lemke (1995) elaborates, explaining that the notion of text and discourse is complementary. He writes that to focus on the specifics of an event is to refer to an event as ‘text’; to look at patterns, commonality, and relationships that embrace different texts is to speak of discourse.

Foucault “did not characterise himself as a political theorist or philosopher” (Gordon, 2002, p. xi) but as a historian of the present. He saw himself not as someone who sought to tell the past as it had been, but someone who tried to describe how today’s continuities and discontinuities are constituted through many potential and possible pasts. The texts and artefacts of the past are used to describe present day notions of what is similar or dissimilar, of continuity and discontinuity (Lemke, 1995). As a historian, Foucault used texts – written documents surviving in archives – to reconstitute:

... on the basis of what the document says, and sometimes merely hints at, … the language of a voice since reduced to silence, it’s fragile, but possible decipherable trace. (Foucault, 1972, p. 6)

The point to grasp about Foucault’s notion of discourse is not the production of ‘things’ by ‘words’ (the why and what), but how what is said fits into a network that has its own history and conditions of existence (Foucault, 1972); it is to:

1) Treat past discourse not as a theme for a commentary which would revive it, but as a monument to be described in its character disposition.

2) Seek in the discourse not its laws of construction, as do the structural methods, but its conditions of existence.

3) Refer discourse not to the thought, to the mind or to the subject which may have given rise to it, but to the practical field in which it is deployed. (Foucault, 1978, p.15)
In this thesis, an analysis is framed by Foucault’s (1972) archaeology to explore the discourses nurses use in the ‘practical field’ of their work at a private hospital.

**Foucault’s archaeology of discourses**

In *The Archaeology of Knowledge*, Foucault (1972) looks not to “what was being said in what was said” (Foucault, 1972, p. 28), that is to search for hidden meanings, but seeks to describe the interplay of relations in what is said. Foucault’s (1972) concern is not on the meaning of ‘what is said’. He focuses on how statements come into existence, remain in circulation, and disappear; “it is description of things said, precisely as they are said” (Foucault, 1972, p. 109). Foucault (1972) refers to his approach as ‘archaeology’, which describes an archive. The archive:

... defines a particular level: that of practice that causes a multiplicity of statements to emerge as so many regular events, as so many things to be dealt with and manipulated. It does not have the weight of tradition; and it does not constitute the library of all libraries ... it reveals the rules of a practice that enables statements both to survive and to undergo regular modification. It is the general system of the formation and transformation of statements. (Foucault, 1972, p. 130)

When questioned about his method, Foucault (1991) makes the comment that the target of his analysis was not “institutions”, “theories” or “ideologies” but practices. His critique aimed to understand the conditions that made these practices become acceptable at any one moment because such practices “played out in the real” (Foucault, 1991, p. 85). Foucault regards a moment of discontinuity as the starting point for identifying transformations or historical change. In order to show that “things weren’t as necessary as all that” (Foucault, 1991, p. 76), in *The Archaeology of Knowledge* he provides very complex and subtle accounts of social relationships and their historical changes in terms
of discursive formations. His intention in this work was to define a method of analysis (Foucault, 1972) written, in part, to justify what he had done in previous works. This book is the only text in which Foucault attempted to describe in detail the form of discourse he had intended; the form of historiography he had formulated, used, and refined in his previous work (Allen, 1999). It is where Foucault (1972, p. 17) shows the position from “which [he] was speaking” in those earlier works, corrects the methodology he was developing, and indicates “the directions in which the research [his subsequent work] will proceed” (Foucault, 1972, p. 65).

Foucault’s (1972) work analyses “discourses as practices as specified in the element of the archive” (Foucault, 1972, p. 131). As a nurse and researcher, I have found using Foucauldian theory confronting because:

… it is not possible to describe our own archive, since it is from within these rules that we speak … The analysis of the archive, then, involves a privileged region: at once close to us, and different from our present existence, it is the border of time that surrounds our presence, which overhangs it, and which indicates it in its otherness; it is that which, outside ourselves, delimits us. The description of the archive deploys its possibilities. (Foucault, 1972, p. 130)

In my thesis, the archive of a culture of nursing in private health is delimited by what I can or cannot say about nurses’ work within an historical period of time of which my own biography/history, and this work, is a part.

Hall (2001) writes that discourse is not purely a linguistic concept. It is about language and practice attempting to overcome the traditional distinctions between what one says (language) and what one does (practice). Discourse, “rules in certain ways of talking
about a topic, defining an acceptable and intelligible way to talk, write, or conduct oneself” (Hall, 2001, p. 72) and also “rules out, limits and restricts other ways of talking, of conducting ourselves in relation to the topic or constructing knowledge about it” (Hall, 2001, p. 72). Discourses that figure the nursing workforce as in ‘shortage’, for example, produce, constrain, and frame what can be thought and said about that workforce at that time. Representing nursing as in shortage has an effect on healthcare delivery in so far as it closes off, or in Hall’s (2001) words, “rules out”, other ways of thinking about nursing workforce issues. Moreover, discourse normalises such discussions, in effect reducing discussion to some parameters where others may be more productive/fruitful.

The organisation of this thesis

This chapter has focused on how neo-liberal political rationalities are employed in the governance of nursing, with a view to translating the work of nurses from the macro-level and the programmatic to the micro level of everyday practice. As I will argue throughout this thesis, technologies of governance found in organisational texts such as job descriptions or in methods of nursing workload measurement are mechanisms through which a certain and active subjectivity is produced for nurses; a subjectivity in which a nurse, in private healthcare, is expected to be business savvy. As such, this makes for a certain way of thinking or knowledge(s) about nursing that underlies government through the exercise of a very sophisticated form of power.

Chapter 2 builds on the theoretical argument outlined in this chapter by tracing how the health workforce, and nursing in particular, is constituted within the literature. The constitution of the nursing workforce as in ‘shortage’ and ‘ageing’ makes for a nursing
workforce that is a problem requiring governing. In this chapter, I illustrate how the literature focuses on representations of the characteristics of the workforce, consequently deflecting the problems with nursing to the profession and not to the healthcare agencies or government. In doing so, the profession reframes the problem of nursing as a workforce in shortage to nursing as a workforce that is (in)visible; one that is to be made visible only through the calculation of nurses’ working time.

Chapter 3 introduces the study setting and describes the research method. In particular, this chapter discusses some of the challenges of conducting ethnographic research, the problem of access, and the importance of issues of power and ethics.

Foucault’s archaeological method structures Chapters 4 to 8 in so far as the four groups of ‘rules’ identified by Foucault (1972) as characterising a discursive formation provide for a possibility of uncovering the creation and subsequent maintenance of a particular discourse or knowledge. The conceptual headings, identified in *The Archaeology of Knowledge* (Foucault 1972) – formation of objects, enunciative modalities, formation of concepts and strategies – and the elements described within each of these provide the methodological frame for the chapters. Exploring the discourses or kinds of knowledge(s) about nurses’ work through Foucault’s (1972) archaeology reveals the discourses that shape understandings about nurses’ work in the private hospital setting within the private health arena. As we will read in this thesis, discourses that nurses use are not necessarily those of the widely reported nursing ‘shortage’ but those of ‘business’, amongst others. These discourses govern the manner in which nurses conduct their work in this hospital.
Chapter 4 centres on Australia’s healthcare system and private health as a programme of government in a neo-liberal political rationality. The chapter begins by tracing nurses’ talk, situating nursing within this context. It problematises nursing in private health, not as a problem of shortage but as a problem of business management.

In Chapter 5, organisational texts such as job descriptions are employed as technologies in the government of nursing, translating health policy from the macro level of government to the micro level of day-to-day practice. Job descriptions, competency standards, mission statements, and in-house forums are the mechanisms through which a particular nursing subjectivity is produced, which takes nurses beyond that of nurses as ‘employees’ to that of an ‘expert’ nurse whose skill and experience combine to manage the cost of nursing care time for the hospital.

Chapter 6 shows the way in which time, as time management, becomes central to nurses’ practice with the dominance of business and economic discourses. In this chapter, contemporary discourses of care begin to be conceptualised in terms of the financial cost to the hospital of nurses’ working time. Time governs the configuration of nurses’ work through nurses’ accounts of, and attention to, hospital occupancy rates and the places and spaces of their work area.

Chapter 7 considers how “themes or theories” (Foucault, 1972, p. 64) such as ‘care’ become ‘strategies’ that govern nursing practice. A central argument of this chapter is how an ethos of enterprise or business operates through a nursing rationality of care where the organisation markets nursing care as its defining feature. This ethos ensures that nurses are responsible for the health of the hospital as well as the experience of the
patient, effectively enrolling them in the hospital’s aims and mission. In this chapter, nursing values such as ‘care’ are transformed to where market relationships and values govern nurses’ work, (re)problematising the nursing ‘problem’ anew for organisations as one of care.

Chapter 8 is concerned with how discourses of care are operationalised despite the uneasy tensions between the business management of the hospital and nursing, particularly around cost and importantly around reducing nurse labour costs as nurses make their nursing hours ‘work’. This occurs in their allocation and handover practices. An analysis of these practices illustrates nurses’ pragmatism and their use of sophisticated knowledge(s) to accomplish reduced labour costs.

The concluding chapter summarises the main argument developed in this thesis and comments on the relationship between nursing professional knowledge(s) and organisational governance, and its implications for the profession.

**Conclusion**

This chapter has described the theoretical and methodological framework adopted for this thesis. Foucault’s (1979) notion of governmentality as the over-arching theoretical framework illustrates how nurses’ work is represented as a problem for governance and government. Ethnographic methods were used to generate data for analysis through an extensive period of fieldwork. These data represent the experience of work in a private hospital. Foucault’s (1972) *The Archaeology of Knowledge* is the analytical framework applied to explicate how certain knowledge(s)/representations of nurses’ work emerge and become part of the day-to-day discourses of the nurses’ working day. The next
Chapter outlines the discourses that frame how the nursing workforce is presented in the academic and professional literature, and in parliamentary documents. This literature is analysed to illustrate how statistics and classification systems that quantify nurses’ work talk about nursing as a ‘labour force’, (re)presenting that work as ‘time’ in order to frame an analysis of the nurses’ work in a private hospital.
CHAPTER 2

PROBLEMATISING NURSING WORKFORCE KNOWLEDGE(S)

One of the great innovations in the techniques of power in the eighteenth century was the emergence of ‘population’ as an economic and political problem; population as wealth, population as manpower or labor capacity ... Governments perceived that they were not dealing ... with a “people” but with a “population” with its specific phenomena and its peculiar variables: birth and death rates, life expectancy, fertility, state of health. (Foucault, 1976, p. 25)

This chapter uses the notion of governmentality (Dean, 1999; Foucault, 1979; Miller & Rose, 2008; Rose 1999a, 1999b) to frame a wide range of literature discussing the organisation of nurses’ work. In turn, it examines how an “avalanche of numbers” (Hacking, 1986, p. 222) has constituted government statistics and research into the nursing workforce, which have configured and interacted with government policies in “making up” (Hacking, 1986) nurses. I trace how this making up occurs, first through demographic and employment characteristics regarding the nursing workforce in Australia and internationally. This is presented to illustrate how the healthcare workforce, and nursing in particular, is configured as a problem; as a workforce in ‘shortage’. Second, I consider the research relating to the impact of nurse staffing levels on various outcomes for healthcare delivery. This literature is discussed with reference to how the nursing classification literature and nursing commentary around it goes about highlighting nurse staffing levels. Part of this discursive framing is to expose the work done to define nursing to determine the cost of nurses, not only at the micro level of the hospital but also for government. Much of this definitional work is used to establish

Chapter 2 - Problematising nursing workforce knowledge(s)
particular ways of talking and thinking about nursing availability. The conclusion summarises the discourses that frame the work carried out in attempting to quantify and define just what nursing is and does. This operation of discourses (mostly of an economic and business kind) governs the calculations of nursing numbers, leaving the care of the sick (Nelson, 2001) dependent upon how those numbers are distributed rather than on nursing knowledge(s) about such care.

What counts as nursing shortage?

Over the past decade or more, healthcare provision in Australia, as in other countries around the world, has seen a number of reforms in the delivery and financing of health services. These reforms have resulted in significant changes to how healthcare is delivered, as well as to the healthcare workforce. Many authors have drawn attention to the shortage of nurses worldwide (Andrews & Dziegielewski, 2005; Buchan, 2006; Buchan & Calman, 2005; World Health Organization 2006; Stone et al., 2003) and in Australia (Armstrong, 2004; Creegan, Duffield, & Forrester, 2003; Cowin & Jacobsson, 2003a, 2003b; Duffield & O’Brien-Pallas, 2003; Forsyth & McKenzie, 2006; Hegney, Plank, & Parker, 2003). A number of reports specific to Australia relate to nurses’ working conditions and the relation of this to nurse retention and recruitment, including recent government inquiries describing the present nursing shortage, all predicting a worsening situation (Access Economics, 2004; Garling, 2008; KPMG, 2009; Productivity Commission, 2005; Senate Community Affairs References Committee Secretariat, 2002). It is in this context of a recognised global nursing shortage that the issue of workloads in nursing became a subject for considerable debate and discussion.

Questions surrounding staffing levels and skill mix, and increased use of the
employment of temporary, agency, bank, or ‘supplemental’ staffing to overcome daily shortages dominate the literature (Adams, Lugsden, Chase, Arber, & Bond, 2000; Aiken, Clarke, Xue, & Sloane, 2007; de Ruyter, 2004; Manias, Aitken, Peerson, Parker, & Wong, 2003; Massey, Esain, & Wallis, 2009) along with concerns with nurse numbers in relation to patient safety and risk, nurses’ professional role, and the extent to which nursing might be and/or is valued. All these questions are set against a backdrop of cost containment pressures, marketisation (Beynon et al., 2002) and managerialism (Traynor, 1999) that serve to shape not only the intensity of nurses’ work but also their working time (Willis, 2002). Many of the reports record nurses citing excessive workloads and other issues such as unattractive rosters or schedules (Aiken et al., 2002; Wright, Bretthauer, & Côté, 2006) as the source of their dissatisfaction with their job, and relate these issues back to their intention to leave (Aiken, Clarke, Sloane, & Sochalski, 2001a; Aiken et al., 2001b; Fagin, 2001; Lynn & Redman, 2005; McGillis Hall & Kiesners, 2005; Parry, 2008; Takase, Maude, & Manias, 2005; Weinberg, 2003). The presentation in the literature of the problem of the nursing shortage is underpinned by the prominence of ‘numbers’ – as facts and figures – collected about nursing to show how it is thought about as a problem for government.

**Defining a workforce through numbers**

Governing is dependent upon knowledge and, in the case of this study, isolating that knowledge “as a sector of reality” (Rose, 1999a, p. 6) in nursing entails identifying the characteristics and “processes proper to it; to make its features notable, speakable [and] writable” (Rose, 1999a, p. 6). Therefore, the artfulness of government depends upon the production, circulation, organisation, and authorisation of truths that incarnate what is to be governed, which is rendered thinkable, calculable, and practicable (Rose, 1999a).
Making calculations about a population requires highlighting the attributes of the population as the ‘raw material of calculation’ (Rose, 1999a, p. 6); in other words, to have information about it. Knowledge then takes on a physical form; for example the transcription of births, deaths and illnesses into data upon which political and economic calculation can work (Rose, 1999a). Calculation depends upon processes of “inscription” (Rose, 1999a, p. 6) that translate the world into material forms; written reports, charts, and importantly, numbers (Hacking, 1986). The term given to these practices of inscription is ‘statistics’ – the science of the state – where the population is rendered into a form to be used in political arguments and administrative decisions (Rose, 1999a). In the next section, I explore how the economic and/or management problems of the health workforce are argued through numbers in various government reports and national statistics to inform the administrative decisions of policy makers and the profession. I now discuss these reports and statistics as the characteristics of the nursing population, as a labour force, are identified as issues for management.

Perceptions of impending health workforce shortages, in nursing in particular, are situated within concerns by government and/or policy makers about the impact of ‘population ageing’ on the supply and demand for health professionals and the healthcare system (Commonwealth of Australia, 2010b; Productivity Commission, 2005). In its 2005 report on Australia’s health workforce, the Productivity Commission details shortages in general practice, various medical specialty areas, dentistry, nursing, and allied health areas. Nursing comprises more than 50 percent of the health workforce of 450 000 people. Medicine accounts for 12 percent and allied health workers account for about 9 percent. While there was a rise of 11.6 percent in the total number of nurses in Australia between 2004 and 2008 (AIHW, 2010d), there are questions about whether
this is sufficient to meet growth in demand for healthcare services (AIHW, 2010a; KPMG 2009). Governmental calculative practices heavily influence economic discourses around demand for, and supply of, healthcare workers and the nature of the services they provide. Collectively, the federal, state, and territory governments provided $71.2 billion or 68.7 percent of the $103.6 billion (9.1% of GDP) spent on healthcare in Australia in 2007–08. The remainder ($32.4 billion or 31.3 % of total funding) was provided by the non-government sector that comprises individuals, private health insurers, and workers’ compensation (AIHW, 2010a). These statements about population numbers and the ways in which they are presented, divided, and examined are what centres Foucault’s classic definition of governmentality as:

The ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics, that allow the exercise of this very specific albeit complex form of power, which has as its target populations, as its principle form of knowledge, political economy and as its essential technical means apparatuses of security ... this type of power which may be termed government. (Foucault, 1979, p. 20)

Governments regulate, and are major employers of, health workers (Productivity Commission, 2005). If governmentality is understood as power that operates at the level of population, it is useful at this point to consider how the health workforce, and in particular nursing, figured as in ‘shortage,’ came to be understood as a problem for government. The International Labour Organization\(^3\) thesaurus succinctly defines workforce or the labour force as the “the economically active population” (ILO, 2008). It is reference to the ‘economic’ in this definition that is important because to “govern effectively, government works through the wealth and security of the population”

\(^3\) International Labour Organisation (ILO) was founded in 1919 and is an agency of the United Nations. It is the global body responsible for drawing up and overseeing international labour standards.
(Gunn, 2006, p. 709). Thus, in liberal democracies, to ensure the wealth of the population means government has to ensure the health of the population because its security “leads to more economic and social prosperity” (AIHW, 2010a, p. 6).

It is widely known that there are health workforce shortages within Australia, as noted above. These shortages vary not only by health profession – doctors, nurses, allied health – but also by speciality and geographically by state and territory. They also vary by metropolitan, regional, rural, and remote areas of the nation (KPMG, 2009; Productivity Commission 2005). The authors of reports about shortages of the healthcare workforce suggest that the factors influencing and impacting the health workforce shortages experienced in Australia and elsewhere are constituted as supply and demand factors. All of this entails that government requires further understandings about these factors to then provide governmental strategies to rectify such ‘things’ through policy.

The common governmental discourses that are used to organise the debates about the nursing workforce focus on ‘drivers’. A recent report for the Australian Health Workforce Taskforce (KPMG, 2009), for example, identified factors influencing the supply and demand of the health workforce. Supply factors identified include the structure of education and training programmes, competing demands for labour, workforce intentions and availability, migration of health workers into and out of Australia, workforce choices made by health workers, and the changing profile of entrants into the health workforce. Factors driving the demand for health worker services include changing population demographics (age, ethnicity), prevalence of chronic conditions, and contributory factors such as obesity, changes in clinical practice,
models of care, new treatment options and therapies, and number of visits to allied health, community health and primary care providers. As a matter for policy intervention, the Taskforce interest was in understanding the supply factors that constituted the current health workforce shortage. The premise was that the current system could not continue to supply enough health professionals to meet demand if they continued to train, recruit, deliver care, and utilise staff as they had done traditionally (KPMG, 2009). Given that to govern is to know (Rose, 1999a), in the ten years 1999–2009 the federal, state, and territory governments commissioned numerous reports relating to nursing recruitment, retention, and training (see for example, Access Economics, 2004; AHWAC, 2004; Karmel & Li, 2002; KPMG, 2009; Preston, 2006; Queensland Health, 1999; Senate Community Affairs Reference Committee Secretariat 2002; South Australian Department of Human Services, 2002). While these reports had any number of recommendations for nursing workforce planning, at the conclusion of yet another report on nursing workforce Professor Peter Brooks, the then interim director at Australian Health Workforce Institute, was quoted in a press release as saying:

Australia has sufficient information, both at a national and state level, on the key nursing workforce indices to progress to an action phase. Rather than further studies into the nursing workforce problems, the focus should now be squarely placed on orchestrating solutions. (Kronos®, 2008)

Members of Parliament claim that “in the past we have not collected any national data about our health workforce and this makes it even more difficult to plan in response to these [health workforce] shortages”; the “previous government did not plan for these workforce shortages”; and “it has become critical” (Rishworth, 2009, p. 4388).
The assumption underlying such statements is that government can, in fact, plan for health workforce shortages, as the economic and workforce modelling in the literature attests (Fritjers, Shields, & Wheatley Price, 2007; Preston, 2006; Productivity Commission, 2005; Segal & Bolton, 2009). Nevertheless, in an effort to make Australia’s health workforce more responsive to the nation’s health needs, the Australian Government, acting on recommendations outlined in the Productivity Commission (2005) report into the health workforce, legislated for the establishment of Health Workforce Australia, in July 2009, through the Health Workforce Australia Act 2009 (Cth). This is a national workforce authority to support workforce planning and policy development, and manage health reform.

Concern with the health workforce is also evident in the professional literature, which is dominated both here and overseas by the framing of the health workforce as in shortage, and nursing in particular as in crisis (Buchan, 2006; Dockery, 2004; Nowak, 2005; Oulton, 2006; Shannon & French, 2005), as read in some highly emotive titles such as ‘Health Care’s Human Crisis: the nursing shortage in America’ (Kimball & O’Neill, 2002); ‘Nursing: profession in peril’ (Emerson & Records, 2005); ‘Can you hear us? There’s a nursing shortage!’ (Armstrong, 2004); ‘Stop telling us to cope’ (Buchanan & Considine, 2002); ‘Nursing workforce, from crisis to chaos’ (The Lamp, 2001); ‘More nursing, fewer deaths’ (Clarke & Aiken, 2006); ‘When supply fails demand, a patient care catastrophe looms’ (Colosi, 2007); and ‘Nursing in the crossfire’ (Steinbrook, 2002). Commentary in one British medical journal, The Lancet, writes of the nursing shortage as a ‘national security concern’ for the United States of America (USA) in the face of potential threats of bioterrorism (Nelson, 2002). It is of a magnitude akin to calling a Code Green alert (Weinberg, 2003). The nursing shortage is also often
described as ‘a perfect storm’\(^4\) (Bleich & Hewlett, 2004; Curtin, 2007; Hassmiller & Cozine 2006; Hindshaw, 2008; O’Neil, 2006; Talsma, Grady, Feetham, Heinrich, & Steinwachs, 2008). In a press release, Kronos® (2008), a leading health workforce management consultancy firm, and the Australian Health Workforce Institute (AHWI) announced the findings of a three-month meta-research project into the nursing workforce, declaring that “research confirms Australian nurses [are] on endangered species list” (Kronos®, 2008). Whether this is hype or not, the seductiveness and privileging of the use of workforce numbers is ubiquitous. Such statements within the nursing literature, government reports, and indeed this thesis all concur and often reference the same sets of government statistics, reports, and research to defend the constitution of nursing as in ‘shortage’ and to argue for more nurses. The constitution of discourses about the nursing workforce through population numbers illustrates the productive role of government in shaping particular understandings of the ‘problems’ of this workforce.

**Australian nurse labour force: predications and figures**

The nursing workforce shortage is posited as a problem for government and is certainly one which, when reported in the literature and media as being experienced by employers, nurses, and patients alike, places an onus on government, employers, and the profession itself to address it in policy, because:

... policy cannot get to work without first problematising its territory ... the function of problematisations is to reduce complexity, to provide a field of delimitation regulating what can and cannot be said. (Osborne, 1997, p. 175)

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\(^4\) Metaphor used to describe an especially bad situation caused by a combination of unfavourable circumstances (Oxford Dictionary, 2010).
It is in the problematisations of the territory of nursing as a workforce in shortage that nursing comes to be understood further “both as an object and end of government through statistical measurement” (Gunn, 2006, p. 706). The next section continues to explore these statistical measurements for what is said and how each report or author(s) uses the key demographic characteristics, as set out by government and researchers, to impress us about the problem.

**Nursing as an ageing workforce**

Alongside the perceived nursing shortage, the average age of the world’s nursing workforce is increasing (Buchan, 1999; Aiken & Cheung, 2008; Buchan & Calman, 2005; World Health Organization, 2006). In the USA, the average age of the nursing workforce is 47 years (US Department of Health and Human Services, 2010). Here in Australia, the Australian Institute of Health and Welfare (AIHW, 2010d) reports that the nursing workforce continues to age, with the average age calculated as 44.1–43.9 years for registered nurses and 44.6 years for enrolled nurses nationally. While the average age of nurses increased slightly in 2004–2008 within the peak age group of 45–49 years for registered nurses, the proportion of nurses aged 50 years or older increased from 29.7 percent to 34.9 percent during this period. Overall, this is indicative of a trend in a reduction of the proportion of nurses in the younger age categories and an increase in older age categories.

The ageing of the nursing population has created challenges for nurse retention. When the age distribution of the nursing workforce is taken into account, it is seen as indicating that many are approaching retirement age, raising concerns that there are insufficient numbers of experienced nurses to take their place, which will deepen the nursing shortage (ICN, 2008) with a resultant loss of nursing expertise. Such an
argument contends that Australia, as in many countries internationally, will be “facing a demographic double-whammy – they have an ageing nursing workforce caring for an ageing population” (Buchan, 2006, p. 457), which raises the question of “who will be there to nurse?” (O’Brien-Pallas, Duffield, & Alksnis, 2004, p. 298).

Schofield (2007) notes that little information is available from Australia or other countries on the rate and timing of nursing retirement. Schofield used specifically defined extracts from the Australian Bureau of Statistics (ABS) Censuses of 1986–2001 to measure and project future nursing retirement through to 2026. The Australian Bureau of Statistics population projections were used to estimate the size of the labour pool from which the future nursing workforce will be drawn. Schofield predicted that during 2006–2026 Australia would lose almost 60 percent of the present nursing workforce to retirement – an average of 14 percent of the nursing workforce every five years. Schofield calculated that a total of about 90 000 nurses would be leaving the profession through retirement processes alone. Such calculations are used to argue the challenges – essentially economic ones for government and healthcare organisations – of providing healthcare for, and with, an ‘ageing demographic’ (Commonwealth of Australia, 2010b). Thus, not only is the nursing workforce constituted as being in shortage for government, it is an ageing one at that. The value in these sorts of statements is that this is:

... not defined by their truth ... but [one] which characterizes their place, their capacity for circulation and exchange, their possibility of transformation, not only in the economy of discourse, but, more generally, in the administration of scarce resources. (Foucault, 1972, p. 120)

Projections from Evans and Kelley’s (2008) study of trends in women’s labour force
participation in Australia suggest a dramatic increase from 59 percent in 2002 to 89 percent by 2022 in participation rates for mature aged women over 55 years with children past school age. The labour force participation rate of 78 percent for single women in 2002 is predicted to increase to 95 percent by 2022. This is significant given the predominantly female professional health workforce. Evans and Kelley’s point is that although the healthcare workforce is represented as a scarce resource, this potentially may not be the case. Improving mature age workforce participation rates is firmly on the Australian Government policy agenda – one of the ‘3P’s – ‘productivity, participation and population’ (Commonwealth of Australia, 2010b, p. 21) – as the Government responds to the economic and fiscal pressures of an ageing population. Participation rates among mature age nurses have implications for government design and implementation of recruitment and retention policies for this category of nurse, regardless of whether or not their participation declines (Andrews, Manthorpe, & Watson, 2005; Graham & Duffield, 2010). The above arguments focusing on the ‘mature age’ of the nursing workforce are based upon assumptions about nursing, which serves to constitute the profession as a ‘scarce resource’ (Foucault, 1972, p. 120) on one hand, and a resource amenable to further (re)problematisations for administration on the other (Bacchi, 2009).

**Nursing as a gendered profession**

Nursing in Australia is predominantly a female occupation. In 2008, females comprised 90.6 percent of employed nurses, with only 9.4 percent of nurses being male (AIHW, 2010d). While the proportion of male registered nurses (9.6%) increased between the

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3 The labour force participation rate is defined as the ratio of the labour force to the working age population (age 15–64 years) expressed in percentages. The breakdown of the labour force by sex and age group gives a profile of the distribution of the economically active population within a country - the Key Indicators of the Labour Market (KILM). The mature age participation is defined as 55–64 years (OECD, 2006).
years 2004–2008 (up from 8.7% in 2004), over this same period of time the proportion of male enrolled nurses decreased from 9.1 percent in 2004 to 8.7 percent in 2008 (AIHW, 2010d). It is this inescapable ‘fact’ about nursing – that it is predominantly female – that cannot be ignored when thinking about nursing workforce issues. Many nurses’ decisions to be a nurse, and to remain in or leave nursing, are made because they are female (Nowak, 2005). The characteristic of the ‘feminine’ expressed in the “subordination of self to the ‘needs’ and demands and desires of significant others, be they family members, [or] friends” (Odih, 2007, p. 88) sees nursing employment patterns configured to this day “by domestic circumstances and the workings of the household” (Odih, 2007, p. 99). The problem of the nursing workforce shortage is pitched increasingly at a specific age category – the mature age nurse – making assumptions and contradictions about gender and the gender role in people’s career choices implicit in a reading of this category of nurse.

A study by Huppatz (2010) explored gender and class practices within the field of paid caring work, interviewing 39 Australian women who worked and studied in the occupations of nursing and social work. The study found that differently classed women are differently motivated to pursue caring work. While the desire to care was a strong motivating factor for all women, nursing provided upward mobility and economic stability for working class women. It did not provide this mobility for middle-class women, a finding reflective of their class histories, with caring associated with middle-class femininity. However, both classes “experience limited financial benefits because they are operating within a feminized field” (Huppatz, 2010, p. 130).

Some people regard the dominance of nursing as a feminised occupation as an
impediment to entering the profession. The problem with such a focus is that highlighting nurses’ individual characteristics (for example, gender) perpetuates traditional discourses about nursing, where nursing is still viewed as ‘women’s work’; and a vocation (White, 2002). Assumptions about the particular type of person that will choose to do nursing are embedded in such reports. Stereotyping the occupation in this way influences career choice. Thus, despite the high demand for nurses, the occupation’s status as highly feminised is discussed as a barrier to school leavers (Dockery & Barns, 2005) and Career Advisors do not actively promote nursing as a career option in schools (King, Hardie, & Conway, 2007). Even with the educational preparation of nurses changing significantly here in Australia to university-based education for registered nurses and post-graduate preparation to meet the demands of the workplace where nurses are undertaking more complex roles and tasks, focusing on characteristics – gender, employment patterns, and age – serves to compound the “well-recognised disamenity associated with the nature of work nurses perform and their working environment” (Dockery & Barns, 2005, p. 352). Nevertheless, gender plays a role, as it does in relation to other factors deterring recruitment to nursing, such as pay and status (Huppatz, 2010; Meadows, Levenson, & Baeza, 2000; Neilson & Lauder, 2008; Staiger, Auerbach, & Buerhaus, 2000).

Studies show that pay is not a significant factor for the retention of nurses in the workforce, but that is not to say that it is not important (Aiken et al., 2001b; Buchanan & Considine, 2002; Di Tommaso, Strøm, & Sæther, 2009; Dockery, 2004; Fritjers et al., 2007; Nowak & Preston, 2001; Preston, 2005). While unions place great emphasis on pay as a key policy issue for increasing recruitment and retention of nurses (Fritjers et al., 2007), the recognition among young people that nursing is relatively low paid is
likely to influence decisions (Nowak & Preston, 2001). Broadening the attraction of nursing as a career option amongst young people requires consideration of the pay question (Nowak, 2005).

Dockery and Barns (2005) reported on data taken from an Australian national panel survey of young school leavers, a survey of first year university students in Western Australia, and in-depth interviews with 28 young women studying for their Western Australian Tertiary Entrance Examinations in 2003. The study found that in relation to other young people surveyed, those aspiring to be nurses gave preference to intrinsic over extrinsic rewards, suggesting that people entering nursing place less priority on career and longer-term financial rewards, greater priority on family, and a strong priority on working with people. The findings reported by Dockery and Barns (2005) are consistent with findings by McCabe, Nowak and Mullen (2005) from the Western Australian Registered Nurse Survey 2002 that practising nurses placed greater emphasis on intrinsic rewards. This supports the proposition that those who choose to do nursing understand nurses’ relative pay position. Alternatively, one could argue that those who choose not to do nursing see relative pay as one of the disincentives (Nowak, 2005); a disincentive that stems from nurses’ wages being figured as ‘wages of virtue’ (England, Budig, & Folbre, 2002), where those who work in occupations involving care face a relative wage penalty compared to those who work in jobs that have similar demand, skills, and qualifications.

While school leavers may perceive that nursing is poorly paid, Nowak and Preston (2001) found it was the lack of remuneration for experience and qualification that set

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6 Relative pay or wage is the wage paid to nurses relative to wages paid in alternative occupations – ‘comparators’ such as police, teaching and social work.
nursing apart from other professions, thus lowering nurses’ appeal as a long-term career; nurses’ “experience earning profile is flat” (Nowak & Preston, 2001, p. 236). This lack of recognition of nurses’ experience and qualifications was also remarked upon by Buchanan and Considine (2002), Duffield and O’Brien-Pallas (2003), and more latterly Garling (2008) in his *Inquiry into Acute Care Services in New South Wales Public Hospitals*, where he noted the eight-year pay threshold for nurses who chose to remain at the bedside as a disincentive for nursing expertise to remain at the bedside. While this issue has been somewhat addressed industrially through state and hospital collective bargaining agreements\(^7\), and in the introduction of a new national industrial award by the Commonwealth Government – the *Nurses Award 2010* (FWA, 2011b) as of 1 January 2010 – issues about recognition of qualifications and experience persist, particularly within the private hospital and aged care sectors.

Fritjers et al.’s (2007) investigation into the quitting behaviour of public sector nurses in the United Kingdom (UK) also found that while pay was important, higher average hourly wages in the NHS are insufficient compensation for the “disagreeable non-pecuniary working conditions experienced” (Fritjers et al., 2007, p. 71). Young nurses, nurses new to the job and those in managerial positions are significantly likely to leave. A similar finding was noted in Australian research by Hegney, Plank and Parker (2006), which sought to identify the intrinsic and extrinsic work values perceived by members

\(^7\) As of March 2011, collective Agreements that have increased pay thresholds greater than Year 8 and/or recognise Masters and PhD qualifications for nurses in the public sector include: *Nurses Victorian Public Sector Multiple Business Agreement 2007 – 2011* (Victoria Health, 2009); *Registered Nurses, Midwives and Enrolled Mental Health Nurses Australian Nursing Federation Western Australian Health Agreement 2007* (Western Australian Government, 2007); *Nurses/Midwives South Australian Public Sector Enterprise Agreement 2010* (Government of South Australia, 2010); *Nurses and Midwives (Queensland Health) Certified Agreement (EB7) 2009* (Queensland Health, 2007); *Northern Territory Public Sector Nurses’ 2008–2011 Union Collective Agreement* (Northern Territory Health, 2008); *ACT Public Sector Nursing and Midwifery Staff Union Collective Agreement 2010–2011* (ACT Department of Health, 2010); *Public Health System Nurses’ and Midwives’ (State) Award* (New South Wales Government Health, 2011).
of the Queensland Nurses Union (QNU) in Queensland, Australia to influence job satisfaction. This study found that length of employment influenced nurses’ perceptions of adequacy of remuneration, with newly employed nurses most dissatisfied. Shields and Ward (2001) reported that nurses’ dissatisfaction with promotion and training opportunities were found to have a stronger impact than pay.

In thinking about the above discussion, we can read how discourses surrounding health workforce policies and nursing constitute nurses as a problem, taking attention away from the structural issues of the healthcare system to shape nurses’ working life. Representations of nursing through headcounts, gender, age, grade, and/or time reinforce existing power relations in healthcare delivery. The following section explores further how numbers are used to widen discourses about how nursing is constituted.

**Employment status as an indicator of nurses’ workforce participation**

In 2008, the most recently available workforce participation survey for Australia indicated a majority of registered and enrolled nurses were in the nursing labour force (87.2%). They were either employed in nursing (96.4% and 96.2% respectively), on extended leave (2.6% and 1.5% respectively) or looking for work in nursing (1.0% and 2.3% respectively); a high labour force participation rate. Almost half of the estimated 29,469 registered and enrolled nurses not in the nursing labour force in Australia (47.9% and 55.8% respectively) were not employed and not looking for work in nursing. The number of registered nurses not looking for work in nursing steadily increased between 2004 and 2008, however the numbers of nurses actually employed in

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8 Australian Institute Health and Welfare (AIHW) Nursing Labour Force Survey collects information on the demographic and employment characteristics of nurses and midwives who are registered or enrolled in Australia at the time of the survey. It is conducted annually by State and Territory health departments. Questionnaires are distributed in most jurisdictions by the Nursing and Midwifery Registration Boards in conjunction with the registration renewal process.
nursing increased by 11.8 percent during this same period (AIHW, 2010d). In the 2006 Australian Census, 49 percent of nurses worked part-time (ABS, 2006). The nursing profile in terms of employment sector has altered little during this time; most nurses were employed in the public sector (65.4% in 2004 and 67.3% in 2008), with the private sector accounting for 34.6 percent in 2004 and 32.7 percent in 2008. Nurses working in the public sector worked slightly more hours than nurses employed in the private sector. The average hours worked per week in the public sector was 34.1, with 31.9 in the private sector (AIHW, 2010d). Some authors interpret nurses not working full-time as a potential reservoir of supply (Aiken & Cheung, 2008), assuming that these nurses could be attracted back to full-time employment. Similarly, another potential reservoir is the “shadow workforce” (McIntosh, Val Palumbo, & Rambur, 2006), that is, individuals who no longer work in nursing, but who, on paper, at least are qualified and/or hold lapsed or inactive registration (Buchan, 2006). As recently as 2008, the Australian Nursing Federation (ANF), in a submission to the Australian Federal Government’s inquiry into pay equity and associated issues related to increasing female participation in the workforce, highlighted drawing on this “untapped pool of nursing labour” (ANF, 2008, p. 14) as a strategy to increase nurses’ participation levels.

As attractive as it may be for governments to tap into this reservoir of potential nurses – assuming that these nurses would even want to be employed in nursing, but then again some may – attention needs to be paid to why these nurses left “in the first place and what needs to be done to get them back” (Buchan, 2006, p. 752). What is interesting is how the use of this metaphor of the reservoir reframes the nursing shortage problem. On the one hand numbers indicate just how ‘real’ this shortage is and the serious concern for government, while on the other hand a reservoir of nurses, or perhaps more precisely
potential ‘nursing hours’, does in fact exist, at least statistically. If we are to consider the above argument in terms of supply, the potential for tapping into this labour pool closes off considerations of some of the characteristics of the nursing labour market that perhaps makes it different to other labour markets. Shields (2004, F466) sums up what are considered to be the assumed characteristics of the nursing labour force:

1. that nursing is a female-dominated profession and lengthy career interruptions for child-rearing are common,
2. the majority of nurses are second-earners in the household, which means their response to changes in wages is likely to be different to other professions,
3. at least in the foreseeable future, there are no close substitutes for nursing skills, and
4. nursing is a ‘caring’ profession and factors other than wages are likely to be important in determining nurses’ attachment to the job.

These statements reflect the taken-for-granted views that continue to underpin assumptions of much of nursing’s work; produced discursively as matters of ‘fact’.

In summary, given some of the data about current and projected shortages of nurses being faced by governments worldwide, in terms of dealing with the problem the literature focuses on issues of recruitment of school-leavers, encouraging nurses no longer working in nursing to return, and improving the retention of current staff. However, what remains at the core of the issues of shortage, retention and recruitment is nurses’ working conditions. It remains the proverbial ‘elephant in the room’, despite numerous studies showing that is where much of the problem lies (Aiken et al., 2002; Duffield et al., 2007; Weinberg, 2003, Duffield, Gardener, & Catling-Paull, 2008). It is
by focusing on the characteristics of the nursing workforce ahead of the place of work that highlights the privileging of “numerical technologies” in governing (Rose, 1999b, p. 198), such as the Australian Institute of Health and Welfare collections of statistics, census, and budgets. These techniques, through the language of ‘categories’, allow for what Dean (1999, p. 64) refers to as the “key terms in vocabularies of rule” – such as ‘shortage’ in this study – to become embedded in government practices:

... how they actually allow practices and programmes of reform to operate ... [and] makes it possible to grasp the reason for the longevity and difficulty of abandoning such notions in public policy. (Dean, 1999, p. 65)

The following section considers these “programmes of conduct” (Dean 1999, p. 32) as the government and the profession respond to the ‘real’ situation of an ageing nursing workforce that is in shortage:

... there is a relation between the thing which is problematized and the process of problematization. The problematization is an answer to a concrete situation which is real. (Foucault, 1988, p. 17)

**Governmental practices and programmes**

**Government response: bringing nurses back**

In response to what is perceived as a health workforce shortage, the government and the professions have implemented a number of programmes to address the problem. In the
case of nursing, the *Bringing Nurses Back into the Workforce* (BNBW)\(^9\) programme was one recent federal government initiative to entice nurses back. The programme’s stated aim was “to reduce the nursing shortage” (DoHA, 2010a) by targeting some of the 30 000 qualified nurses currently “outside of the nursing workforce” (DoHA, 2010a) to return to work in public and private hospitals. The government earmarked 8 750 of these nurses for the public sector and 1 550 for the private sector. A “cash bonus” (DoHA, 2010a) of up to $6 000 was to be paid to eligible nurses/midwives who returned to work in a participating public/private hospital. Each participating hospital was to receive a $1 000 payment to employ an eligible nurse/midwife (DoHA, 2010a).

Interestingly, there was limited uptake by nurses; a mark of their resistance perhaps. In a 2009 media report, the Australian Minister for Health announced that 541 nurses had taken up the bonus in the 18 months since its inception (Bloom, 2009). One could argue that the failure of the ‘bonus’ – however generous it may be – to entice nurses back to work ignored the underlying problems faced by the profession; problems that are about the healthcare system’s structural issues. Ceci and McIntyre (2001) discussed the issue of framing the nursing workforce and its problems as one of supply and demand, stating that such framing gives rise to nurses’ sense of expendability and reinforces these beliefs for them.

On the one hand, the government and employers alike may have assumed that a policy such as this provided a concrete response to deal with the nursing workforce shortage by

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\(^9\) In January 2008 the Australian Labor Government announced that it was committing $39.4 million over five years to provide places for nurses and midwives in public and private hospitals and in residential aged care facilities. Funding for up to an additional 1,170 ongoing university nursing places per year was also included in this initiative. The Australian Government 2010-11 Budget, released in May 2010 saw funding for this scheme redirected to a number of new nursing and aged care initiatives. These include Rural Nursing Locum Scheme, Building Nursing Careers in Aged Care, Aged Care Nurse Practitioner – Models of Practice Projects and the National Regulation of Personal Care Workers/Assistants in Nursing project (Commonwealth of Australia, 2010a; DoHA, 2010a, 2010b).
tapping into that ‘reservoir’ and assumed that nurses would take immediate advantage of the opportunity; on the other hand, this has not occurred. Here, one could argue that what this effectively did was silence existing, practising nurses in that this policy could be read as a “dividing practice” (Foucault, 1983, p. 208), separating nurses into those currently practising and those no longer practising. The ‘bonus’ for existing nurses may be regarded as rewarding nurses who, for whatever reason, have chosen to leave the profession rather than rewarding those who have stayed. This is perhaps indicative of the value placed on nursing; an assumption being that anyone can ‘do’ or go back to it.

Presuppositions about what nursing is, and what it is that nurses do, remain unquestioned within this government ‘bonus’, and these remain at the crux of nursing workforce shortage issues. The constitution of nursing workforce knowledge(s) – as in shortage, gendered, and ageing – serves to present nursing as the problem rather than looking to the structural issues of the healthcare system that shape nurses’ working practices, thus leaving nurses “wary of returning to [the] workforce” (Jenkins, 2009).

**Nursing response**

The constitution of the nursing workforce within government policy, statistics, and research produces what Bacchi (2009) refers to as “governing knowledges” about the profession. The discursive effect of these knowledges is that it limits other ways of thinking about nursing within “regimes of practice” (Dean, 1999, p. 21) such as those of the Australian healthcare system. Remembering that “regimes of government do not determine subjectivity, they elicit them” (Dean, 1999, p. 32), the government, the employer and the profession’s representations of the nursing workforce as ‘in shortage and ageing’ shape nurses’ subjectivity. According to Foucault:

... for a domain of action, a behavior, to enter the field of thought, it is
necessary for a certain number of factors to have made it uncertain, to have made it lose its familiarity, or to have provoked a certain number of difficulties around it. These elements result from social, economic, or political processes. (Foucault, 2000b, p. 117)

The uncertainty of a secure nursing workforce has provoked a number of difficulties for governments, employers, and the profession alike in determining how many nurses are required for care delivery. Interestingly, the profession has responded to what are essentially economic issues of supply and demand as a measure of nurses’ work by seeking to justify nurses’ worth to the healthcare system, particularly in terms of their working time. A number of studies, the majority originating from North America, have demonstrated the relationship between the time nurses spend with patients and decreased patient mortality, or adverse outcomes associated with failure to rescue, such as cardiac or respiratory arrests, hospital-acquired infections, pressure ulcers, and length of stay (Aiken et al., 2001b; Aiken et al., 2002; Buerhaus & Needleman, 2000; Buerhaus et al., 2007; Cho, Ketefian, Barkauskas, & Smith, 2003; Estabrooks, Midodzi, Cummings, Ricker, & Giovanetti, 2005; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002; Sochalski, 2004; Tourangeau et al., 2007; Tschannen & Kalisch, 2009). More recent work has come from the UK (Rafferty et al., 2007; Schuldham et al., 2009), Belgium (Van den Heede et al., 2009), Australia (Duffield et al., 2007) and New Zealand (McCloskey & Diers, 2005), all of which have differently organised and financed healthcare systems.

The literature suggests a number of adverse consequences associated with inadequate workforce planning not only for patients but also for nurses and the organisations where they work. Solutions to the problems include restructuring the nursing workforce through approaches of measuring patient acuity or dependency, and linking them to
various models for determining nurse staffing levels and skill mix – what Dean (1999) refers to as the technical means of government, all of which will render:

Aspects of existence thinkable and calculable and amenable to deliberated and planful initiatives: a complex *intellectual* labor involving not only the invention of new forms of thought, but also the invention of novel procedures of documentation, computation and evaluation. (Miller & Rose, 1990, p. 8)

It is these processes of inscription where nurses are defining the nature and characteristics of their work – what they do – that allow for the translation of nurses’ work, ultimately expressed as nursing time, into a number. This number, in turn, will be (re)presented mathematically as algebraic equations in econometric nursing labour force studies (Shields, 2004), and in arithmetic, geometrics, and statistics for example. Hacking (1982, p. 280) writes that “enumeration demands *kinds* of things or people to count. Counting is hungry for categories”. It is the thinking about some of the kinds of things that count as nurses’ work that is discussed in the next section.

**Reframing the problem again: nursing ‘(in)visibility’**

Thus, problems with nursing ‘invisibility’ remain and continue to be raised in a context of an international shortage of nurses, and an increased need for government accountability, transparency, and regulation of nurse staffing practices, for example in legislation that mandates minimum nurse-to-patient ratios in California (Assembly Bill 394; Seago, 2002; Spetz, 2008) and the Australian State of Victoria (AIRC, 2000). That said, it is the processes of making ‘things’ visible that challenge the profession to consider or, more precisely, to reconsider what counts as nursing work. Where on one level the nursing problem is framed literally as one of headcounts, as seen in government statistics making up nursing as a commodity – as an interchangeable unit to
be costed – on another level there is an urgency for government to ensure an adequate healthcare workforce covering all of the health professions.

**Responding to (in)visibility: nursing classification systems**

Nursing minimum data sets (NMDS), nursing classification, and patient and/or workload measurement systems are all methods put forward as a means of identifying and hence making visible nursing contributions to care delivery. The nursing minimum data set may be defined as:

[A] minimum set of items of information with uniform definitions and categories concerning the specific dimension of nursing which meets the information needs of multiple data users in the health care system. It includes those specific items of information that are used on a regular basis by the majority of nurses in any care delivery setting. It is an abstraction system, or tool, designed for the collection of uniform, standard, comparable, minimum nursing data for use across various types of settings and patient groups. These data also are useful to other health professionals and researchers. (Werley, Devine, Zorn, Ryan, & Westra, 1991, p. 422)

Nursing minimum data set systems have been developed in a number of countries with applications organised primarily in terms of phenomena (diagnosis), interventions, and outcomes. They relate mostly to resource allocation (Mac Neela, Scott, Treacy, & Hyde, 2006) and serve as the overarching framework for coding and classification work in nursing (Bakken & Mead, 1997). Alongside nursing minimum data sets sit nursing classification systems, all aiming to establish a generally accepted language to capture and represent nursing through the establishment of a nursing dictionary or thesaurus. Some examples include: the North American Nursing Diagnosis Association (NANDA) classification; the University of Iowa’s Nursing Intervention Classification (NIC);
Nursing Outcome Classification (NOC); and the International Council of Nurses, International Classification of Nursing (ICNP®) classification – a classification system that was at a time posited as “nursing’s next advance” (Clark & Lang, 1992). In Clark and Lang’s (1992, p. 109) often quoted words, “if we cannot name it [nursing] we cannot control it, finance it, teach it, research it, and put it into policy”. While there may be an assumption that it is through ‘naming’ nursing where some of the solutions for the profession may lie – by making ‘it’ visible – particularly at a policy and an industrial level, one could argue that any notions of controlling, financing, and/or putting ‘it’ into policy remain somewhat elusive.

**Naming nursing and its antecedents**

The majority of classification systems have their origins in the USA and define nursing in terms of nursing judgements and activities. In October 2008, the World Health Organization Family of International Classifications (WHO-FIC) endorsed the International Council of Nurses (ICN), International Classification of Diseases (ICNP®) as a WHO-FIC related classification (WHO-FIC, 2008); a move regarded as significant for nursing.

The formal initiatives to standardise classification systems for nursing practice began in the USA in the early 1970s with Gebbie and Lavin’s (1973) nursing diagnosis. In 1987, the North American Nursing Diagnosis Association (NANDA) submitted to the WHO for the possible inclusion of nursing in what is the current 10th revision of the International Classification of Diseases (ICD-10). The submission, supported by the Canadian and American Nursing Associations, was rejected by the WHO due to lack of

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10 The WHO-FIC is a suite of classification products that may be used to compare health information internationally and nationally. The purpose of the WHO-FIC is to assist the development of health statistical systems at local, national and international levels (Maddern, Sykes, & Bedirhan Ustun, 2007).
international support (Carpenito, 1995). In response, the Canadian and American Nursing Associations lobbied the International Council of Nurses to become involved in the development of an international classification (McGuiness, 1998). The ICN Council of National Representatives passed the resolution to establish an International Classification for Nursing Practice (ICNP®) in 1989. The resolution highlighted the need to describe nursing practice in the financing of healthcare, and that the articulation of nursing practice would have practice, research, education, and policy-making implications (ICN, 2005). How successful the ICNP® or any of the other classification systems has been in articulating nursing practice is contentious, nevertheless the ongoing development and refinement of classification systems for nursing practice persists with a burgeoning number of systems and categories describing the minutiae of work in increasingly finer and finer detail.

Depth and breadth of activities being categorised

The NANDA-I taxonomy provides an example of the depth and breadth of nursing activities being categorised. It includes 206 nursing diagnoses that are grouped within 13 domains or categories of nursing practice: Health Promotion; Nutrition; Elimination and Exchange; Activity/Rest; Perception/Cognition; Self-Perception; Role Relationships; Sexuality; Coping/Stress Tolerance; Life Principles; Safety/Protection; Comfort; Growth/Development. Twenty-one new diagnoses were added to the taxonomy and six were retired in the 2009–2011 edition of NANDA-I. An example of the sorts of things being categorised under the Domain of Coping/Stress Tolerance, including some of the new diagnoses identified, sit diagnoses such as Readiness for Enhanced Relationship, Impaired Individual Resilience, Readiness for Enhanced Resilience, and Risk for Compromised Resilience (Herdman, 2009)
The Nursing Interventions Classification (NIC) taxonomy classifies interventions that nurses perform. The classification includes both physiological (for example Acid-Base Management) and psychosocial (for example Anxiety Reduction) interventions. There are interventions for illness treatment (for example Hyperglycemia Management), illness prevention (for example Fall Prevention), and health promotion (for example Exercise Promotion). Most of the interventions are for use with individuals but many are for use with families (for example Family Integrity Promotion), and some are for use with entire communities (for example Environmental Management: Community). Indirect care interventions (for example Supply Management) are also included.

The 5th Edition of NIC identifies 542 interventions that are grouped into 30 classes and seven domains. The domains are: Physiological - Basic, Physiological; Complex; Behavioral; Safety; Family; Health System; and Community. Each intervention is assigned a number or code. The NIC interventions link with NANDA nursing diagnoses and NOC outcomes (Bulechek, Butcher, & McCloskey Dochterman, 2008).

The Nursing Outcomes Classification (NOC) describes patient outcomes sensitive to nursing intervention. The Nursing Outcomes Classification, 4th Edition contains 385 outcomes, each with a label, a definition, and a set of indicators and measures to determine achievement of the nursing outcome. The taxonomy has five levels: domains; classes; outcomes; indicators; and measurement scales. All five levels are coded. This edition of NOC identifies 58 new outcomes, for example:

- 3014 Client Satisfaction
- 3015 Client Satisfaction: Case Management
- 3016 Client Satisfaction: Pain Management
• 2008 Comfort Status
• 2009 Comfort Status: Environment
• 2010 Comfort Status: Physical
• 2011 Comfort Status: Psychospiritual
• 2012 Comfort Status: Sociocultural
• 1309 Personal Resiliency. (Moorhead, Johnson, Maas, & Swanson, 2008)

Similarly, the elements that make up the ICNP® include nursing phenomena (nursing diagnoses), nursing actions, and nursing outcomes. Here, a 7-axis model provides access to ICNP® concepts and definitions. These are focus, action, client, judgement, location, means, and time (ICN, 2011a). As an example of just what is being categorised and coded in the ICNP® catalogues under the nursing action axis, we find:

Hugging

Description: Touching: Squeezing tightly in one’s arms

Type: action

Code: 10009198. (ICN, 2011b)

Not wanting to dismiss the seriousness of classification systems for nursing, nor the time spent by administrators, clinicians, and researchers on designing and developing these systems, the desire for rendering nurses’ work countable and thereby visible dominates the professional literature and is an example of governmentality at work. The logic and techniques these nurse governors draw upon in making nursing ‘visible’ render nursing more and more administrable and the subject of government.

Thus, while authors such as Clark (1999b) claim that nurses disdain naming what nurses
do, a reality requiring acknowledgement is that nursing is being defined, managed, and controlled by such systems (Clark, 1999b). Having said that, nursing’s “vocabulary problem” (Bakken, Campbell, Cimino, Huff, & Hammond, 2000) remains at issue as illustrated by the discussion between Clark and Clarke (Clark, 1999a, 1999b; Clarke, 1999a, 1999b) in one English nursing publication. Liam Clarke (1999a, p. 41) is critical of the imposition of “taxonomies of excessive elegance onto an occupation singularly uninterested in intellectualizing away the practical nature of its origins and status”.

Nevertheless, as elegant and/or excessive as these taxonomies may be, here we can see how the profession defends the supposed problem of nursing invisibility. Focusing on nursing’s (in)visibility suggests a failure by the profession to recognise where the impetus for this discourse originates, nor does it question some of the assumptions made about the need to calculate and account for nurses’ work. It is a lack of critique that is reflected in the ever expanding number of categories developed in readings of classifications systems for nursing, however named. Furthermore, it is the work of classification systems such as NANDA, NIC, NOC and ICNP® that sees them utilised as a potential “framework” (de Cordova et al., 2010) for the development of a nursing workload measure, although not necessarily in all nursing groups internationally.

Paraphrasing Hacking (1986), this would call for even more new slots in which to fit and enumerate people.

The next section illustrates how classifying nurses’ work continues to necessitate further “subdivisions and rearrangements” (Hacking, 1986, p. 223).
Nursing workload measurement

Methods of nursing workload measurement sit together with nursing minimum data sets and classification systems. The assumption is that measuring nursing workload is a prerequisite to identifying adequate staffing levels (Twigg & Duffield, 2009). Researchers and administrators have attempted to conceptualise and measure nursing workload in many ways. These include conceptualising it in terms of nursing intensity, patient dependency or acuity, or the severity of patient illness (Brennan & Daly, 2009; Connor, 1961a, 1961b; Hurst, 2005; Needham, 1997; Prescott & Phillips, 1988). While these terms may be considered conceptually similar in describing nursing work and nursing workload, they define and measure that work in different and often contradictory ways (Morris, Mac Neela, Scott, Treacy, & Hyde, 2007). The significant problem of a shortage of nurses available to deliver care means that nursing workload measurement methods are regarded as important in hospital human resource management.

At its simplest, nursing workload measurement may be defined as a method of quantifying nursing activity for staffing purposes. Nursing workload measurements are about capturing the variable nature of nurses’ work and ultimately its cost. There are several approaches to measuring nursing workload, ranging from a simple mathematical formula of the nursing hours per patient day (NHPPD) to nurse-to-patient ratios, and several commercially available software packages or systems. Some of these commercially available systems here in Australia are Excelcare, E-care, and Trend Care®, while in North America there is Grasp® (2011).

The limitations of nursing workload measurement methods have been reported
extensively in the literature. Limitations include a lack of sensitivity to patient acuity or severity (Arthur & James, 1994; Duffield, Roche, & Merrick, 2006; Hurst, 2005; Proctor, 1992); lack of clarity of design and application (Van Slyck, 2000); issues with reliability and validity (Carr-Hill & Jenkins-Clarke, 1995a, 1995b; Giovanetti, 1979; Hoi, Ismail, Ong, & Kang, 2010; Hughes, 1999); and nurses’ use and manipulation of patient classification systems to reflect a phenomenon known as ‘acuity creep’ to inflate staffing needs. Van Slyck (2000) wryly notes that ‘acuity’ here reflects nurses’ acuity, that is, nurses’ “busyness” rather than patient need for direct care. While ‘acuity creep’ may be occurring, managers also undermine nurses’ input into these systems by assuming acuity creep where there may be none. Managers are purported to downgrade patient care categories entered by nurses (O’Connor, 2001). The effect of thinking of ‘creep’ in this way is that it constitutes nurses as doers and not thinkers, and where what nurses do is defined by the interventions they perform, for example, such as those identified in the NIC classification. It actually makes nurses the problem, again. This effectively contradicts what nursing academics, administrators, and researchers are trying to achieve in ‘solving’ their (in)visibility problem, and speaks much about the politics of managing nurses in a milieu of cost containment and shortages of resources in the healthcare system.

Despite the variety of approaches to nursing workload measurement, questions of semantics – whether systems are patient classification, dependency or acuity systems – and the differences that exist between them, they all aim to estimate the total hours of nursing staff required to care for patients (Edwardson & Giovanetti, 1994).

While nursing may be considered to be an (un)quantifiable entity (Hughes, 1999), there
is some serious work being done worldwide to do precisely that – to quantify, and hence render visible, what nurses do. The vast amount of work in research and development with classification systems for nursing practice and in models of workload measurement is indicative of some of the difficulties with attempting to define the discipline.

American nursing educationalist and leader Isobel Hampton Robb (1909, cited in Van Lanschot Hubrecht, 1912, p. 21; see also Clark, 1998) proposed the development of a unifying language for nursing – what she called a “nursing Esperanto” – yet more than a century later developers and researchers continue to try to define and find the commonalities of the discipline and profession of nursing. In Foucault’s (1971, pp. 14–15) words:

The novelty is no longer what is said, but in its reappearance. For a discipline to exist there must be the possibility of reformulating – ad infinitum – fresh propositions … there is more, and there is more, probably, in order that there may be less.

**Conclusion**

The task of problematisation is to question the taken-for-granted assumptions that are embedded within representations of the nursing workforce. An analysis here is not so much about ‘solving’ the nursing workforce problem but about how representations of this workforce imply certain understandings about it – a particular (govern)mentality (Bacchi, 2009). Thus, with so much time spent in writing nursing into being, one has to question whether what is being said about nursing is indeed saying less and less, and

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11 Esperanto is a constructed or artificial language devised in 1887 as an international medium of communication, based on roots from the chief European languages. It retains the structure of these languages and has the advantage of grammatical regularity and ease of pronunciation. It originates from the name *Dr Esperanto*, used as a pseudonym by the inventor of the language, Ludwik L. Zamenhof (1858–1917), Polish physician; the literal sense is ‘one who hopes’ (based on Latin *sperare* ‘to hope’) (Oxford Dictionary, 2010).
leaving nurses’ work “neither invisible nor hidden” (Foucault, 1972, p. 108) within classification systems and models of workload measurement for nursing that reduce nurses’ visibility to a number. It is the process of enumeration that allows for the accounting of nurses’ work to determine what counts as the nursing hour.

In this chapter, I have examined a wide range of literature about the nursing workforce – academic, government debates and reports, and media statements – to build a picture of the issues, debates, and discourses used to frame the figuring of the nursing workforce problems. I have analysed how numbers dominate in constituting the nursing workforce as a problem for government. The nursing workforce is (re)presented as in shortage, ageing, gendered, and not fully at work, and presents a very real challenge for governments and employers with reference to issues of nurse staffing. Having said that, to some extent government continues to construct the nursing shortage as a problem for the profession and not for healthcare agencies or governments. The discursive effect of this on nursing is that it reframes the nursing workforce problem as one of nursing (in)visibility through the kinds of ‘things’ located in classification systems and models of workload measurement that equate nurses’ ‘worth’ to the delivery of healthcare with working time. Therefore, rather than nursing made visible, time has become the dominant way of bringing nursing into ‘sight’ through a process of reducing nursing work to a number – the nursing working hour.

I have considered how, in governing, there is a need to know about the nursing population through numbers. This shapes arguments about the nursing workforce; the forms of knowledge(s) or discourses that these arguments rely upon (Bacchi, 2009). Discourses about the nursing workforce, such as in ‘shortage’, operate as a political
rationality for how problems of this workforce are understood. This chapter has shown how the kinds of ‘things’ being counted in categorising and (re)categorising nursing and nurses feed into ways of thinking about the nursing workforce, leaving unproblematic other ways of thinking about workforce issues such as (in)visibility, where (in)visibility may not be a problem at all.
CHAPTER 3

THE STUDY

Ethnography shines a light, sometimes a very strange one, on what people are up to .... (Van Maanen, 2011, p. 229)

In this chapter, I outline the research approach, describe the field and other aspects of design, and explain in some detail the organisation, forms, and processes of data collection and analysis employed in this study; a study, to borrow from Tony Watson (2011), that is about ‘how things work’ in organisations to address what nurses are up to at work. It focuses on the way nurses’ work is managed, not only by the hospital but by nurses themselves, tracing some of the changes of that work and the implications of these changes to the nature of nurses’ work within a context of private healthcare. The field study was carried out in an Australian private hospital. The research took place over a period of a year and focused on two wards of an acute care medical surgical unit. The data generated from the use of ethnographic methods centred on participant observation with the compilation of extensive fieldnotes and semi-structured interviews at the study site, and document analysis. I encountered some issues in carrying out the study, specifically with research access and those of a more pragmatic nature around ethnographic writing. Some of these issues are explored in this chapter.

This study sought to examine how the problematisation of the nursing workforce as in shortage, ageing, and gendered, as represented in statistics, research reports, and literature, is maintained as a problem for government, employers, and the profession (and the nurses that make up this) alike. A vast amount of work has been done in attempting to ‘solve’ the problems of the nursing workforce, as we have read in the
preceding chapter. This work has focused on enumeration of many kinds, and the
development of tools such as those found in methods of workload measurement and
classification systems for nursing. Despite this, the majority of studies, understandably,
focus on the work of nurses in the public healthcare sector. This study, in contrast,
explores the private sector. How does the work of nurses play out in private healthcare,
assuming that issues of shortage, an ageing workforce, and work intensification are also
‘problems’ for this sector? What knowledge(s) do these nurses draw upon to manage
care in private health? Is care so different in private health?

It is the work of ethnography to problematise what is taken for granted, to explicate
what is “hidden in the ordinary exchanges of ordinary people in an ordinary day”
(Ybema, Yanow, Wels, & Kamsteeg, 2009, p. 1). Ethnography explores the details of
everyday working /life, which otherwise may go unnoticed “trying to read the tacitly
known scripts and schemas that organize ordinary activities” (Ybema et al., 2009, p. 2).
This thesis describes “organizations as they happen” (Schatzki, 2006, p. 1863) in the
ordinary, day-to-day activities that nurses engage in. In an effort to get “better quality
stuff” (Agar 1980), I listened, watched and created questions appropriate to the topic
and context. This chapter proceeds by describing the research design, the hospital, and
participants, as well as how this was affected by the process of undertaking the research.

**Research objectives**

Issues surrounding nurse staffing and workload are increasingly of interest for
government, employers, and the nursing profession. Changes to the financing and
delivery of healthcare, an increased importance placed on patient outcomes, quality of
care, and a global nursing shortage challenge nurses to examine how they work and how
that work is in turn accounted for. The ongoing refinement of methods of workload measurement and classification systems for naming nurses’ work suggests that these systems are not measuring enough and need to measure ‘more’. What that ‘more’ is, how that is achieved, and what these systems accomplish were some of the questions that informed this study. The previous chapter demonstrated that government policy focuses on bringing nurses back into the workforce, which is underpinned by commonly held assumptions about the characteristics of that workforce, such as ageing and gendered, and the nature of the desirability of nursing work. In thinking about some of these assumptions, I designed the research to reflect the work of nurses in private healthcare. The research objectives were to:

- explore and analyse how nurses organise themselves in their work, the ward, and the processes they use and what occurs when nurses do that;
- analyse how nurses’ taking up and working with ‘hours’ structures their work and workload;
- show how nurses manage the work intensification arising from changes to the organisation of their working time;
- explore the discourses used by nurses working in private healthcare;
- examine the ways in which discourse constitutes nurses’ subjectivity;
- determine how modes of workload measurement are used within the organisation;
- analyse some of the assumptions underpinning representations about nursing;
- consider the discursive effect of representations of the nursing workforce for the profession; and
- analyse and critique how the nursing workforce is constituted as a problem for government and governance.
In addition to the much touted nursing shortage, private health faces different challenges that are not all limited to private healthcare financing, for example. Recognising that the nursing shortage can be attributed to excessive workload and poor work environment, there is a heightened interest within organisations with systems and/or methods which can provide an ‘objective’ assessment of the number of nurses required on a given ward with a given workload. In light of the workload measurement method used by the organisation, the thesis reveals the discourses nurses’ draw upon in talking about how to organise their work.

**Location: the hospital**

The study was located in a small, not-for-profit, acute care, metropolitan private hospital in Australia. Situated in one of the oldest residential areas in an Australian state’s capital city, the hospital is set within “tranquil, heritage-listed gardens”\(^{12}\) and is minutes from the city central business district. The hospital provides inpatient, outpatient, and same day services across a range of medical and surgical specialties as well as obstetrics, and has radiology and pathology services on site. There are two other larger private hospitals and a public hospital situated within a narrow radius of this hospital, which has a close working relationship with these hospitals, particularly as it does not have an emergency department or the capacity to care for critically ill patients for a sustained period of time. There was no resident medical officer on site. The hospital was very much a local hospital with a strong, valued, community presence in the area as well as a close-knit culture:

… we are like family here. … we’re a small place, we know each other very well.

*(Linda RN, Interview transcript, p. 3)*

\(^{12}\) Hospital website
It was this sense of cohesiveness in the organisational culture that I noted in my first jottings:

*Intimate—that is what I’ve written at the top of the page in my notes. Yes, there is a ‘closeness’ or intimacy about the organisation. More about that sometime later perhaps, but it is there … everyone knowing what is going on, knowing each other and that invariably will include me. … I certainly was being made to feel part of the family.* *(Fieldnote #1, p. 29)*

**The wards**

The focus of the study was on a 54-bed medical/surgical unit. There are two wards in this unit; a 34-bed medical/surgical ward that includes a four to potentially eight-bed Level 1 Critical Care Unit\(^{13}\) (Ward A) and an 18-bed medical/surgical ward (Ward B). This unit comprises the hospital’s main general admission area, is consolidated to one floor, provides a wide range of services and specialties, and is characterised by rapid changes in patient numbers and the resultant categories or casemix of patients and associated nursing activity. The services and specialties include breast, Ear, Nose and Throat (ENT), gastroenterology, gynaecology, general surgery, oncology, ophthalmology, orthopaedics, plastic surgery, palliative care, respiratory medicine, urology, and vascular surgery. Ward A also accommodates Maternity overflow patients.

While the unit encompasses one floor of the hospital, the wards are located in different buildings and linked via a corridor that connects the two wards with the Operating Theatre Suite, Day Procedure Suite and Recovery Room. The Operating Theatre

\(^{13}\) Level 1 Critical Care Unit provides immediate resuscitation and short-term cardiopulmonary support for critically ill patients. It is capable of providing mechanical ventilation and simple cardiovascular monitoring of patients for several but usually no longer than 24 hours. Provision of care for more than 24 hours is allowed for patients with what is called single system failure and within the context of support of a larger intensive care unit where the host unit has an established referral relationship. Typically, patients admitted to this type of Unit are those post-surgical patients requiring special observations and care, unstable medical patients requiring care beyond the scope of a ward and patients requiring short-term mechanical ventilation *(CICM, 2010)*.
complex is located to one side of the corridor. The other side has windows with street views. Access to this link is restricted to hospital personnel and visiting medical and allied health professionals only.

Ward B is located in the hospital’s new wing. This wing was built some two years prior to me commencing fieldwork. It is part of a multi-million dollar redevelopment of the hospital’s facilities, which also include a specialist centre and preadmission clinic. The redevelopment has seen the provision of all single rooms with ensuite facilities for patients in the new ward and upgraded maternity facilities, setting the “benchmark for private hospital accommodation”\(^{14}\) in the city at that time and since. Ward B is the ward most likely to close during periods when the unit experiences low patient occupancy.

**Recruitment of participants**

I initially wanted to examine the perspectives of those working on nurse staffing with nursing workload measurement methods, and how these measurements then went on to influence how nurses actually work. Therefore, participants included nurses working on the wards across all grades or levels. Participants reflected the diverse ways that nurses’ work is organised from a ward to administrative level, across all shifts, thus providing varying perspectives about the organisation and management of nurses’ work and how that is achieved. Participants were drawn from a group of 79 people. All nursing staff working on the participating wards and administrative personnel were invited to participate voluntarily.

Volunteers were called from Wards A and B. Ward A nursing staff included a clinical

\(^{14}\) Hospital website
manager, clinical nurses and 30 registered nurses. All the nurses worked part-time, with only one registered nurse and the clinical manager working full-time. Experienced nurses staffed the wards. All except two of the nurses working on the ward were Year 10 or above (that is registered as nurses over 10 years ago). One was a Year 3 and another a Year 8.

Ward B nursing staff comprised the clinical manager, two clinical nurses and 15 registered nurses. All nurses worked part-time and the clinical manager worked full-time. All nurses on Ward B were Year 10 or above. Thirteen registered nurses were employed on a casual basis and worked across both wards. There were no recent graduates or enrolled nurses working on the wards at the commencement of fieldwork, however, as data collection progressed, enrolled nurses were increasingly employed. In addition, there was discussion surrounding the re-introduction of a Graduate Nurse Programme for novice registered nurses at the hospital for the following year.

The nursing administrative group included After-Hours Coordinators (AHC), Admission and Discharge Coordinator, and a Level 2 registered nurse who worked as the Admissions Officer. All of the AHC worked part-time while the Admission and Discharge Coordinator and Admissions Officer worked full-time.

The hospital’s Human Resources Department made the initial approach to potential participants, sending out the Information Sheet (see Appendix One) via its Payroll Service as an attachment to pay slips to all nurses working on the two wards. This included those employed on a casual basis and nursing administrative personnel, informing them of the study and directing volunteers to contact the researcher. The
Nurse Unit Managers also posted the Information Sheet in each ward’s communication book and notice board. This sheet also served as the advertisement for the study. During the course of fieldwork, I also carried this sheet with me, distributing it to anyone who may express an interest in the study. The sheet, along with the University Letter of Introduction (see Appendix Two) – a letter signed by the supervisor of the study – was given to participants at the time of obtaining consent to observe and/or interview them, and for some participants again at interview (see Appendix Three and Appendix Four).

Data collection

The study used ethnographic data collection methods, as stated previously. Ethnography refers to a set of research activities; a way of doing research work ‘in the field’. Ethnographic field research involves the study of people and how they go about their everyday lives. The ethnographer enters into a social setting and gets to know the people involved in it, participating in its daily routines and developing relationships with the people in it, all the while observing what is going on. Participant observation characterises this basic research approach (Emerson et al., 1995). It performs the dual purpose of placing the researcher both inside (participating in) and outside (observing) the social world of the host community. The researcher is expected to be both insider and outsider (Spradley, 1980). Participant observation rests on the assumption that it is possible to participate with/in the lives of the people you are studying – that it is possible for a while to be one of them whilst at the same time maintaining enough analytical and intellectual distance to undertake observations, and analyse and interpret what is going on (Wind, 2008). Participant observation and the fieldnotes I made constituted a large part of the data collected. How this aspect of the research was conducted is discussed in greater depth later in this chapter (see pages 67 – 69).
Other methods included interviews and document analysis. In this study, the data obtained from participant observation and interviews was used to explore how nurses sorted themselves out in their work, given the workload measurement method used by the hospital, while local level discussions about the organisation of work were then analysed for what nurses said about that work.

The participants

The study was conducted in a climate of significant organisational change, particularly within the nursing department, which saw the resignation and redundancy of a number of key nursing personnel and nurses from both wards, and included five participants. Eighteen nurses participated in the study. Participants came from both Wards A and B, and from Nursing Administration. Participants from Ward A included the Clinical Manager, Clinical Nurse and nine registered nurses. All of the nurses other than the Clinical Manager worked part-time, with the manager working full-time.

Ward B participants included the Clinical Manager, a clinical nurse and two registered nurses. Again, all the nurses worked part-time and the Clinical Manager worked full-time. There were three participants from the Nursing Administration personnel, all working as the hospital’s After-Hours Coordinators. One participant worked permanent afternoon shifts while the other two participants worked permanent night duty. All the After-Hours Coordinators were employed in a part-time capacity and worked set afternoon or night shifts. All participants were experienced registered nurses (Year 10 or above), with many having worked in various capacities not only within the hospital but in their professional careers. There was one male participant.
The length of employment service of the participants ranged from a minimum of six months to a maximum of 21 years, with the majority having worked at the hospital for seven years or more. Three participants had worked in the hospital for three years, one for four years and one nurse for 18 months. One participant was employed for just over six months before resigning. Fifteen of the 18 nurses who participated were interviewed at the end of the observational data collection, as planned. Five participants resigned from the hospital in the course of me conducting the fieldwork, as noted previously, and two of these were not interviewed further.

**Participant observation**

Rabinow (1977, p. 11) wrote in his *Reflections on fieldwork in Morocco*:

> How ethnographic. In Morocco only several days … set up in a hotel … having coffee in a garden, and had little to do but start “my” fieldwork. Actually it was not exactly clear to me what that meant, except that I supposed that I should wander around Serfrou a bit. After all, now that I was in the field, everything was fieldwork.

Participant observation was one, albeit large, aspect of data collection. Somewhat like Rabinow (1977), although in nowhere near as exotic a location as Morocco, my time was spent wandering around – perhaps more than ‘a bit’ – observing what went on. In designing the study, I envisaged that participants would agree to a period of observation of their professional practice and/or interview about their practice. Aspects of ward life that yielded data included nursing handover (or change of shift report), ward meetings, admission and discharge processes, and interactions between nurses at the nurses’ station and staff room. In addition to these ward-based observations and interviews with nurses, I had planned to generate data from interviewing senior nursing administrative personnel.
Nurses from all levels (seniority, years of service, and employment status) and administrative personnel (nurse managers) participated. These participants reflected the diverse ways that nurses’ work is organised, thus providing rich sources of information/data in terms of their varying perspectives about nurses’ work.

The participant observation phase of the fieldwork occurred over a nine-month period. It was undertaken for up to four hours a day, ranging from at least once to at most three times a week. All participants who were observed for up to two hour periods consented to the observation (see Appendix Three). Data collection was undertaken across all shifts and weekdays, including weekends, where I observed the numerous times nurses and/or nurse managers organised their work. I did not always watch the same nurse or manager. Some of these times were the more obvious moments where nurses organised the allocation of care against patient numbers. These included events such as change of shift report or handover times, and observations of the formal ‘bed’ meetings with the Admissions Coordinator, Admissions Officer, and Clinical Managers and/or After-Hours Coordinators, for example the meetings that determined the ‘bed’ movement within or between wards, ward closures, and nurse staffing. I also observed meetings on the ward with nurses and/or managers. At other times I observed nurses as they sorted out their nurse-to-patient allocations, or assignments and incidences of trouble-shooting. Most of these meetings occurred at the nurses’ station, in ward corridors, and the ward staff room. Nurses were also observed during peak admission and discharge times for the wards and hospital. The time that any one nurse was observed was at the most three times for a period of at least two to three hours duration on each occasion. Post-observation interviews were short, between 15–30 minutes. A formal one-hour interview was undertaken at the end of fieldwork with those who agreed.
Fieldnotes

Data collection consisted of fieldnotes. My work lay in the actual writing of fieldnotes; what Murphy and Dingwall (2001) refer to as the foundational moments of ethnographic representation, or the ‘data’ of fieldwork (Emerson et al., 1995). Fieldnotes being ‘de-rigueur’ in ethnographic fieldwork (Van Maanen, 1995), it was, as Emerson et al. (1995, p. 25) state:

... a defining moment in field relations when ... [one] takes out a pad and begins to write down what people are saying and doing in the presence of those very people.

Write I did. Where initially my fieldnotes were not much more than a few jottings, I was seen around the wards writing with my “notebook in hand” (Emerson et al. 1995, p. 25), openly/visibly recording nurses’ talk and work as it occurred. Notes were taken contemporaneously in the main and subsequently written up in more detail close to the time of observation – sometimes at the end of the day, or on the day or night following an episode of participant observation. However, some – three to be precise – were written literally months after an episode of observation; a lag time of three, four, and seven months respectively. An example is presented below and although I do not want to dwell on why this occurred, I reflected in my notes what made writing up these fieldnotes memorable and late:

These fieldnotes are being written retrospectively, over 3 months since I even have read/looked at these for whatever reason – tired, behind in writing up other notes, tediousness of this process, simply undisciplined I could go on really – that I may have had to continue to do so. From my readings about writing up fieldnotes I take some comfort that there is no ‘right’ way of going about this – though I glean that as soon as possible after the event seems to be a ‘good thing’ to do – where you may write thoughts, feelings, emotional responses as they are experienced at
the time, the immediacy of the situation, that the notes have an immediate quality to them and so that this is not lost (Van Maanen, 1995). Yet having said that, as I re-read the notes that I took, even a quick read of what I wrote at the time, has managed to invoke some of those responses again and this may have to do with the amount of detail that I took down at the time, though in writing some notes have noticed how some of that detail, that I thought I had wasn’t there after all; memory. Some of this lack of detail I may attribute to being distracted at the time, loss of concentration or simply trying to sort out what I am meant to be watching when there’s not much to see – assuming that there is something to see, I tend to waver. Then again, some of the notes are so v. detailed; obviously very struck by what was going on that I tried really hard to get it all down. In writing about fieldwork or more precisely the writing up of fieldwork, Van Maanen (1995, p. 7) is right to say, ’fieldwork remains a sprawling, highly personal ... activity’.

(Fieldnotes #28, p.1)

As we read above, just what to observe and how to write about it were some of the practical issues I experienced during the course of fieldwork. Regarding the focus of fieldnotes, Emerson et al. (1995) distinguish between descriptions (or inscriptions) and dialogue (or transcription). Descriptions portray in “concrete detail” (Emerson et al., 1995, p. 69) the ambience of the setting, “the people, places and things” (Emerson et al., 1995, p. 72), and actions observed. Dialogue is the written representation of something that was said, for example, conversations recorded with participants where the researcher is present or those that participants report having had with others. Writing up both descriptions and dialogue in fieldnotes can be quite difficult, however it will make for richer accounts (Emerson et al., 1995; Mulhall, 2003). Goffman (1989), “on fieldwork”, suggests fieldnotes be written “lushly” and written “loosely” where the researcher can put themselves into them where they can say, “I felt that” (Goffman, 1989, p. 131), and some of my work with writing up fieldnotes was trying to convey such feelings. Even so, writing fieldnotes:
… may be regarded as a kind of backstage scribbling … a little bit suspect, not something to talk about too openly and specifically … revealingly personal, too messy and unfinished to be shown to any audience. (Emerson et al., 1995, p. ix)

Atkinson (1991) sees the construction of fieldnotes as a “literary” activity. Fieldnotes, as a literary endeavour, are written, crafted, and come “encoded with the author’s conscience understandings and interpretations” (Coffey, 1996, p. 66). Fieldnotes are selective, purposed, angled, and voiced in their writing (Emerson et al., 1995), making fieldnotes personal and private; they are the “secret papers of social research” (Van Maanen, 1988, p. 123). In line with calls for greater reflexivity rather than reflective writing in nursing research (Allen, 2004; Rudge, 2002), where reflexivity is understood as recognising how the data were collected in the field and how the empirical material obtained is influenced by the researcher’s presence, history, interests, and the theoretical framework used, I used my notes to record not only my observations of what was going on and conversations, but also to record some of my more personal views. In writing up (or is it down?) my fieldnotes, I did not separate my descriptive and beginning analytical writing from my personal feelings and emotions into a separate journal or diary as some researchers have done (see Coffey, 1999; Allan, 2006; Emerson et al., 1995). I preferred to keep mine all together; close at hand.

Concluding interviews

Formal interviews were conducted at the end of the observation period with 15 participants. Aspects of the qualitative data collected included nine open-ended questions (see Appendix Five), beginning with questions of a more biographical orientation (‘How did you come to work at this hospital?’), progressing to asking participants to respond to a question of ‘What are some of the changes that you have
noticed in your time here?’ and using responses to this to ask participants about ‘How have these changes affected how the work is done?’ The questions where participants were asked to describe and then explain what were ‘good’ and ‘bad’ days for them elicited some interesting responses. The question where participants were asked ‘How would you describe the processes that organise nurses’ work here?’ proved to be more complex and required further clarification for some participants.

Meeting times were arranged at a time suitable for both of us. Formal interviews were mainly conducted at the participant’s workplace. All but two participants were interviewed in their own time, either before or after working a shift or on their days off. Interviews were held in a quiet, private location within the hospital grounds; two interviews were conducted at a private residence. The hospital’s lecture theatre was used for most interviews. Other locations included the handover room or the lounge room on one of the wards. On one occasion, a participant was interviewed in the staff dining room prior to her working a night shift. On another occasion, an interview was conducted in an unoccupied patient room on one of the wards.

All participants had the right to access any personal information, including the right to correct or remove information at any time. Taped interviews were transcribed verbatim as soon as practicable after data collection for participants to sight and amend as necessary. Here, I am able to report that no amendments were made to transcripts other than many participants apologising for, and expressing a desire to correct, the grammar in their transcripts.
Document analysis

A third element of data involved document analysis. This involved putting together the texts of:

… what might be called the ‘library’ or documentary field’, which includes not only the books and treatises traditionally recognized as valid, but also all the observations … [and] the mass of statistical information [found in the academic, parliamentary and grey literature data]. (Foucault, 1972, pp. 51–52)

The documentary field also included a wide range of organisational literature, both formal and informal documents. Formal organisational documents included patient information material, such as brochures, industrial awards, in-house and regulatory policies, nursing rosters and patient allocation documents, the hospital’s annual reports or ‘Annual Review’, newsletters, and publicly available material located on the hospital’s website. Informal documents included those noted on the staff notice-board, communication notes between staff such as the ward communication book/diary, staff allocation book, nurses’ scraps of paper, – and some literally were ‘scraps’; a paper towel, Post-It® notes – and nurses’ handover sheets or worksheets. These sheets also included what was, for many nurses, their ‘second sheet’ – a document of varying formats that nurses put together themselves to supplement the ward’s allocation sheet or Daily Care Chart. This material was chosen as part of the textual detail of nurses’ everyday interactions of their working day, and all played a role in governing the context and content of nurses’ work. While some of these texts were located at the macro level of work organisation, for example industrial awards and policy documents, it was some of the more ordinary texts, such as nurses’ bits of paper and handover

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15 Post-it® – Trademark that belongs to a line of stick-on stationery products manufactured by 3M.
The study sheets, which became of increasing interest in explicating nurses’ organising practices. It was these seemingly marginal texts, which nurses handled/used daily to sort out their work, that increasingly came to represent this work and form a part of the analysis not previously recognised in the project’s aims.

**Ethics and access to the field**

**Access: getting in**

Research access was initially discussed with a colleague and friend who worked at the study site in an senior administrative capacity to ‘sound out’ her thoughts regarding the possibility of conducting the study at the hospital and, more specifically, on her unit. At the time, I was unsure about the size of the unit, if the study were to be conducted solely on one ward, and determining which ward(s) and specialty, if any.

My initial discussion with this colleague was useful in getting an idea or feel for how management may possibly regard this study, given the research topic about workloads in nursing and ‘nursing hours’ being conducted at the hospital. This colleague immediately offered support for the research and explained some of the pragmatics of gaining access to the hospital and the process for ethics approval. She highlighted that, as a rule, institutional ethics approval was conditional on my first obtaining University ethics approval. Upon confirmation of University approval for the study, hospital ethics approval would usually follow. She also indicated that she would speak with the nursing executive during the course of that day to inform her that there was some external interest in conducting a study at the hospital. This is precisely what happened. Discussion with the nursing executive\(^{16}\) occurred later that day, whereupon the

\(^{16}\) Throughout this thesis the term nursing or nurse executive is used to denote the executive position
executive was advised that a colleague was interested in conducting research about nursing workloads in private hospitals. This was met with a reply of *let me know if we can help*\textsuperscript{17}. Thus, to put in train the process of access, I rang the hospital to make an appointment to see the Nurse Executive. The main switchboard put me through to the nursing executive Personal Assistant who requested that, in the first instance, I forward all documentation relating to the study electronically to their office for the Nurse Executive to review, who would in turn contact me. I duly forwarded an email to the Nurse Executive office, with the University’s Human Research Ethics Committee Application and supporting documents. In this email, I also indicated that I was seeking a letter from the hospital for the University Ethics Committee confirming that there was in-principle support from the hospital for the conduct of the study at this site.

**Ethical considerations**

The relevant University Human Research Ethics Committee (see Appendix Six) granted provisional approval for the study, being for the observational component, requesting that a list of interview questions on completion of observational data collection be submitted to the committee prior to the conduct of individual interviews. On receipt of this letter from the University (see Appendix Six), the hospital’s Human Research Ethics Committee (see Appendix Seven) approved the study and I commenced fieldwork almost immediately. Final approval for the study was granted some six months later following submission of the formal interview questions (see Appendix Five).

\textsuperscript{17} Anita Nurse Unit Manager, Fieldnotes #1, p. 4.
Participants were interviewed individually and in private to maintain confidentiality. All were briefed at the beginning of each session to assure them that their comments would remain anonymous and confidential. Permission was sought to observe nurses’ organising practices – how they sorted themselves out – and tape-record interviews only. The study did not involve me observing patients and/or staff attending to patient care. Each participant was advised that the research was not being undertaken by the hospital and that their names would not be identified either verbally or in writing to persons within the organisation. The voluntary nature of participation was stressed and participants were free to withdraw at any time without prejudice.

Managing confidentiality, or more precisely anonymity, was a key issue for me throughout this study, with ensuring the anonymity of the study site and participants being particularly problematic. Managing this included me removing any names from interview transcripts and observational data, including those that could identify the hospital in any way and with no record retained as to how data relate to individuals. Participants are identified with pseudonyms and occupational designation in this thesis. Pseudonyms were taken from the cast of Fellini’s (1963) film La Dolce Vita and do not in any way reflect participants’ original names or ethnicity. Interviews were transcribed as soon as practicable by a transcriber known to the University, who also signed a confidentiality agreement (see Appendix Eight). This is also indicated on participants’ Information Sheet(s) (see Appendix Two). Similar to what Wiles, Charles, Crow, and Heath (2006, p. 292) found in their study of researchers, I “had, at times, to leave out some of what [I] consider to be [my] best data” to ensure the anonymity of participants who were themselves known in a ‘community’ in the study, in my case nurses working in a small hospital. This entailed more than the use of pseudonyms and the removal of
identifying references. Kaiser (2009) notes that while changing names may remove personal identifiers, contextual identifiers remain. This author adds that unlike changing names, changing additional details to make the data unidentifiable may render it useless in addressing the research question (Kaiser, 2009). Van den Hoonaard (2003) argues that ensuring complete anonymity for participants is impossible in ethnographic studies. In closed or intimate settings such as hospital wards or units, people will attempt to discover who has spoken about what “or what is even worse, claim that they can recognize them when they are, in fact, wrong” (Punch, 1998, p. 176). In the end, van den Hoonaard (2003) suggests that what may preserve participants’ anonymity may be the public’s profound disinterest in social [or nursing] research, and the time lapse between data collection and actual publication. While I may like to think that there remains some interest in this research, there has been a four-year time lapse between fieldwork data collection and submission.

**Access: getting on and out**

My initial access to the hospital was very straightforward, or so it seemed, and much could be attributed to the support of a colleague who facilitated my introduction to the hospital, not only to the then nursing executive – prior to this person’s redundancy – but thereafter throughout the project. This colleague’s position within the organisation provided not only line authority to support the research but it facilitated my introduction to others within the organisation. Whilst the Chair of the hospitals’ Human Research Ethics Committee was my key contact person with regard to research issues, it was this colleague who was in many ways instrumental in facilitating research access.

The significant role of sponsors and/or gatekeepers in qualitative research projects has
been written about extensively, with studies noting how individuals who not only exercise control over physical access but also provide or withhold information are often those who hold pivotal hierarchical positions within the organisation being studied (Burgess, 1991; Chapman, 2001; Magolda, 2000; Reeves, 2010; Street, 1992). Access is sometimes easier for researchers who have existing links with those in power (Duke, 2002). Yet, “just as sponsors may open some doors, their support of a project may close others and make participants suspicious of their motives” (Burgess, 1991, p. 46).

Fieldwork at the hospital went smoothly for the most part, despite an ‘organisational predicament’ (Toffoli & Rudge, 2006) experienced after almost a year. This incident resulted in suspension of the study for six months while the matter was dealt with via the relevant University channels (see Appendix Nine).

The suspension of the study brought to a close any further data collection at the hospital. I had planned to interview the nursing executive as part of the original study design, but with the suspension of the study this did not occur. In order to further safeguard the anonymity of the organisation, participants were asked to sign a confidentiality agreement as an addendum to their consent form. This was a specific request by the hospital. Continuation of the study was conditional on this requirement being met. In line with the National Health and Medical Research Council ‘National Statement on Ethical Conduct in Human Research’ (NHMRC, 2007) and in light of the concerns raised by the hospital, I also instructed participants not to disclose their names or any personally identifiable information about their fellow participants or the hospital to others, and asked that this requirement be respected.

Although the suspension of the study was disappointing, it was, to some extent, unsurprising. Hospitals are, after all, highly structured, protected, exclusive, and
excluding institutional spaces (Foucault, 1973/1997; see also Long, Hunter & van der Geest, 2008, p. 71), making access to ethnographic research not necessarily easy. If anything, I had been surprised how easy it was to negotiate initial access. Chapman (2001) writes that access when researching companies is nearly always a problem, not only because of companies feeling ‘over-researched’ and issues with exploitation of contacts and friendships, but also that a company is a “potentially highly sensitive and litigious organisation” (Chapman, 2001, p. 31). In the ‘risky’ climate in which healthcare organisations operate, research into nurses’ work that may be perceived to result in disclosure of confidential material about business contracts, organisational issues, and/or a fear that the researcher will make public concerns expressed by nurses highlights the vulnerability of organisational reputations. Fichter and Kolb (1953) write that there is a “difference between imaginary and objective derogation of reputation” (Fichter & Kolb, 1953, p. 49; see also Becker, 1970, p. 109). These comments are as pertinent now as when they were first made. Becker (1970) suggests that organisations and participants may fear harm where none is likely. Nevertheless:

Fieldworkers, it seems, learn to move among strangers while holding themselves in readiness for episodes of embarrassment, affection, misfortune, partial or vague revelation, deceit, confusion, isolation, warmth, adventure, fear, concealment, pleasure, surprise, insult, and always possible deportation. Accident and happenstance shapes fieldworkers’ studies as much as planning or foresight; numbing routine as much as living theatre; impulse as much as rational choice; mistaken judgements as much as accurate ones. This may not be the way it is reported, but it is the way it is done. (Van Maanen, 1988, p. 2 emphasis added)

This chapter and thesis endeavour to report to some extent the way my research was done.
Researcher identity

Hammersley and Atkinson (2003) state that gatekeepers, sponsors, or those that act as hosts to the research operate in terms of the researcher’s identity – one constituted as ‘expert’ or ‘critic’ – with either positioning serving to make gatekeepers uneasy about the likely consequences and effects of research conduct. Researcher identity proved to be a shifting position throughout the course of fieldwork. My hospital Identity Badge identified me as Research Registered Nurse and while I did not wear a registered nurses’ uniform, or a white coat as other researchers studying nursing have done (for example, Latimer, 2000; Allen, 2001), I dressed what could be best described as ‘for the office’ – smart casual, with flat heeled shoes. Although I was a doctoral student, being identified as a registered nurse enhanced and gave me some legitimacy to be ‘there’, if you like, particularly for the times when I assisted nurses with patient care. Examples of this include helping to take and/or collect patients from theatre and recovery room in the absence of theatre personnel or porters, assisting with patient hygiene, bed-making, answering phones, and relaying messages to staff, patients and doctors. Establishing my researcher credibility in the hospital – as opposed to my nursing one – I engaged in what Goffman (1989, p. 126) refers to as ‘telling practices’ or some well-rehearsed lines to account for my presence; a presence that was neither expert nor judge – or so I thought. My first day in the field one nurse commented you’re the one here to judge us18. While I reassured this nurse that I was not there to ‘judge’, I reflected in my fieldnotes that:

... in some respects there is judging, no doubt I’ll be comparing – especially with [private hospital where I work] ... will be hard not to. (Fieldnotes#1, p.11)

My fieldnotes are interspersed with references to managing my identity or researcher position. I was fighting familiarity from the outset (Delamont & Atkinson, 1995) as I

18 Fieldnotes #4, p. 1
sought to work out my role:

*I am quite clear that I am not there as a nurse, for a start I am not employed by the hospital in any capacity and that alone defines what I can and cannot do.* (Fieldnotes #8, p. 2)

Later that same day, however:

*Already…I am fighting with my familiarity of nurses’ work, the private hospital system, my own familiarity with and to the staff/personnel… intimacy.* (Fieldnotes #8, p. 2)

Allen (2001) points out that situations are neither totally familiar nor totally strange. Although I had worked as a nurse in private health for the best part of my professional life I was not employed by the hospital, I was not known to the majority of the staff, and while there was much that was familiar, there were things that were not. So, how was I positioned? As a colleague by some, or as someone who was potentially another pair of hands, where, after I had listened to handover, one participant asked me: *Can you stay until ten thirty?*19 Others positioned me as an After-Hours Coordinator or Nurse Manager from a competing private hospital. Associated with that particular positioning was a perception that there was potentially a conflict of interest. Some nurses, and more latterly the hospital executive, considered this to be the case. Whilst there was this perception of a conflict of interest – and this was certainly an argument put forward by the Nurse Executive when the hospital sought to halt the study after almost a year of fieldwork – I had resigned from my workplace by the time of the incident.

The hospital was undoubtedly challenging in terms of access. While I had my suspicions from the outset about issues of access with getting in, let alone getting on

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19 Yvonne RN Fieldnotes #13, p. 2
with it and getting out (or thrown out as was the case), some of the nursing staff perceived my presence in the hospital suspiciously from day one. On my first day in the field, within the space of an hour of walking onto one of the wards, I was confronted by a registered nurse who immediately and quite sharply questioned my presence in the hospital, wanting to know why I had chosen this particular hospital (rather than conduct the study in my workplace) and if ethics approval for the study had been granted. Whilst this nurse had every right to question my presence on the ward/hospital and was possibly more forward than others in doing so, I could identify with, and was not unsympathetic to, her concerns. In my fieldnotes I wrote:

... why wouldn’t they [nurses] be suspicious of someone coming in to do research about what they do? Perhaps this comes down to nurses being wary of nurses doing research and I’ll include myself here. Some of my thoughts return to things I’ve heard said over the years about nurse researchers ... that there’s something about nurses doing research compared to other disciplines. Is there still a cringe element? ... Possibly? ... Perhaps we haven’t come a long way after all.
(Fieldnotes #4, p. 5)

Now, whether or not there is a cringe element with nurses conducting research on nursing remains a point for discussion. Is research into nurses’ work by nurses, rather than other disciplines, simply too threatening, however much nurse researchers and academics may like to think otherwise?

Burgess (1991), writing about maintaining access in educational settings, notes that the root of rumours and concerns by participants lies with concerns of the study’s independence from organisational authority and the implications the study would have. It may be argued, along with Burgess (1991), that in this study of nurses’ organising practices it was precisely this independence from organisational authority that got me into trouble! Nevertheless, my presence in the organisation was variously explained.
away as working with the Australian Nursing Federation (ANF) or union, given that the hospital’s enterprise bargaining agreement (EBA) discussions were underway. On one occasion, while following one of the After-Hours Coordinators, a nurse asked if I was a new staff member being orientated to the role. I was frequently positioned as a confidant, someone who nurses could talk to and who was perhaps perceived as neutral but at the same time someone they thought could do something with their concerns, given the research topic; I was privy to hospital gossip and included in conversations. Others simply saw me as someone from the university. This would suggest an ambiguous positioning – student, researcher, not nurse:

*It is all very friendly and I certainly feel part of the hospital yet at the same time not part of the place bit more part of it than I thought I would be. One nurse makes comment about my presence and likens it to a cameo; ... my records are a cameo of the hospital.* (Fieldnotes # 25, p. 9)

The dictionary defines a cameo as “a short piece of writing which neatly encapsulates something [and] a small distinctive part played by a distinguished actor” (Oxford Dictionary 2010). Flattering as it may be to be thought of as a distinguished actor playing a part, albeit small, it was this comment, that of ‘a cameo’, that for me elegantly encapsulated the researcher position. Although, having said that, fieldwork was also marked with some rather inelegant moments. Watson (2008) writes that fieldwork requires a sophisticated level of identity work (both inward looking and outward looking) to handle the tensions of switching back and forth, in my case from being nurse or researcher, or was it is both (Borbasi, 1994)? During the 1990s, publications about the identity work experiences of nurse researchers were a focus of some discussion (Borbasi, 1994, 1995; Gardener, 1996; Lawler, 1995; Rudge, 1995); a discussion that remains unresolved. Identity aside, my predicament may have occurred as a
consequence of the amount of time I had already spent at the hospital – almost a year. Murphy and Dingwall (2007) suggest that as researchers become more integrated into a setting, their hosts may come to overlook the research purpose and the researchers’ identity so much so that the researcher fades into the background. This was certainly my experience. It was only when I approached the Nurse Executive for what I had expected to be one of the final interviews, if not the final interview for the study, that my presence at the hospital was foregrounded, leading the organisation to halt the study.

**Data analysis**

Van Maanen (1996) writes of the work involved in producing ethnographic research. The practices that produce an article, book, or in my case a thesis, are ‘textwork’. In his words:

> Textwork concerns the ways we manage to get from printouts to narratives, from fieldnotes to ethnographies, from ideas to theories … Our ways with words inevitably involve many others. (Van Maanen, 1996, p. 377)

In my study, the writing and re-writing of fieldnotes, draft chapters, the transcripts of the interviews conducted, organisational documents/texts collected, conference presentations, conversations, emails, notes with supervisors, discussions with colleagues and friends, and my readings all constituted the textwork involved in producing this thesis. Selection of text for this study constructed a corpus; a plethora of material with my fieldnotes comprising the largest part. Analysis of the corpus allowed me to trace the ways in which nurses’ work is thought and talked about; how it is constituted as discourse. As explained in Chapter 1, the analytical framework of Foucault’s (1972) archaeology was used to explicate how certain knowledges or representations about
nurses’ work shape nurses’ everyday practices. The following chapters (4–8) are framed by the four criteria Foucault describes in Part II of *Archaeology of Knowledge* (Foucault, 1972) that need to be met in order to define a discursive formation. In this thesis, archaeology is used to uncover the discourses that are manifested in representations of the problems of nursing. The representation of nursing in a particular way has implications for how nursing is thought about and how it is practised. The analysis is informed by governmentality theory as the over-arching analytical framework; a theory that focuses on how a particular way of thinking or mentality governs practice(s), and is most relevant to the thesis exploration of the relationship between discourse and governance in private healthcare.

**Lessons learned and limitations**

The issue of maintaining research access persisted throughout data collection and while there was little difficulty with gaining access to the study site – a very straightforward process – the incident that led to a six-month suspension reinforced some of my initial misgivings about the research. These misgivings stem from knowledge built up in working for the best part of my professional life as a registered nurse in the private healthcare sector. Chapman (2001) notes managers’ disaffection with the practices of business research and suggests that one way of dealing with maintaining research access “is to work for the company under study” (Chapman, 2001, p. 32 emphasis in original). While this is a pragmatic and corporate view of research access in organisations, there comes a point, as I discovered, where, as a researcher, a decision is made about ‘who’s side are we on?’ (Becker, 1967). Access was not simply about entry to the study site, something negotiated once and then forgotten about. It was something that had to be examined both for the way it transformed research and was continuously negotiated
throughout the time of fieldwork (Hirsch & Gellner, 2001). Given the inquisitiveness and intimacy of this form of inquiry (Van Maanen, 1988), any sense I had of being ‘part of the family’ or ‘at home’ was perhaps “a danger signal” (Hammersley & Atkinson, 2003, p. 115); a sign of things to come and something that, with hindsight, I should have heeded. Then again, it may not have mattered because, as Cohen (2000, p. 319) points out:

> The roots of our problems in the field often begin long before we enter the field – with the theoretical questions which we define in the classroom, in the library and in consultation with other [nurses].

The research was always going to be political, and my incident only reinforced the political nature of the study and the sensitivities for organisations with workplace research. My insights, rather than being dismissed, needed to be acknowledged for what they were – insights. As a researcher, I possessed a somewhat shared history (Coffey, 1999) with the nurses employed in this hospital in so far as I was of a similar age and experience, and had worked in private health for most of my professional life. I knew the industry. It may have been more of a concern if what I had experienced and/or found was very different in other private hospitals. If so, raising questions about what this hospital and its nurses were doing differently, and indeed if it was very different, would say a great deal; operating or working outside the norm or ‘standards’ as it were. After all, I was studying the familiar and as Spradley (1980, pp. 61–62) observes:

> I would offer one word of caution: the more you know about a situation as an ordinary participant, the more difficult it is to study it as an ethnographer. It is no accident that ethnography was born and developed in the study of non-Western cultures. The less familiar you are with a social situation, the more you are able to see the tacit cultural rules at work.
Goffman (1989) reminds us that the rationale of fieldwork for the researcher is to develop a “deep familiarity … getting material on a tissue of events” (Goffman, 1989, p. 130). Thus, coming into the field with a ‘deep familiarity’ of nursing in private health, whilst not without its issues, enabled me to ‘get on’ with fieldwork for almost a year during what was a challenging and sensitive time for the organisation. However, what I learnt was that ‘getting in, getting on, getting out and getting back’ (Buchanan, Boddy, & McCalman, 1988) was simply more than a question of obtaining ethics approval and getting permission from senior management; nor was my comportment enough to ensure access. Organisational reservations about the study – with issues of confidentiality and the question of ownership of the data, where an executive believed that they (or the organisation) had rights to these data resulting from their power as gatekeepers – made for a challenging end to fieldwork. My ‘ethically important moment’ (Guillemin & Gillam, 2004) may also have come about through the hospital executive’s lack of understanding of qualitative and/or ethnographic research, and differing expectations of research ‘outcomes’. Van Maanen (1991) writes that the work routines of a fieldworker are regarded as unusual – hanging around, snooping, chatting, taking notes, and asking odd (often dumb) questions. Wind (2008) contends that these activities, where researchers are perceived as “doing nothing” (Wind, 2008, p. 83), may not come across as work and certainly not as academic research.

**Conclusion**

Experiencing and accepting that the “unbearable slowness of ethnography – from ‘getting in’, ‘getting out’ to ‘writing it up’ – is an enduring feature of the work” (Van Maanen, 2011, p. 220) highlighted what is for some the problem of time in ethnographic work (Willis, 2010); time, as the length of time spent in the field, as captured in my
fieldnotes, and the time taken to write this thesis. While time was problematic – it has certainly taken long enough – more important for me was the problem with writing this work, whether in my “private data sets of fieldwork” (Marcus, 2009, p. 21) or the final thesis.

This chapter has described how I sought to ‘figure out’ ethnography (Fortun, 2009). It has touched on some of the problems and dilemmas I experienced. The ethical dilemma that I experienced, particularly around ensuring confidentiality and anonymity by naming or not naming people, the hospital, and where in Australia this study was located, raised some very practical issues for me about managing research. I learnt that in assigning pseudonyms to participants and/or the hospital\(^{20}\) – what I regarded as an expectation of research practice and one that is also addressed to obtain ethics committee approval – this practice was not as simple as it seemed; nor were verbal or written assurances about ensuring confidentiality and/or anonymity in the writing of fieldnotes or the thesis.

The issue of research access was a defining feature of my fieldwork experience, as were some of the practicalities of writing fieldnotes and how to best represent whatever ‘small discovery’ (Tjora, 2006) I made while respecting the hospital’s requirement for confidentiality and anonymity. During my fieldwork I learnt very quickly that ethnography was no soft option – not that I ever thought it would be, but that aside, to quote Punch (1998, p. 159), ethnography is not a “soft-option, but rather represents a demanding craft that involves both coping with multiple negotiations and continually dealing with ethical dilemmas”.

\(^{20}\)In the end, I did not give the hospital a pseudonym. It is referred to throughout the thesis as ‘the firm’, ‘the hospital’ or ‘the organisation’.
This chapter has touched on some of those dilemmas. Ouroussoff (2001, p. 35) writes that what distinguishes ethnographies in organisations from other studies “is its goal: to extend perceptions of cultural differences”. This thesis endeavours to extend perceptions of nursing work in private healthcare as it considers the discourses that govern nurses’ work in a private hospital. The following chapters present material from this ethnographic exploration of nurses’ organising work, its particularities and intimacies, and detail it in a way that no mode of nursing workload measurement can.

The next chapter begins to explore how nurses are governed by identifying the discourses that influence how nurses and nursing are managed in this hospital.
CHAPTER 4

TAKING CARE OF BUSINESS

Drawing upon Foucault’s (1972) archaeology, this chapter begins to analyse nurses’ discourses in private health. As we read in Chapter 1, Foucault, when questioned about his method, commented that his focus was to analyse ‘practices’ or, more precisely, ‘regimes of practices’, where “what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect” (Foucault, 1991, p. 75). A moment of discontinuity is the starting point for identifying where what is said and done transforms into historical change. In taking this form of analysis into “the ‘talked’ and ‘textual’ nature of everyday interaction in organisation” (Alvesson & Karreman, 2000, p. 1126), the hope is to identify nurses’ organising practices. The starting point for an analysis of nurses’ work in this hospital is situated within reforms to the private healthcare system over the past decade and, as a consequence, patients’ demands in terms of their ‘private’ care. An analysis is framed by one of the four criteria described by Foucault (1972) in Part II of Archaeology of Knowledge – the formation of objects. The other criteria, formation of enunciative modalities, concepts, and strategies will be taken up separately and frame the following chapters.

The aim of this chapter is to map the objects of nurses’ talk by focusing on three aspects: the surfaces of emergence, authorities of delimitation, and the grids of specification (Foucault, 1972). It is in exploring and weaving through the chapter the relations between the “authorities of emergence, delimitation and specification” (Foucault, 1972, p. 44) that make the emergence of new objects possible. Working through these relations allows the object of nurses’ talk to emerge. As we will read, this
talk centres on the cost and the business of delivering private healthcare where discourses of business management govern practice.

I briefly outline how the private healthcare system is situated within the context of neo-liberalism by describing the Australian private healthcare system and exploring legislation pertaining to private healthcare to set the context of nurses’ work. These descriptions serve partly to contextualise the following chapters. The discussion illustrates how, within the political rationality of neo-liberalism, aspects of the healthcare system are problematised for government. Understanding that political rationalities are about certain kinds or “way[s] of thinking about the nature and practices of government” (Gordon, 1991, p. 3), this chapter moves to show the manner in which nurses in the studied hospital discuss particular understandings about private health. In an attempt to ascertain what was being said about whatever ‘it’ is within a grid of discourses that constitute nurses’ work in private healthcare, in the first instance I explore:

... the first surfaces of their emergence: … the conditions required if one is to ‘say anything’ about it, and if several people are to say different things about it. (Foucault, 1972, pp. 41–44)

The following section begins to describe the object of nurses’ talk by tracing, in the first instance, what was simply being said within the context of the political rationality of neo-liberalism.

**Neo-liberalism, nurses and private healthcare**

Talk of ‘excellence’ and ‘quality’ emerged very quickly from an immediate reading of the observational and interview data. The emergence of discourses that focus on
management concepts of excellence and quality at this juncture, within a context of healthcare reforms driven by neo-liberal governmental rationalities, requires explanation. These concepts feature an emphasis on the market, minimal state intervention, and individual choice, composing strategies for what Miller and Rose (2008, p. 34) call “government at a distance”. Rose (1996) identifies three characteristics of neo-liberalism – a changing relationship between expertise and politics, a new pluralisation of social technologies, and a new specification of the subject of government. I now elaborate on these characteristics.

**Changing relationship between expertise and politics**

Changing power relationships in liberal modes of rule shift power from reliance on truth claims of expert knowledges to those found in “calculative regimes” (Rose, 1996, p. 54) that promote “Making people write things down, prescribing what must be written down, and how, is itself a kind of government of individual conduct, making it thinkable according to particular norms” (Rose, 1996, p. 55).

Audits are a key mechanism in such a regime, and in the process of ‘things’ being made auditable, they produce new grids of visibilities for the conduct of organisations and those who inhabit them (Rose, 1996). Particular understandings about nursing are framed within economic discourses of supply and demand found in the Australian Government’s annual data collection on the demographic and employment characteristics of Australia’s nursing workforce, as demonstrated in Chapter 2. This is also reflected within nursing in the quantification of nurses’ working time and development of classification systems for nursing practice that standardise care.
A pluralisation of social technologies

Neo-liberalism is marked by increasing privatisation and marketisation as the market is applied to areas outside the usual realms of state governance such as health and education. In Burchell’s (1996) opinion, this occurs through reference to contrived forms of the free, entrepreneurial, and competitive conduct of individuals, and saw “the supplanting of certain norms, such as those of service and dedication, by others, such as those of competition, quality and customer demand” (Rose, 1996, p. 56). This statement resonates with the changing professional norms of nursing, and is manifested in private healthcare and the changing constitution of ‘care’. That aside, how the state manages to limit its role is through what Rose (1996, p. 56) calls the “quango-ization of the state”. This is where quasi-governmental organisations, for example the Australian Nursing and Midwifery Accreditation Council (ANMAC), take on the state’s regulatory functions. The Australian Nursing and Midwifery Accreditation Council (ANMAC) is an ‘independent’ accrediting authority for nursing under the National Registration and Accreditation Scheme. The Council sets standards and accredits nursing and midwifery courses and providers (ANMAC, 2011). Although quasi-autonomous, these types of organisations are also accountable to the state and to governance through meeting accountability measures such as targets and performance indicators (Rose, 1996). While the state limits its role in governance on the one hand, it continues to influence how rule occurs through ANMAC, for example, on the other. It does so by encouraging organisations and individuals to conform to market norms by making themselves ‘marketable’. In relation to my study, the hospital ensures that they and their staff meet regulatory standards as set by institutions such as ANMAC or others. As for nurses, meeting these standards is the basis for their future employability.
A new specification of the subject of government

A final consideration is creation of subjectivities that sees “the enhancement of the powers of the client as customer – consumer of health services, of education, of training” (Rose, 1996, p. 57). Rose (1996) argues that ‘advanced liberal’ strategies of rule are found in diverse areas such as workplaces, development programs, educational institutions, and health and welfare agencies that encourage people to see themselves as individualised and active subjects responsible for their own welfare. Individuals become enterprising subjects, an “entrepreneur of himself or herself” (Gordon, 1991, p. 44), enhancing their quality of life through the choices they make and fulfilling themselves within domains such as their families and workplaces. Nursing has not been immune to the effects of neo-liberal attempts to make Australian healthcare more competitive and these are particularly evident in the private healthcare sector. As part of neo-liberal efforts elsewhere, for example, there is a history of scholarship with workload measurement systems and/or methods for nursing from industrial engineering (Connor, 1961a, 1961b) and a proliferation of work in North America in the 1980s with the advent of managed care (De Groot 1994a, 1994b; Giovanetti, 1979; Malloch & Conovaloff, 1999; Malloch et al., 1999; O’Brien-Pallas, 1988; Van Slyck, 1991a, 1991b). Changes to healthcare delivery, as well as financing worldwide and within the Australian context, have contributed to foregrounding the calculations of nurses’ working time for administrators and nurses alike. I now turn to an analysis of the Australian context.

Australian healthcare environment

In this section, I describe the main discursive influences on the Australian healthcare environment, a system that is a complex mix of public and private service providers,
and a variety of funding and regulatory mechanism (AIHW, 2010a). Understanding the policy and funding context frames the discursive influences on the nurses in a small private hospital. The Australian government at a federal, state, and territory level, health insurers, and individuals fund the healthcare system. Australians can elect to be treated as either public or private patients in the public health system. Medicare, Australia’s universal taxpayer-funded health insurance scheme, was established in 1984. Administered by Medicare Australia (formerly the Health Insurance Commission), the scheme provides for free or subsidised treatment by medical practitioners, participating optometrists, services delivered by a practice nurse on behalf of a general practitioner (GP), certain diagnostic and therapeutic procedures and, for certain services, eligible dentists and allied health practitioners. Australian taxpayers contribute to the cost of Medicare through a Medicare levy. According to the Medicare Levy Act 1986 (Cth), the levy is 1.5 percent of taxable income for those earning above $18,488 for singles and $31,196 for families. The low-income threshold for people on pensions below aged pension age is $27,697. Individuals and families on higher incomes may have to pay a one percent surcharge in addition to the Medicare levy if they do not have private hospital insurance. This surcharge was introduced as part of a number of health policy reforms known as the Private Health Insurance Incentives Scheme (PHIIS) by the then conservative Liberal-Coalition government (1996–2007) in the late 1990s, which aimed to increase enrolments in private health insurance and reduce public healthcare costs (Elliot, 2006; Ellis & Savage, 2008). The first of these reforms under the Private Health Insurance Incentives Act 1997 (Cth) and Private Health Insurance Incentives Act 1998 (Cth) provided income-based tax incentives for people to take out private cover, with the tax penalty (the Medicare Levy Surcharge) on high income earners imposed from 1 July 1997. The second reform, the 30 percent rebate, came into effect from 1 January
1999. It granted a federal subsidy on allowed health insurance premiums. This replaced the previous rebate for low income earners only but the tax penalty for high earners remained. The third reform, *National Health Amendment (Lifetime Health Cover) Act 1999*(Cth) or Lifetime Health Cover (LHC), came into effect on 15 July 2000. This reform aimed to encourage people to take out insurance earlier in life and to maintain their cover, with premiums now based at age of entry (Ellis & Savage, 2008), which made it a more viable option for people.

Lifetime Health Cover involves a financial loading in addition to standard hospital cover premiums for people who delay taking out hospital cover. Division 31-1 of the *Private Health Insurance Act 2007* (Cth) states:

> People are encouraged to take out hospital cover by the time they turn 30. A person who is older than 30 when he or she takes out hospital cover for the first time, or who drops hospital cover after having turned 30, may have to pay higher premiums for hospital cover. This scheme is known as lifetime health cover.

There are exceptions to the Private Health Insurance (Lifetime Health Cover) rules. According to the *Private Health Insurance Act 2007* (Cth), people born on or before 1 July 1934 are exempt from the Lifetime Health Cover loading, as are those who turned 31 and were overseas on 1 July 2000, hardships cases, and those who have joint hospital cover. Changes to legislation in 2007 eliminated this loading if a person had had hospital cover for a continuous period of 10 years. All of these reforms have influenced how private hospitals manage care. As a result, the number and size of private hospitals has changed, with a decrease in the number of smaller private hospitals and a trend toward corporate/group ownership of private hospitals (Access Economics, 2002).
Private health insurance industry

The private health insurance sector in Australia comprises 35 operational funds. Twenty-two of the funds are available to the general public (open membership) and 13 are restricted access funds (PHIAC, 2010a). The restricted access funds are in the main industry specific, for example, banking, defence, doctors, police, and teachers.

The industry is tightly regulated. The main industry regulator is the Private Health Insurance Administration Council (PHIAC). At the centre of the regulation of private health insurance in Australia is community rating, the principle that health funds may not discriminate on the basis of a person’s health status, gender, race, sexual orientation or religious beliefs, age (other than age at which health cover is first purchased as per Lifetime Health Cover) and claims history. Additionally, health insurance funds must charge everyone the same premium regardless of individual health risk. Also, the government is able to regulate health funds through conditions imposed on registration relating to matters such as waiting periods, portability between funds, categories of membership, and the types and levels of benefits. If the requirements are not met, a fund can be de-registered (Private Health Insurance Act 2007, Cth). These regulations have led the private health insurance industry to operate primarily as a financing system rather than a genuine insurance market (Access Economics, 2005).

The Private Health Insurance Act 2007 (Cth) replaced the regulatory regimes for private health insurance contained within the National Health Act 1953 (Cth), Health Insurance Act 1973 (Cth), and Private Health Insurance Incentives Act 1998 (Cth), with new regimes contained within a single Act on 1 April 2007. Essentially, the changes were about clarifying and simplifying legislation relating to private health insurance. The Act allowed consumers a broadening of the range of services covered by private insurance.
health insurance to include services delivered outside of hospital; services that substitute for, or prevent hospital care, such as chemotherapy, dialysis and allied health services, and programs that support and sustain healthy lifestyles (Abbott, 2006). The Act had a requirement for funds to provide standard information statements (SIS) about health insurance products for their members. It also saw the removal of the Lifetime Health Cover loadings for members with ten years continuous membership to recognise and reward:

... people who have made the effort to maintain their cover overtime having first joined after the age of 30. They have made the effort and they deserve credit for their commitment and loyalty. (Abbott, 2006, pp. 7–8)

There is no doubt that the Australian Commonwealth Government considers that strong private sector involvement in health services provision and financing is essential to the viability of the Australian health system (DoHA, 2011), although it is not allowed untrammelled control. The private health sector contributes significantly to Australia’s healthcare system, with private hospitals providing 33 percent of the national total beds and accounting for 40 percent of the 8.1 million separations\textsuperscript{21} reported nationally (AIHW, 2010b).

Very briefly, to reiterate, the private healthcare sector is comprised of health insurance companies, medical practitioners and hospital providers. The sector is regulated through legislation at a Commonwealth, state and territory level. Privately insured patients seek benefits above public sector services, such as choice of doctor and hospital, and timing

\textsuperscript{21} Separation is an episode of care for an admitted patient, which can be a total hospital stay (from admission to discharge, transfer or death), or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care either by being discharged, dying, transferring to another hospital or changing type of care. (AIHW, 2010a)
of procedures. Payment of an extra subscription allows those covered by private health insurance to obtain assistance with meeting the costs of private sector services that are not covered completely by Medicare, such as dental, optical, physiotherapy, and podiatry services (DoHA, 2010b). As of September 2010, 44.8 percent of Australians had private health insurance to cover hospital treatment (PHIAC, 2010b).

**About private health hospitals: some figures**

Each year the Australian Institute of Health and Welfare (AIHW), Australia’s national agency for health and welfare statistics, publishes a summary report describing the characteristics and activity of all Australian hospitals. In 2008–09, Australia had 737 public acute hospitals, 19 public psychiatric hospitals, 285 private free-standing day hospital facilities and 276 other private hospitals (AIHW, 2010b). Private hospitals operate as for-profit, that is, they are funded by private investors, and not-for-profit, which in the main are operated by religious/charitable organisations or other not-for-profit organisations such as community or memorial hospitals.

Between 2004–05 and 2008–09, the number of separations in private hospitals (including free-standing private day procedure hospitals) increased by 4.1 percent compared to an increase of 3.2 percent in the public hospital sector. Over that same period of time, the number of patient days in private hospitals also increased by 10.1 percent compared to a public hospital increase of 7.4 percent (AIHW, 2010b). Private hospitals tend to do more procedures\(^{22}\) than public hospitals. In 2008–09, 96 percent of total private hospital separations involved procedures, compared to 82 percent of public

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\(^{22}\) Procedure is a clinical intervention that is surgical in nature, carries a procedural risk, carries an anaesthetic risk, requires specialised training and/or requires special facilities or equipment available only in the acute care setting. This includes not only surgical procedures but also non-surgical investigative and therapeutic procedures such as X-rays and chemotherapy (AIHW, 2010a).
hospital separations (AIHW, 2010b). What is important here is the significant role that private hospitals play in the provision of healthcare in Australia. Whether private hospitals deliver better services, or Australians are guided, some would say even coerced, into private care by policy directives and incentives subsidised at the expense of the public healthcare systems (Vaithianathan, 2004; Elliot, 2006; Ellis & Savage, 2008; Productivity Commission, 2009), is not the focus of this chapter or thesis.

It is well recognised that nursing makes up the largest staffing category in hospitals. In Australia, nurses made up 45 percent of the full-time equivalent staff numbers in public hospitals in 2008–09. Medical officers comprised 12 percent of full-time equivalent staff, and diagnostic and allied health professionals comprised 14 percent. The staffing mix is somewhat different in private hospitals because most medical services are not provided by hospital staff and the range of services provided is different. Nurses working in private hospitals also make up the largest staffing category, with 60 percent of the full-time equivalent staff numbers in 2006–07. Medical officers and diagnostic and allied health professionals comprised seven percent of full-time equivalent staff (AIHW, 2010b).

In its submission to the National Health and Hospitals Reform Commission23 in 2008, the Australian Private Hospitals Association (APHA), the peak national body representing private hospital interests in Australia, argued that government initiatives fail to optimise the potential of private hospitals to assist in the delivery of health system objectives and priorities. One of the challenges faced by private hospitals is a...
tendency by policy makers to view the sector through the prism of private health insurance. According to the APHA (2009), this is both an outdated and incorrect view of the industry.

While private health insurance has been the subject of much of the preceding discussion – and how can that not be, given that over 79 percent of private hospital separations reported in 2008–09 were funded by private health insurance (AIHW, 2010b) – the APHA (2009) reminds us that private hospitals are ‘funded’ by their owners and operators, and all costs incurred in running a private hospital are the sole responsibility of the hospital’s owners and operators. It is the services provided to patients treated in private hospitals that are partially or fully subsidised from a number of sources, including private health insurance funds, Australian Department of Veterans’ Affairs, Medicare, Pharmaceutical Benefits Scheme (PBS)24, third party insurers such as compulsory motor vehicle third party insurers, state and territory governments, and out-of-pocket payments by patients. This peak body asserts that there is no ‘funding’ from any of these sources to underwrite the maintenance, replacement, or expansion of infrastructure in these hospitals, or the day-to-day costs such as nursing and allied health staff salaries involved in running a hospital. Quality improvement activities and education, and the costs involved in the training of health and medical trainees (with the exception of positions funded under the Specialist Training Program25) are met by the hospitals (APHA, 2009). While this undoubtedly is the industry view, one cannot but consider private hospital funding through the prism of private health insurance. It is

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24 Pharmaceutical Benefits Scheme (PBS) is a national, government-funded scheme that subsidises the cost of a wide range of pharmaceutical drugs, and that covers all Australians to help them afford standard medications (AIHW, 2010a).

25 Specialist Training Program provides for specialist medical training to be undertaken in a range of settings beyond traditional public teaching hospitals, such as private hospitals, specialist’s rooms, clinics, day surgeries, regional, rural and community health settings. Funding is equivalent to a registrar’s salary (DoHA, 2011).
through this prism where nurses believe much of the change to private hospitals, and consequently to their work, lies, as Emma observes:

Hospitals have become a lot more aware of the private funding issues, the health funds have taken over a lot of control, even though they don’t actually have a say in the running of the hospital, they do, because of the funding that they allow for each particular operation there. (Emma RN, Interview transcript, p. 2)

Thus, as hospitals become more aware of private funding issues, so do nurses.

**Work intensification in private health**

Given some of the preceding discussion, if nurses in private health thought that their work had intensified, as indicated by hospital separation rates, it is because it has. Work intensification is defined as “having too much to do, in too little time, at too high a pace, with few resources” (Wichert, 2002, p. 97), although Green (2001) distinguishes extensive work effort (the time spent at work) and intensive work effort as being the “intensity of work during the time at work” (Green, 2001, p. 56). During my fieldwork, I observed the many times where nurses experienced work intensification as described by Green (2001). Nurses would stay on duty longer, at times work double or split shifts, and/or re-arrange their rosters or schedules to cover staffing shortfalls. Although it was done willingly, Emma observes:

... a lot of the girls there are quite flexible about extending their hours and working a double shift without complaint. Without complaint they’ll just say, ‘Oh, I’m not doing anything tonight, yeah, ok’. So, the expectation wasn’t there that you would say yes, though. ... after you do say yes once, they [management] do tend to migrate to those who have said yes before they suss out anybody else. (Emma RN, Interview transcript, p. 35)

The stress associated with ‘babysitting’ patients (or the hospital for that matter) was also
talked about: it is stressful when [you are] left babysitting patients until someone starts later. What participants are talking about here is that they are often carrying their own and some-else’s patient load until that person comes on duty. This staffing practice occurred across all shifts because work start and finishing times were closely tailored to meet inpatient demand. This issue is explored further in Chapter 8. Clearly, there were pressures on nurses’ working time ‘flexibility’, where flexibility meant nurses were working during the busiest times of the day rather than those times where it was purportedly not so busy, for example the start of a morning shift when there were few, if any, new admissions, or mid-afternoon when many patients were going to/or were in theatre. How did these ‘times’ appear during my fieldwork? Most obviously in the numbers located in numerous organisational texts, such as each ward’s staff allocation sheet and rosters. However, what was specific about some of these organising times that led to work intensification for nurses was not only patient numbers and acuity, or how sick patients were, but the compounding effect of the configuration of the nursing roster. This excerpt from my fieldnotes describes how nurses work when ‘babysitting’ patients until someone comes on later. The excerpt comes from early fieldwork and the notes reflect how I was trying to write things up at the time:

0701 We go to handover, though not before some discussion between the night staff. Linda and the other nurse who is working with her this morning about the staffing for the shift. Staffing issue continues to be the topic of conversation as we walk over to the handover room, located diagonally across from the nurses’ station. This morning three nurses are rostered to work on the ward. All are registered nurses. There is no ward clerk. Staffing this morning sees one nurse allocated to care for six patients, including one ‘palliative’, and a couple of ‘joints’ as the orthopaedic patients are referred to here. Linda is allocated five patients as is the nurse starting at 0830. Effectively there are two nurses for 16

26 Yvonne RN, Fieldnotes #5, p. 3
patients from 0700 until 0830.

Linda and her colleague are both very accomplished, experienced nurses who have worked at the hospital for many years. Standing together at the desk in the Nurses’ Station, the ward’s ‘Daily Sheet’ or allocation page opened out in front of them, they study the nurse-to-patient allocations for the shift. The allocations had already been assigned to them by their colleagues the evening before and they do not change them. Staffing this morning is tight though not unusual in how it’s organised. Linda’s colleague, looks up and turns slightly towards one of the two night duty nurses who are in the room and asks that they contact the Clinical Manager and/or the Clinical Nurse in the adjoining Oncology Unit to see if they can help admit one of the new admissions and/or help with turns for the ‘hips’ when needed as one is particularly ‘heavy’ while they go to listen to handover.

Generally patients who have undergone major orthopaedic surgery such as a total hip replacement are classed as heavy especially in the immediate post-operative period when they are resting in bed for most of the time. These patients lie in bed with a Charnley pillow in between their legs to prevent dislocation of the newly-replaced hip joint. Nursing care during this time requires two nurses to turn them for hygiene and pressure area care. These patients return to the ward with a wound drain, intravenous therapy as well as pump containing intravenous analgesia – patient controlled analgesia (PCA). Two of the patients on the ward this morning had hip replacement surgery yesterday hence the reference to them in the nurses conversation.

Hand-over this morning seems to take ages though the tape is not stopped at all and finishes after 15 minutes. I listen and take notes. As always the patient list or handover sheet is there ready, marked with their names and those of their patient’s highlighted with highlighter pen.

All the patients on the ward bar the palliative care patient have all had recent

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27 Charnley pillow is a wedge shaped foam pillow, vinyl covered, with straps that tie at the ankles and is placed between patients legs immediately post-operatively and for the first few days when patients are resting in bed.
surgery. There is a diverse type of patient or casemix on the ward that ranges from major urological and gynaecological surgery, breast, orthopaedics and Ear, Nose and Throat (ENT) surgery to hernia repairs. One patient has had an excision of a pilonidal sinus. Of the 16 patients on the ward this morning, nine patients had their surgery yesterday. Of these nine patients, four had extensive surgery – orthopaedics and breast. Although these patients were all now one day post-operative – if we take day one as starting from midnight – in reality two patients were less than 12 hours post-surgery having returned to the ward in the evening at 2000 and 2145 respectively. There are two new admissions for 0700 and one at 1000. The two admissions at 0700 are both for surgery this morning – one woman for a hysterectomy and the other a mastectomy. There are seven discharges.

0715 Following handover, everyone has congregated back at the nurses’ station, pouring over the allocation page and discussing staffing once again. At this point the Clinical Manager of the area, Marcello walks into the room. Marcello has started work at 0700 and is working as the Hospital Coordinator or ‘resource’ as this role is sometimes referred to. He has come up to the ward to let the nurses know that he will admit the 0700 admission and is available to help with the ‘hips’ as needed during the day. Linda remains standing at the desk going through her allocated patient’s medical records or case notes and the ‘blue folders’. These folders hold nursing care records – for instance clinical pathway documentation, Fluid Balance Chart (FBC) and patient’s medication chart. In organising their work nurses prepare for the incoming shift by routinely collecting all the blue folders and leaving them on the desk in the nurses’ station in numerical order in readiness for the next shift. This practice allows nurses to check their charts more efficiently as the folders are all in one location, along

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28 The urological surgery referred to in these notes is a colposuspension. This surgery is for treatment of stress incontinence in women in which the upper part of the vaginal wall is fixed to the anterior abdominal wall by unabsorbable suture material. It may be performed through an abdominal incision (Burch colposuspension) or using a laparoscope (laparoscopic colposuspension). (Oxford Dictionary, 2010).

29 Hernia is a protrusion of an organ or tissue out of the body cavity in which it normally lies. An inguinal hernia occurs in the lower abdomen; a sac of peritoneum, containing fat or part of the bowel, bulges through a weak part (inguinal canal) of the abdominal wall (Oxford Dictionary, 2010).

30 Pilonidal sinus a short tract leading from an opening in the skin in or near the cleft at the top of the buttocks and contains hairs. The sinus may be recurrently infected, leading to pain and the discharge of pus. Treatment is by surgical opening and cleaning of the sinus (Oxford Dictionary, 2010).
with the patient’s medical record, rather than going in and out of rooms – a more efficient use of time I guess.

0725 Night staff leaves. (Fieldnotes #8, pp. 1-2)

The above excerpt describes what ‘organised’ intensified work looks like. In this excerpt, nurses’ organisational knowledge, such as knowing what resources are available to them, ensures that patients are attended to in a timely manner so they can be admitted, taken to theatre, comforted, set up for breakfast, and prepared for discharge. In this hour and a half, nurses are also attending to doctors’ rounds, answering telephone queries, writing up doctors’ orders, and faxing scripts to pharmacy. Much of the work is done by 0830 in the morning as nurses wait for their colleagues to arrive, yet there are only two nurses and a floating person to do the work of three due to working time ‘flexibility’. In the following chapter, I discuss the contradictions that exist as nurses are made responsible for the nursing budget, while at the same time it is their expertise that is relied upon and allows the hospitals to configure staffing in this way. Any or all of these factors (number of allocated patients being cared for and the pace of work) led nurses to comment:

I’m working harder than I’ve ever worked in my whole career … I’m working harder now both physically and mentally. (Yvonne RN, Interview transcript, p. 25)

It’s always been hard for nurses, but it’s worse now because it’s more. (Lily RN, Interview transcript, p. 34)

You’re working harder and faster, and even then it’s still not enough. (Sandra RN, Interview transcript, p. 2)

As we will read in this and the following chapters, the dominance of what du Gay and
Salaman (1992) write of as the ‘(cult)ure of the customer’ – changing staffing policies and working time practices along with increases in hospital separation rates – have led nurses to experience work intensification. The intensification of work in nursing is by no means limited to the private healthcare sector, nor is work intensification unique to the healthcare industry. Other industries also report the adverse impact of work intensification on the quality of work, family, and personal health (Pocock, van Wanrooy, Strazzari, & Bridge, 2001; Beynon et al. 2002; Green, 2006). There have been numerous reports of increased workloads within nursing (Aiken et al., 2001b; Buchan, 2006; ICN, 2006; Needleman et al., 2002; Weinberg, 2003), with a number of government inquiries specific to Australia reporting on nurses’ experiences of work. These inquiries claim that nurses’ work has intensified in their workplace (Access Economics, 2004; Duffield et al., 2007; Garling, 2008; Productivity Commission, 2005; Senate Community Affairs Reference Committee Secretariat 2002), serving to test nurses’ elasticity of endurance (Allan, 1998b). Much of the nursing literature supports Green’s (2001) definition of work intensification, with nurses and managers alike reporting that their time at work has increased through both working longer and often unpaid hours and overtime, and/or the pace of work intensifying (Duffield et al., 2007; Rankin & Campbell, 2006; Townsend & Allen, 2005). White and Bray’s (2003) account of the changing role of Nurse Unit Managers in an Australian public hospital found that these nurses experienced an increase in their workload while at work which, more often than not, forced them to work longer hours or take their work home.

Work intensification in this study stemmed from an increase in the volume of work. The tasks undertaken were not any different from, or wider than, established work practices. It was a case of doing more of the same. Interestingly, much of the Australian nursing
work intensification literature focuses on work of nurses in the acute care public health system (Allan, 1998b; Buchanan & Considine, 2002; Duffield et al., 2007; Garling, 2008; Gough & Fitzpatrick, 2000; Newman & Lawler, 2009; Willis, 2002; White & Bray, 2003; Wise, 2007). There is little about the work life of nurses in private health.

The issue of nursing workloads is situated within wider issues of recruitment and retention of nurses, where nurses are literally ‘churning’ through the work (Duffield et al., 2007). So what is it about the context of nurses’ work in private health? What is the object of nurses’ discourse of working in this sector? At this point it is useful to once again return to the legislation surrounding the private healthcare industry and the interview data to analyse what is being privileged and how that shapes understanding about private healthcare for patients, doctors, and nurses.

**Demanding expectations**

There is a requirement within legislation for private health insurers to communicate the benefits of their products, and for hospitals and doctors to provide information about treatment costs. The *Private Health Insurance Act 2007* (Cth) also requires the Private Health Insurance Ombudsman (PHIO) to publish the *State of the Health Funds* report after the end of each financial year to provide comparative benefits (for example, for pre-existing conditions and portability of cover between funds) (ACCC, 2009; PHIO, 2010). Given the above concerns, the cost of private health and an increasing demand for top quality care identified as a “key factor in the rapid expansion of private hospitals” (Thomson, 2007, p. 23), there is an onus on private hospitals to deliver just

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31 The *Private Health Insurance Act 2007* (Cth) identifies a pre-existing condition is an ailment, illness or condition, the signs and symptoms of which, in the opinion of a medical practitioner appointed by the health insurer, existed at any time during the 6 months prior to the member becoming insured under the policy.
that – top quality care. What patients ‘demand’ is evident in nurses’ talk about the shift in how people regard private healthcare, where:

... patients have greater expectations then they ever did before... they think they are coming in for a holiday and this is a hotel. (Doris CN, Interview transcript. p. 34)

People ... see it more as the hotel not the hospital. (Sandra RN, Interview transcript, p. 3)

But, it’s a 5-star hotel ... and that’s what they [patients] say to you, and that’s what they expect. (Lily RN, Interview transcript, p. 35)

Participants considered the notion that patients perceived private hospital care as ‘5-star’ as one of the distinctions between the public and private sectors. In Joan’s opinion, while the public sector hospitals had also experienced a “tightening [of] their belts”, although perhaps not to the extent “of private places”, the implications of promoting the organisation as a “5-star hospital” compounded any difficulties nurses experienced with care delivery as they dealt with tight nurse staffing budgets. As Joan observes:

I haven’t worked in the government sector for 12 years or so, uh but well I know they’re tightening the belts but not to the degree as private places are. And particularly with ... [patient’s perception that it is] a 5-star hospital, oh wow, I mean they’re really pushing it there. (Joan RN, Interview transcript. p. 4)

Perceptions of, and demand for, ‘5-star’ accommodation bring patient expectations of standards. These standards may be related to the room or ‘care’, where nurses are expected “to work around them [patients]”:

There’s an expectation now from the clients that they do have a private room and a lot of them do demand it .... Patients also have become more aware of their rights in the last 15 years and are a lot more demanding about a standard of care,
whereas in fact, I think they’ve got a higher standard of care 15 years ago, they are now demanding a private room and a television and a fridge and all those sorts of things. And, that doesn’t improve their care, it improves maybe their comfort level but it doesn’t improve their care, and they [patients] expect … nurses to work around them, rather than them [patient] work around when nurses are available. So they’re a lot more demanding in that respect. (Emma RN, Interview transcript, p. 3).

Nurses speak of the difficulties in maintaining ‘excellent nursing care’ as constituted now within a managerialist discourse. One participant, Laura, recalls her job interview some 15 years ago where she “was asked to give excellent nursing care” by the then Director of Nursing. Not only was this, one could argue, a company directive and/or expectation, but one that Laura thought for a time was possible:

…when I came here and it was actually possible for the first time in my life, I thought I could give excellent nursing care. … Then changes started happening, I can’t remember how long ago, it was probably about 7 years ago or so when the pinch was felt financially, this hospital was thriving up till then, and then they [hospital executive] said financially they couldn’t really continue that way. (Laura RN, Interview transcript. p. 2)

In the next excerpt of data, Linda recounts some of the expectations of the organisation as to what constituted the ‘high standards’ of patient care in the past:

I can remember the interview with [then Director of Nursing] … and she said that we have high standards of care. … And she said, ‘And you will, every day, everyone [patient] will receive a flannel and a face washer, a bathmat and a towel and every day you will change the bottom sheet and a pillow case. And whether the patients are one day post-op or 7 days down the track post-op, everyone will get pressure area care and they’ll get it regularly. Back washes, there should be…’ She basically had an expectation of what I thought was quite outstanding care and I was happy because I thought, ‘Brilliant. You know, these, this is me. I fit in
here’, and it was fine. (Linda RN, Interview transcript, p. 3)

Some nurses relate a perception of declining standards of nursing care to a perception that there was deterioration in the quality of staff, which was of concern because we have high standards here\(^{32}\). It is Doris’ opinion that:

… there is a definite deterioration in the quality of staff that we’re getting as far as … being uh casual staff like as in agency that sort of thing. The quality is just not there, even in the RNs the quality is not there, in basic knowledge … most times I’m grateful to get an extra pair of hands (Doris CN, Interview transcript, p. 33).

While the quality of staff “is just not there” for Doris, she does not define just what “there” is, other than a reference to nurses’ “basic knowledge”. One could argue that the lack of nursing knowledge is not “there” simply because there are not enough nurses to be “there”, let alone for nurses to concern themselves with what constitutes the quality of staff. Doris thinks care delivery is hampered not simply because of a lack in the number of nurses but also because of a lack of nursing knowledge among practising nurses (Mitchell, 2003). What Doris seeks is a skilled clinician, someone who is capable of delivering what Purkis and Bjornsdottir (2006) refer to as intelligent nursing care – an intelligent nurse – but failing that, Doris is left grateful for an extra pair of hands; someone who is ‘good enough’ (Allan, 2001).

When nurses were asked to indicate how ‘things changed’ for them, they spoke of change not only as a period of time that had passed but changes to how nurses thought about their work, with nurses working on the wards now thinking about the ‘budget’. According to Sandra:

... we weren’t thinking about the dollar and how much, and budgets and things.

\(^{32}\)Anita Nurse Unit Manager, Fieldnotes #3, p.3
We just did the best we could for our patients. Whereas now it’s always comparing have I got time, money, can the hospital afford this, the whole time, so you’re consciously aware of more issues than just patient care. (Sandra RN, Interview transcript, p. 2)

Analysis of nurses’ talk reveals the tensions for nurses, as professionals, to be able to simply do their job, which may be at odds with patients’ demands. Again, this may be attributed in part to the “cost of private health”, which in turn is attributed to private health insurance, which is considered on a par with people’s home insurance, and hence situates patients as customers or clients of the private health system who want “value for money”. Sandra explains her feelings:

Very frustrated, because you’re having to balance, re-evaluate your care and still maintain your standards. So what you’re doing is you’re working harder and faster, and even then it’s still not enough. It’s never quite right. Our patients are far more demanding these days, because of the cost of private health. I think they look at it a bit like your home insurance. They want value for money, so their expectations are so different to what they were 15–20 years ago, when they were very grateful for any care and really appreciative of time. It’s quite different. People are very, umm, it is a business, not as umm you know, for illness, it’s quite different. (Sandra RN, Interview transcript, pp. 2–3)

The crux of the issue here is the ‘business’ of private health. Nurses understand that what drives the hospital’s business is the competitive market and the resultant funding pressures the organisation faces. How management respond to these pressures, for example by having working time flexibility factored into employment contracts and negotiated into enterprise bargaining agreements, has nurses across all levels of the organisation taking responsibility for the hospital’s business/viability. Not unlike du Gay’s (1996) ‘enterprising’ subjects of British retailing, nursing at this hospital is
imagined through the managerial discourse of ‘excellence’, with nurses re-conceptualised as:

... self regulating, productive individuals whose sense of self worth and virtue is inextricably linked to the ‘excellent’ performance of their work and, thus to the success of the company employing them. (du Gay, 1996, p. 119)

While there is no end to the amount of information available for patients to access with regard to their private health entitlements at a government and industry level, unsurprisingly, for patients, ‘quality’ in private health is often tied to the level of accommodation provided by their health insurance premium. For the purposes of reimbursement, ironically, nursing remains subsumed with the cost of the ‘bed’ and the professional nursing care patients require remains ‘hidden in plain view’ (Tourangeau, Stone, & Birnbaum, 2003). This situation persists despite the work being done with nursing classification and/or workload measurement systems that have been constructed purportedly to assist with determining and/or articulating the nursing component of healthcare delivery (see ICN, 2010). Yet, if one were to believe nursing were no longer subsumed with the cost of the room or bed, the Australian government private health website definition of accommodation has nursing services well and truly situated with the ‘room’. The government’s own glossary states that accommodation “covers meals and a bed in hospital, and includes all in-hospital-provided services including nursing care. It does not include treatment by doctors or other health professionals” (PHIO 2011).

Australia, like the USA, uses a prospective payment system of funding for hospital care – casemix. Casemix diagnosis-related groups (DRGs) are used to encourage hospitals to
treat patients within an average cost structure, best measured by length of stay as a predictor of resource intensity (Willis, Young, & Stanton, 2005). In the case of nursing, “length of stay is the proxy for nursing care” (Laport, Sermeus, Van den Boer, & Van Herck, 2008, p. 94). Understanding that length of stay – a discourse of time– as ‘proxy’ for nursing care in reimbursement payment systems for hospitals shapes how nurses’ work is understood for professional governance. The effect of this discourse at a programmatic level of healthcare policy is to limit understandings of the nursing workforce and its ‘problems’, such as nursing’s (in)visibility, by locating nurses’ ‘care’ with ‘accommodation’ as part of a hospital’s occupancy rate. Nursing intensity, or its costs, are not currently factored into reimbursement payment methods for hospitals, therefore nursing care time continues to be represented as a ‘cost’ rather than a source of revenue for hospitals, hence making it a target for cost reductions (Aiken, 2008).

**Teasing out the nursing service**

Discursive shifts have co-occurred with the shift to private healthcare casemix funding and with patient expectations. There is an onus for nurses to continue to deliver and maintain the ‘high standards’ set by the organisation. In discussing how that is achieved, nurses’ talk invariably turns to nurse staffing levels. Nurse Managers recount how care delivery is “always governed by the labour hours” as ‘nursing hours’ are referred to in this organisation, and managing the hours with the patient ‘numbers’ is a constant challenge. Nursing hours, specifically the nursing hour per patient day ratio (NHPPD), is the nursing workload measurement method used by the hospital to determine nurse staffing, as stated previously. The NHPPD ratio is calculated by dividing the number of nursing hours by the number of occupied beds. It is the number of occupied beds that is important here because this is linked firmly to what counts as ‘nursing hours’ for the

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33 Anita Nurse Unit Manager Interview transcript: 9
organisation and whether the ‘hours’ are over or under, and is determined by the midnight patient census.

Nurses are well aware that the halcyon days [of having] 4 patients [are] no longer with us\(^{34}\) and that private hospitals can no longer sustain that\(^{35}\) sort of nurse-to-patient ratio and there is a view that it is futile for nurses working in this environment to remain “fixed on numbers”. Here, Mary, who by her own admission has a very ‘Pollyanna’ view of work, acts as an “authority of delimitation” (Foucault, 1972, p. 41) because she supports the established nurse-to-patient ratio. Mary has worked in various senior nursing capacities within the hospital and is employed currently as a Level 1 registered nurse on the ward. In the excerpt below, she rationalises the current staffing levels and states that nurses will “have to look a bit broader than just the number”. Mary comments:

... I think that there are a number of people that are fixed on numbers ... in what their workload is going to be I mean just because you have 7 patients doesn’t necessarily mean you’re going to be really, really busy, you might have you know 4 out of the 7 are completely independent. I think people really have to look a bit broader than just the number and I’ve thought that for a long time and I do try and sort of mention that where I can because I just think it’s so wrong you can’t say a number. You could have 8 patients and be cruising; you could have 4 and not come up for air. You have to look at who you’ve got and you have to look at what, where they’re at, you know you might have 6 patients no say 7 patients but one’s not going to come in until 11 o’clock or you know you’ve got a 7 o’clock admission and they’re going to be in theatre for 4 hours, I just think sometimes people don’t look at that there is a lot of look, panic, and think of it later and that creates ill feeling. (Mary RN, Interview transcript, p. 24)

\(^{34}\) Emma RN Fieldnotes #7, p. 2  
\(^{35}\) Emma RN Fieldnotes #7, p. 2
As one would expect, Nurse Unit Managers and the hospital’s After-Hours Coordinators discussed ‘nursing hours’; what the budgeted nursing hours were and how they were accounted for. In their conversation they easily rattled them off:

... we’re trying to get 4.6 labour hours um on [Ward A] and on [Ward B] it’s 4.7 [NHPPD], in maternity it’s a little bit higher than that we’re looking at 8 and 9, and in CCU um the hours work out around about 10 but when I’m doing those staffing hours it’s roughly working out at the ratio of 1 to 6 in the general wards. (Doris CN, Interview transcript, p. 9)

Although I had come to the field with some expectations about nurses’ understanding of this notion of ‘nursing hours’, my fieldnotes and also the interview data reveal that nurses were not overt in discussing the hospitals’ ‘labour hours’ (referring to nursing hours). That said, nurses at all levels of the organisation were well aware of, and able to articulate, the hospital’s prevailing nurse staffing requirements, although there was no obvious recording of how the calculations of the nursing hours were achieved.

Observational fieldwork notes do not record administrators or nurses actually working out ‘the sums’, as it were. Only once was an administrator observed using a calculator and only then for my benefit, but that said, nurse administrators and nurses working on the wards were well aware of the prevailing nurse-to-patient ratio, so much so that:

… it’s just part of the conversation. … I can’t think what else we talk about. It’s just, it’s there, and we all might be in the office and you hear, ‘Well girls our hours are over. You know, our hours are over for the month. We’ve really got to tighten up; we’ve really got to whatever’. (Linda RN, Interview transcript, p. 14)

Many did not believe that the nurse-to-patient ratio was unreasonable:

... when I first started working [at the hospital] ... I think that staff to patient ratio was about 1 to 4, which I found a very easy load, I thought that was probably too
light a load but it certainly changed over the years, and now some shifts you’re looking after 1 to 4 in CCU [Critical Care Unit], not out on the wards, so, from a safety factor, I think that was not as safe as it could be, but looking after 1 to 6, 1 to 8 out on the, [ward] 1 to 6 is fine, I like that sort of ratio. (Emma RN, Interview transcript, p. 13)

Emma is somewhat critical of some of her colleagues for not being able to manage their allocated patient load:

I can look after 7. I’ve got 4 people that are really well, and 2 that aren’t. I can look after one more. But people aren’t willing to do that. They can’t see past that 1 to 6 and that is all they see. … it’s just an attitude thing, and some people have got the attitude that that’s all I can do, and others are able to take it on. (Emma RN, Interview transcript, pp. 13–14)

This was a view held across all levels of nurses in the organisation and echoed by one After-Hours Coordinator:

We’re not asking for you know additional staff um if it’s a quiet weekend or a quiet night … and 11 patients may be quite acceptable on that night because there’s not a great deal happening and quite a number of them [patients] are preparing for discharge … you know that the staff here are much more flexible than what I hear in some organisations where if a certain number is deemed the acceptable number, it doesn’t matter what the acuity is then they … refuse, … the staff here would not do that they are just so committed … and dedicated that they would deem it as a slur on their professional judgement … because they would say ‘No, that’s ridiculous, we can manage more so you know they're not asking for ridiculous limits. (Rosemary, After-Hours Coordinator, Interview transcript, p. 23)

While Rosemary is critical of what some of the staffing levels are at times for the night shift, those “which push the boundaries of … you know the number of patients they
[nurses] do have to care for … to the absolute outer limits,”\textsuperscript{36} she believes that the nursing staff of this hospital are not prepared to work within ratios set at “ridiculous limits” either. One could also argue that perhaps at a local level some of these statements fly-in-the-face of the much publicised mandated minimum staffing levels as the preferred strategy for managing nurse staffing (Buchan, 2005; Gordon, Buchanan, & Bretherton, 2008; Nelson, 2008). This particular strategy was employed in the USA with the passing of landmark legislation in the State of California in 1999 (Assembly Bill 394, 1999) and taken up with varying measures of success in Australia by the State of Victoria (Gerdtz & Nelson, 2007; Wise, 2007). Established in 2001 in Australia, the nurse-to-patient ratios specify the minimum staffing levels for different types of nursing work and skills. This is legally enforceable (AIRC, 2000).

What emerges in “the grid of specification” as being “divided, contrasted, related, regrouped, [and] classified” (Foucault, 1972, p. 42) as the object of nurses’ discourses through managerial notions of quality and excellence is the financial ‘health’ of the hospital as nurses go about taking care of business. Some serious impression management (Goffman, 1959) is engaged in to promote the hospital and its services to ensure its competitive edge as an independent healthcare facility in what many regard as a fiercely competitive private healthcare market (Standard & Poor’s, 2006). This notion of quality extends not only to the presentation of the healthcare facility and its grounds but also to the services provided by the hospital. Nurses tell how patients, as customers, are “very in tune with what they can get, or [what] they’re entitled to”\textsuperscript{37}. However, as ‘entitled’ as patients may like to think they are, their understandings of what they are entitled to and what nurses consider to be patients’ entitlements brings tensions to how

\textsuperscript{36} Rosemary AHC, Interview transcript, p. 8
\textsuperscript{37} Sandra RN, Interview transcript, p. 29
nurses manage care. In this excerpt from an interview, Sandra explains:

... things as you know, ‘My wife’s fasting, can I have her breakfast?’ ... You know, completely, they’re looking, well, you know, I’m paying for today, you know. If I’m fasting, my husband can eat my meal, and they find it very hard to say, to accept that ‘No, that’s part of your process of pre-operative care’. Um ‘What’s in it for me that’s free?’ ... ‘Can I have home help that’s free? Can I have this that’s free? Give me some extra bandages, I’ve paid a lot to come in here’. ... people just think that they can stay here as long as they like, and we do get the pressure of ... making them realise that [they cannot stay] ... [patients] expect [a] more relaxing stay here. Not, ‘You’re here for a purpose, to have surgery, get better, go home’. So, that’s, that’s hard. We’re constantly battling that ... People, don’t realise that you have a duty of care and just because they have a whim and a fancy for something else, and you don’t provide it, they will complain. Well I don’t remember it being like that. ... ‘Why should I pay for this medication, I’ve been a patient?’ Or ‘Can I have my eyes looked at?’ We have a lot that want to have that, I always call it the tacked-on McDonalds sales. ‘Whilst I’m here, can I have my chest x-rayed?’ ‘Oh I think I need to see an eye specialist’. ‘Could a podiatrist see my toes?’ Just because they know that they’re in [hospital], they don’t have to pay, the hospital will wear it. (Sandra RN, Interview transcript, p. 3, p. 29)

Despite consumer demands for extra services, what is telling here is that nurses are thinking about the cost to the hospital of these patient requests. This sees a shift from cost to the hospital being solely the domain of insurers and administrators to the nurses on the wards. It says much about patients’ poor understanding of ‘informed financial consent’. Efforts have been made at a government and industry level to improve patients’ understanding of informed financial consent. Hospitals and funds have administrative processes in place to make patients aware of any out-of-pocket costs they may incur, ideally prior to admission (PHIO, 2010). The Australian Medical Association (AMA) has also sought to address the issue with its ‘Let’s talk about fees’
campaign (AMA, 2006) aimed at medical practitioners. The campaign’s aim was to ensure a patient’s understanding of what constitutes a hospital stay, other than viewing it in terms of staying in a “5-star hotel”\textsuperscript{38}. However, this study reveals that discrepancies continue to exist in understanding what insurance cover provides in terms of supporting the costs of care, with the result that gaps in entitlements are left to nurses to explain. Such gaps in patients’ understanding do not only occur clinically, for example what patients pre-operative care entails; they also occur in relation to entitlements from the organisation. Nurses find themselves correcting misperceptions so that the hospital does not have to “wear it”\textsuperscript{39} in relation to treatments that would directly affect the hospital’s budgetary bottom line, such as the above mentioned podiatry consult or medications.

While informed financial consent has a specific meaning for medical practitioners – the implications for hospitals in managing the length of a patient’s stay – gaps in understanding, while perhaps not of concern for some doctors, provoke patient resistance and are left to nurses to sort out, as explained by Sandra:

> Oh, doctor says I can stay ‘til I’m better, and then you kind of drill them all, no, actually, you’re covered for this amount of time. Make sure you’ve got something organised, and you do all of that preparation, and comes the day or the day before discharge, no-one’s home to collect, no-one’s available to be here ... it’s not suitable for me to go home. ... it is elective surgery, but there never is the right time, so that’s always a challenge, because we’re trying to do the best from our end, and because we haven’t got them [patient] out the door, it’s, we hear from uh management that it’s not acceptable. And yet the doctors have a part to play in this, but they won’t. They don’t like discussing finances or discharge. A lot of them don’t. (Sandra RN, Interview transcript, p. 4)

\textsuperscript{38} Lily RN, Interview transcript, p. 35
\textsuperscript{39} Sandra RN, Interview transcript, p. 29
Patients declaring that they will be staying “until I’m better” are not really an option for nurses in light of their costed length of stay, given that patients are “covered for this amount of time” under DRG funding classifications. This is not to say that patients are unable to stay in hospital longer if need be but nurses are organising their work time to manage both their own time and that of the patient from the outset of a patient’s admission. Nurses work to ensure that the hospital’s “pre-admitted” and “pre-recovered patients” (Heartfield, 2006, p. 153) move through their hospital stay in a timely manner to ensure that the hospital does “pick up a payment”, to use Doris’ words. Doris discusses how funding models and doctors’ practices impact on business:

... the first thing that’s written [on the clinical pathway document] ... is what’s the expected length of stay\textsuperscript{40} and what DRG\textsuperscript{41} are they [are] … everyone [nurses] is aware that we do need to get our patients out at 10 o’clock [morning] and that we need to be proactive in making this work but we do have some doctors who insist [that] their patients will not go home until they’re seen and sometimes they’re not seen until late at night and that causes its own issues because that means then they go home but they’ve been staffed for all day and we [the hospital] don’t pick up a payment for that [patient] after 10 o’clock. (Doris CN, Interview transcript, p. 25)

A patient’s length of stay directly impacts on nurses’ work, not only in terms of their workload, but each hour a patient remains on the ward after ‘ten o’clock’ in the morning impacts on the hospital’s finances. Unavailability of beds sees cases cancelled, but more importantly for nurses, their budgeted ‘nursing hours’ are governed by the number of

\textsuperscript{40} Length of stay refers to the duration of hospital stay. It is the period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type. All leave days, including the day the patient went on leave, are excluded. A same-day patient is allocated a length of stay of one day (AIHW, 2010a).

\textsuperscript{41} Diagnosis related groups (DRGs) range of data collected on an admitted patient, including diagnosis and procedure information; classified using the International statistical classification of diseases and health related problems, 10\textsuperscript{th} edition, Australian Modification (ICD-10-AM). DRG’s classifies acute inpatient episodes into categories based on clinical content and resource consumption. In the case of Australian acute hospitals, AR-DRGs (Australian Refined Diagnosis Related Groups) classify admissions into groups with similar clinical conditions (related diagnoses) and similar resource usage. This allows the activity and performance of hospitals to be compared on a common basis (AIHW, 2010a).
patients remaining in the ward at any one time and ultimately by the midnight bed
census. Thus, there is an imperative that nurses “don’t hold onto” patients while at the
same time being cognisant that the hospital’s occupancy is maintained:

... there are people [nurses] that perhaps don’t promote the discharge philosophy
of 10 o’clock in the morning ... there are ... people [patients that nurses] I would
suspect hold onto a little bit because it’s better the devil you know than the devil
you don’t and yet when you’re ... in the admissions office where patients are being
booked in ... you see that you’ve got 15 patients parked and you’ve got not very
many beds, you sort of think ‘Well, you really have to make it work and I think
there are a lot of people [nurses] that don’t realise that sometimes the impact of
that is that cases get cancelled’. (Mary RN, Interview transcript, p. 34)

There is continual reference to the hospital’s business in nurses’ talk as they work to
move patients through the system. While patients may well “have paid a lot to come in
here”[^42] – and they do – and according to Sandra, patients may like to think that they
“can stay here as long as they like”[^43], ultimately nurses are pragmatic about the
hospital’s role, and that patients “are there for a purpose, to have surgery, get better, go
home”[^44].

When asking why nurses need to concern themselves with the hospital’s business, we
need to place this within the context in which this hospital operates; a very competitive
environment. According to the Australian Private Hospitals Association (2008), one of
the key ways in which these hospitals seek to compete with each other and with the so-
called ‘free’ public sector is on the quality of their services, although that quality may
not necessarily extend to the “tacked on McDonald’s sales”[^45] to which Sandra referred

[^42]: Sandra RN, Interview transcript, p. 3
[^43]: Sandra RN, Interview transcript, p. 3
[^44]: Sandra RN, Interview transcript, p. 3
[^45]: Sandra RN, Interview transcript, p. 29
earlier. In its 1999 report into the Australian private hospital industry, the Productivity Commission (1999) acknowledged the competitive market place of private healthcare, stating that hospitals are in the business of providing services to patients; doctors generate much of that demand; and insurers pay most of the accounts on behalf of their contributors. Thus, there is an onus on hospitals to provide an environment where doctors are willing to treat their patients and to supply their services at a price that is attractive to the health funds. Nurses, with this in mind, are continually translating patient care requirements in terms of what that care may entail for both patients and the organisation.

**Conclusion**

Nurses’ working time, their ‘nursing hours’ and the hospital’s business – a business that is supported financially by what the hospital can negotiate, primarily but not solely with the funds and doctors – has nurses acutely aware of their relationship with private health funding. In this chapter, I have explored the relations “established between institutions, economic and social processes, behavioural patterns, systems of norms, techniques, [and] types of classification” (Foucault, 1972, p. 45) to make visible the object of nurses’ talk. Such an exploration identifies that while nurses’ talk is imbued with management concepts of quality and excellence of service delivery, the object of their talk is with cost of care and how that plays out in the way they think about and organise their work. Discourses of work and cost are enmeshed with talk of nurse staffing, and managing that staffing as the business of private health is made apparent. In the business of private healthcare in Australia, nurses work for the viability of the organisation where they work.
This chapter has focused on some of the contradictions and tensions that exist for nurses between the clinical and economic, and economic and business aspects of healthcare, such as informed financial consent, managing length of stay, and how the hospital is marketed. In private healthcare, ‘busyness’ or intensification of nurses’ work is directly related to the maintenance of a hospital’s viability in a highly competitive market. The promotion of private healthcare as a rational healthcare ‘choice’ for Australians through changes in legislation supports this industry and illustrates the programmatic realm of healthcare design by government so that private healthcare is maintained as a desirable option for individuals. The expectations of patients, as consumers of ‘hospital care’ in such a situation, are predicated on getting value for money where they see private healthcare as ‘5-star’ against the usual care of the public healthcare system within which private care is embedded. Caught in this misperception and the contradictions of ‘care’ in such a portrayal, nurses in this private hospital enact a concern for economical and timely care beyond mere nursing professionalism. Their concern cares for, and supports, the organising of the hospital. Nurses are undoubtedly entrepreneurial in how they respond to neo-liberal government practices. The “calculative regimes” (Rose, 1996, p. 54) of government are present in the management of the nursing labour hour as seen in a ‘discharge philosophy’, where discharge patients are not accounted for in nurse-staffing allocation practices. Yet, nurses actively manage patient care, so that it is ‘5-star’ while ensuring timely payments from hospital funding sources and, in the process, ensuring bed availability for doctors.

The following chapter considers the constitution of nursing subjectivities as the hospital responds to changing consumer norms of private healthcare.
CHAPTER 5

NURSES’ BUSINESS: (RE)DEFINING THE JOB

The previous chapter has demonstrated how the objects of nurses’ talk lay with/in business discourses where the hospital’s viability was viewed as crucial within a competitive private healthcare market. What was being problematised for nurses in the studied hospital was not nursing as a profession in shortage, as figured in the literature, but nursing as business, as reflected in their enrolment in, and use of, managerial concepts of quality and excellence.

This chapter explores in some detail the constitution of nursing subjectivity focusing on nurses’ job descriptions as they translate and articulate programs of governance in the political rationality of private healthcare. Descriptions of nursing work are found in a “web of governance documents” (Bail, Cook, Gardener, & Grealish, 2009, p. 1458) that include Australian Nursing and Midwifery Council (ANMC) Code of Ethics for Nurses in Australia (ANMC, 2008a), Code of Professional Conduct for Nurses in Australia (ANMC, 2008b) and National Competency Standards for the Registered Nurse (ANMC, 2006), federal, state, and territory legislative requirements, and healthcare organisations’ own policy and procedural policies. These texts are the mechanisms whereby ruling activities are translated. These “humble and mundane mechanisms” (Miller & Rose, 2008, p. 32) of deployment are the “technologies of government” (Miller & Rose, 2008, p. 32).

Nurses’ subjectivity is constituted within this setting in the form of co-producers in the business, albeit as a cost to the organisation rather than as a benefit. The chapter
illustrates the dominance of medicine within private health that sees doctors enjoying a different market position in comparison to nurses as far as the organisation is concerned. This positioning enrolls nurses in power relations that promote care for the risk to the business through keeping doctors, as customers, satisfied. Greater concern with nurses’ personal/professional development is also evident in these texts as nurses are ‘responsibilized’ (Burchell, 1996) to ensure a level of expertise that includes having business acumen.

Describing the job

In this section, I will outline how staffing policies and practices that shape employment discursively support the positioning of nurses. I explore how these practices and policies affect entry into employment, the numbers of people employed within the organisation, and the mode and rate of exit, with organisations playing a strong role in shaping the pattern and organisation of working time (Beynon et al., 2002). All participants were registered nurses, as noted in Chapter 3, and thus met statutory requirements for registration as a registered nurse with the relevant Australian state regulatory authority. Most held additional post-graduate qualifications. However, any authority that nurses had to comment on the business of the organisation was firmly linked to their position as employees first and foremost. In thinking about the business of private health and defining ‘the nurse’ within this context, analysis here considers the

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46 As of 1 July 2010 the Australian Health Practitioner Regulation Agency (AHPRA) is the organisation responsible for the registration and accreditation of 10 health professions across Australia that includes nursing. AHPRA is bound by the Health Practitioner Regulation National Law 2009 Acts in place in each state and territory (AHPRA, 2011). These laws see ten health professions regulated by nationally consistent legislation. Each health profession that is part of this national scheme is represented by a National Board. The Nursing and Midwifery Board of Australia has established State and Territory Boards to support the work of the National Board in the national scheme. The National Board will set policy and professional standards, and the State and Territory Boards will continue to make individual notification and registration decisions affecting individual nurses and midwives.
qualifications, job descriptions, people’s position, and their competence that gives them “the right … to practise and to extend one’s knowledge” (Foucault, 1972, p. 50).

All nurses, no matter their role, are appointed in accord with the hospital’s by laws, policies and procedures, and within the terms and conditions of their individual contract (Position description Registered Nurse/ Midwife). A contractual arrangement with an employer – the hospital – sets the parameters of nurses’ work. Contracts commit their signatories to the performance of certain tasks and guarantee, vouch, and/or assure specific actions and advantages to the person or entity – the hospital (Cooren, 2004). In the case of this hospital, nurses’ job descriptions or position descriptions, as the hospital labels this document, reveals the employer’s authority as to how nurses’ work is constituted within the legislative and economic contexts of private healthcare.

All nurses, as employees, are provided with a position description at the time of their employment, which they must sign. The position description is a document that describes the major areas of an employee’s job or position. Each position description makes particular reference to the hospital’s other documents, such as the ‘Vision’, ‘Mission’, ‘Values’, and ‘Performance Improvement System’, and a call to practice that is ‘Evidenced Based’ and common in other calls to efficiencies. The hospital’s mission and values:

... are translated into quality care through the hospital’s Commitment to Service by appropriately qualified, skilled and experienced staff who practice in accord with the hospital’s by laws, Code of Conduct, relevant professional and statutory guidelines, policies and procedures. (Position description Clinical Nurse, emphasis in original)

With team work and quality integral to the hospital’s primary goal of achieving
excellence in patient care (Position Description Registered Nurse/Midwife, emphasis in original) from the outset of their acceptance of a position within the hospital, no matter their role, nurses are enrolled into speaking of what constitutes excellence and quality in their work, and what this entails for the hospital. A textual analysis of the position descriptions sees the organisation define the authority of each registered nurse/midwife, clinical nurse, and manager. As an ‘autonomous text’ (Cooren, 2004), the position description is a particular genre or ‘discourse form’ (Fairclough, 1995). It is a bureaucratic document, written in third person, polite, filled with statements that identify the expectations of the hospital in relation to nurses’ employment, and generic to registered nurses – that is, it is standardised rather than individualised.

Each position statement has nine generic headings: ‘Role description’; ‘Essential Qualifications, Experience and Knowledge’; ‘Desirable Qualifications and Experience’; ‘Key Responsibilities’, covering specific duties that further define the role into further discrete areas of responsibility; ‘Accountability’; ‘Evaluation’; ‘Outcomes’; ‘Review’; and finally ‘Acceptance and signature’. The wording clearly states what the nurses’ employment will entail; what they will be asked to do. The following excerpt from the Registered Nurse/Midwife position description clearly details the nurse’s responsibilities.
2 Essential Qualifications, Experience and Knowledge

- Holds and maintains current registration as a Registered Nurse/Midwife with the Nurses Board of (State);
- Competent in acute medical/surgical and/or specialist clinical practice;
- Demonstrates effective negotiation, communication and interpersonal skills;
- Ability to foster a working environment that embraces change in clinical practice, encouraged collegial potential, and utilises a team approach to the provision of excellence in patient care;

3 Desirable Qualifications and Experience

- Holds or is working toward higher-level qualification in relevant clinical practice;
- Knowledge in the use of information technology, use of email and internet.

4 Key Responsibilities

The Registered Nurse / Midwife at [hospital] is regarded as a clinical practitioner with a sound knowledge base and strives for continuous improvement in clinical practice through an approach that is evidence based.

Furthermore, the Registered Nurse/Midwife contributes to planned, integrated, outcome focused high quality care that is conducted in a manner that is professional, ethical and legal, safe, reflective and contemporary.

The following key responsibilities are integral to the role of the Registered Nurse/Midwife:
4.1 Communication and Confidentiality
- Maintains confidentiality in accord with relevant [Hospital] policies;
- Utilises and maintains effective channels of communication;
- Utilises interpersonal skills conducive to promoting harmony and cooperation both within the hospital and external service providers;
- Establishes and maintains professional and effective working relations with visiting clinicians, hospital staff and external service providers;
- Attends relevant unit based meetings;
- Demonstrates an appropriate level of written and verbal communication skills including problem solving and public relations skills.

4.2 Clinical Leadership and Management
- Ensures the provision of a consistently high standard of clinical care within the unit through the application of evidenced based clinical care practices;
- Ensures the delivery of high standard, timely, planned and expert care in accord with contemporary care guidelines eg [hospital] Care Protocols, Patient Teaching and [Hospital] Patient Pathways;
- Contributes to the development, implementation and review of unit based policies and procedures;
- Acts as a mentor and professional role model for all clinical staff and participates in professional development;
- Enhances the hospital’s profile and reputation both internally and externally; and
- Keeps abreast of organisational goals and global influences on the clinical aspects of the healthcare industry and in particular those relevant to [hospital].
4.3 Professional and Personal Development

- Maintains own professional development and encourages others to do likewise;
- Actively participates in the direct supervision of undergraduate nursing/midwifery students, and the indirect supervision of Enrolled Nurses;
- Annually maintains clinical competencies as stipulated by [Hospital];
- Contributes to identifying, developing, and implementing unit based educational needs, including orientation programs, staff career development, graduate nurse program and annual competencies, and
- Is observable as an expert clinician who maintains current knowledge and implements contemporary clinical practice to achieve the clinical and operational goals for their specific unit.

4.4 Performance Improvement

- Demonstrates personal commitment to continuous performance improvement;
- Actively contributes in and promotes [Hospital] Performance Improvement program including the preparation for and maintenance of the EQuIP program;
- Reports on all aspects of clinical care including patient incidents and adverse events initiating the necessary remedial actions and immediately informing the relevant Clinical Manager and Director of Nursing and Clinical Services, of any adverse event or incident resulting in serious outcomes for the patient;
- Assumes responsibility for workplace health and safety in accord with current OH&S legislation and the [Hospital] OH&S Annual Plan notifying the Manager Personnel immediately of any work related injury and implementing the hospital’s injury management protocol;
- Identifies environmental hazards, instigates appropriate action and informs with the relevant Clinical Manager;
- Identify areas for improvement and in consultation with the visiting practitioners & staff instigates the necessary change to achieve continuous improvement;
4.5 Collaboration with Other Units

- Contributes to the development, implementation and monitoring the effectiveness and use of [Hospital] Patient Pathways;
- Assists in coordinating procedures during an emergency situation;
- Assists the Clinical Manager in coordinating the management of patient emergencies and retrievals which occur within their specified unit; and
- Assists the Clinical Manager in achieving the length of stay benchmarked with the Private Sector peers and consistent with the content of agreements signed by the hospital with its various health insurance partners.

Figure 5.1 Position Description Registered Nurse/Midwife excerpt
The nurse’s position description is written in such a manner that it demands a level of competence that perhaps is over and above that of professional and statutory requirements for registered nurses and/or midwives, or as set by the regulatory authorities’ texts. Overall, the document is very detailed in what it asks. It is professional and highly polished, with the hospital’s reputation and status within the private health market/industry paramount.

The document indicates from the outset that nurses will support the hospital in its vision of achieving excellent clinical outcomes [and that the hospital] will be the first choice private hospital for people located within a nominated metropolitan and rural catchment area of Australia. It stresses its focus on excellence, emphasising that the hospital provides premier, personalised care to its patients in contemporary facilities equipped with state of the art technology. (emphasis in original)

There is no ‘I’ speaking to a ‘you’ (Lemke, 1995) within this document other than at the end under the heading of Acceptance and Signature, and even then statements remain formal. This final heading directs the nurses to read and indicate their acceptance of the position as stated. Dotted lines indicate where nurses and the Nurse Executive are to print their names, signatures, and date. These are the only indicators of what may represent any personal input into the document. It is only in signing this document that nurses, as employees, commit to being held accountable for their role.

In the extract from the Registered Nurse/Midwife Position Description presented in Figure 5.1, we note the organisation assumes authority to circumscribe the work of nurses by making reference to the authority contained in not only nursing professional
and regulatory authorities’ texts but also in those pertaining to the management of the healthcare organisation. The document identifies the minimum qualifications required to perform the essential functions of the job, which are the essential qualifications, experience and knowledge for nurses employed at this hospital. There is an expectation, indeed it is ‘essential’, that nurses are able to demonstrate working knowledge of Australian Council on Healthcare Standards (ACHS) guidelines, specifically its EQuIP program, nursing professional practice frameworks, and codes of conduct and ethics, which, at the time of data collection, were those mandated by what was then known as the Australian Nursing Council Incorporated (ANCI), now the Australian Nursing and Midwifery Accreditation Council (ANMAC). What is taken for granted is that these organisations, for example ACHS and ANMAC, have authority, and that reference to them justifies the hospital’s demand for a prescribed level of professional standards of care at the time a nurse enters into a contract of employment and thereafter.

**Competent nurses**

The national competency standards for the registered nurse are the core competency standards by which a nurse’s performance is assessed to obtain and retain their license to practise as a registered nurse in Australia. These standards provide an individual registered nurse with the framework for assessing their competence. Nursing and midwifery regulatory authorities use these standards to assess competence as part of the annual license renewal process, to assess nurses educated overseas seeking to work in Australia, and to assess nurses returning to work after breaks in service. They are also taken into account where nurses are involved in professional conduct matters. The nursing and midwifery regulatory authorities may also apply the competency standards

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47 Evaluation and Quality Improvement Program (EQuIP) is the core accreditation program guiding organisations through a four year cycle of Self-Assessment, Organisation-Wide Survey and Periodic Review to meet ACHS standards (ACHS, 2011).
to communicate to consumers the standards they can expect from nurses. Universities use the standards when developing nursing curricula, and to assess student and new graduate performance (ANMC, 2006).

A reading of the *Competency Standards for the Registered Nurse* (ANMC, 2006) identifies the various ‘domains’ that constitute a ‘competent’ nurse as opposed to an incompetent one. These domains are identified in this document under the rubric of professional practice, critical thinking and analysis, provision and coordination of care, and collaborative and therapeutic practice. Each of these headings identifies the dimensions of nurses’ work that the profession and healthcare organisations use to account for competent performance – and the nurses’ employability. The authority in this text, coming from a quasi-governmental entity such as the ANMAC, positions nurses as competent or not, and subjects them to all the discourses that constitute this particular positioning. Under the heading of ‘professional practice’, for example, reference is made to legal discourse through the use of key words such as ‘legislation’, ‘common law’, ‘duty of care’, and ‘rights’. The heading of ‘critical thinking and analysis’ relates to self-appraisal and professional development. This heading is underpinned by discourses pertaining to ‘research’, enrolling nurses to practise within a framework that is ‘evidence-based’, which requires nurses to participate in the ongoing professional development of themselves and others, using the “best-available evidence, standards and guidelines to evaluate nursing performance” (ANMC, 2006, p. 7).

Even from a brief analysis of the standards one can see how a discourse of competence – and the components that constitute this – shapes the governance of nurses, and how organisations adopt this discourse, translating it into organisational texts such as job
descriptions. While being competent is enough to meet regulatory authority requirements for registration, the hospital’s registered nurse/midwife position description draws upon a competence discourse to frame how they expect this role to be performed. As we will read, the hospital takes this requirement further by asking for a greater level of clinical expertise of its staff as well as a degree of business management insight. Discourses surrounding the nursing workforce, such as its competence and private healthcare policy, again constitute nursing as a problem, taking the focus away from the organisation’s business practices that shape their working lives.

What we have then is an expectation that all nurses employed by the hospital are competent, which they are deemed to be simply by virtue of their registration, with an onus on nurses to ensure the provision of a consistently high standard of care and importantly that care is timely, planned and expert. A base-level assumption is made about nurses’ knowledge and skill in each of the participants’ position descriptions – they are competent. Yet the position description under the rubric of Professional and Personal Development indicates that for nurses to practise at a competent level of proficiency remains somewhat inadequate for nurses working in this setting, with their practice pitched at an expert level to achieve the clinical and operational goals for their unit/ward and/or hospital. Indeed, documents state that all nurses, whatever their role, are responsible to ensure that they are:

Observable as an expert clinician who maintains current knowledge and implements contemporary clinical practice to achieve the clinical and operational goals for their specific unit (Position description Registered Nurse/Midwife Level 1) (my emphasis).

This statement is evident in each of the participants’ position descriptions, whether it be
the Level 1 Registered Nurse/Midwife as indicated above, the Level 2 Clinical Nurse and Level 3 Clinical and Admissions Manager, Clinical Manager (General), Business Manager (Clinical), or After-Hours Hospital Coordinator. The reason for such an emphasis within nurses’ position descriptions on their clinical expertise, which is ahead of the expectations of the regulatory authorities that set the level for obtaining registration, may be because there is no doctor on site. As one manager told me:

Prior to me starting 3 years ago the position description for a registered nurse ... was that you had to have 5 years nursing experience. That was under the [name] era. I certainly knew 3 years ago that we were going to have a huge workforce shortage if we continued to do that. So she didn’t believe in graduates coming into the organisation, purely because there were no doctors on site and felt that the staff had to be skilled or have a lot of experience I guess behind them. (Anita Nurse Unit Manager, Interview transcript, p. 17)

While it was not stated in the Registered Nurse/Midwife position description that nurses “had to have” a minimum of “5 years nursing experience”, the legacy of these statements remains in so far as nurses’ employment is conditional on having and maintaining a level of clinical expertise. An assumption is that by ensuring a certain level of staff expertise, there is capacity within the hospital to deal with a wide range of clinical care needs – often quite complex – and/or events in the absence of a resident medical officer. The assumption is that these nurses can do more; because of their level of expertise, they will be more productive. Nurses in this hospital deal directly with the patient’s doctor and/or allied healthcare personnel. Thus, in nurses’ position descriptions, doctors, by their transience, influence the calibre of nurses employed by the organisation – an effect of absence more evident in private healthcare although also a part of nursing practice in all areas.
While the above statement refers to the inherent authority of doctors within the private healthcare system, the Nurse Unit Manager’s authority to comment on the hospital’s nurse workforce is also evident. Reference is made to the past; to the ‘era’ of a previous Nurse Executive, where nursing “staff had to be skilled or have a lot of experience behind them” to qualify for employment in the organisation. It is Anita’s opinion that “we were going to have a huge workforce shortage if we continued to do that”, where ‘that’ is reflective of an unrealistic and outdated professional vision by an individual Nurse Executive of a nursing department based on a staffing complement of highly skilled, experienced staff. Now, those in positions of authority could no longer hold onto unwritten employment selection criteria for the kind of staff employed. Nor, perhaps, could they sustain the cost of having such senior staff in terms of labour cost and/or a workforce shortage.

**Performance management**

While nurses may be competent to speak about nurses’ work – nursing – an organisational eye is kept on their work performance. Again, this performance is written into, and accounted for, upon signing an employment contract under the rubrics of *performance improvement, accountability, evaluation and outcomes*. The employer’s authoritative voice is evident throughout the document, with nurses actively enrolled to provide high quality services to the hospital’s clients. There is no doubt that nurses are:

> Regarded as valuable member of the clinical team that contributes to the excellence in the delivery of patient care to ultimately achieve the highest possible patient outcomes. (Registered Nurse/Midwife Position description)

An analysis of the ‘actional component’ (Fairclough, 1995) of the document notes that it
is infused with words that guarantee that nurses’ work is about ensuring the ongoing performance of the hospital’s business. The position description reveals use of words such as *utilises, establishes, ensures, contributes, actively, promotes, keep abreast of* and *achieving length of stay benchmarks*, which draw nurses into actively working for the hospital’s business, its reputation, and standing in a competitive private healthcare market. It also draws them into envisaging that the contribution of their work [labour] is of such high quality that it assures this, for example, the registered nurse:

- **Utilises** interpersonal skills conducive to promoting harmony and cooperation both within the hospital and with external service providers;
- **Establishes** and maintains professional and effective working relations with visiting clinicians, hospital staff and external service providers;
- **Ensures** the provision of consistently high standard of clinical care;
- **Ensures** the delivery of high standard, timely, planned and expert care;
- **Contributes** to the development, implementation and review of unit based policies and procedures;
- **Keeps abreast of** organisational goals and global influences on the clinical aspects of the healthcare industry and in particular those relevant to [hospital].

(Registered nurse/midwife position description, emphasis in original)

The hospital’s status, as employer, speaks directly to how nurses’ work is defined for the benefit of the organisation. Other than the aforementioned voices of legislative and regulatory requirements that are to be met by the hospital, there is a strong emphasis on managerial discourses of quality and how nurses’ work will enhance the hospital’s profile both internally and externally. It is a requirement of their employment that nurses’ practice is *contemporary* – therefore not old-fashioned – and being contemporary includes keeping abreast of *organisational goals and global influences on the clinical aspects of the industry, particularly those relevant to [the hospital]*. This is
no more evident than in the hospital’s requirement that a nurse has a working knowledge of, and:

... actively contributes in and promotes [hospital] Performance Improvement program including the preparation for and maintenance of the EQuIP program;
Assists the Clinical Manager in achieving length of stay benchmarked with the Private Sector peers and consistent with the content of agreements signed by the hospital with various health insurance partners.
(Position Description Registered Nurse/Midwife, emphasis in original)

Contemporary nursing care is well and truly located within managerialist discourses where nurses’ work is as much about achieving organisational goals in line with private sector peers and health insurance partners as it is about achieving patient outcomes. The authority of others – private sector peer organisations and health insurers – also speaks in the nurse’s position description as to how work is ultimately organised, accounted for, and evidenced.

The extent of what information about the content of agreements signed by the hospital is made available to nurses is questionable given concerns of commercial confidentiality, however analysis reveals that nurses are very much reminded of the hospital’s financial position and where they are located within it via forums held regularly by the hospital executive:

We have forums where it is, we’re always reminded that we’re over budget, we’re over-staffed, we’re never quite meeting what the board requires of us, as nursing staff. (Sandra RN, Interview transcript, p. 2)

These forums are a strategy to gain nurses’ commitment to budgetary constraints. The process makes them responsible for meeting business targets, as Linda comments:
... we have the general hospital forums where they show us graphs of the financial picture and show us where we are and how far behind we are and how much our estimated revenue is going to be and how much where we are. Now this is the difference girls, what can we do? We need to pull together. Well we’re pulling ... But it’s, yeah, it’s budgets, budgets and money, budgets and money, and uh not looking after ... And as I say, it’s only because you have the calibre of the nurses who work here that strive to do, to pick up the pieces and keep going that we do what we do. So we actually work in spite of everything that’s thrown at us. (Linda RN, Interview transcript, p. 10)

Managing the budget

In relation to what authority nurses may have in commenting on the ‘budget’ or ‘hours’, as noted above, an invitation is extended to all nurses (and other departments) to attend regular meetings with the hospital executive. An assumption here is that nurses, amongst others, have an opportunity to comment on the state of the ‘budget’:

When they portray these figures that we have at these big meetings where [the CEO] gets up … this is slightly over budget and here we are slightly over budget, they’re [another department are] on target, this [department] is slightly under budget and the nurses, deathly long silence. Well the nurses are over budget and it’s like, I and others have said similar, that sometimes you come away from these meetings feeling like it’s your personal fault . I often feel the nurses are targeted. I mean we are the biggest workforce, it’s a hospital for heaven’s sake, what else do you expect to have here? But nurses. And yes, we cost money. (Linda RN, Interview transcript, p. 15)

Presentation of this data leaves nurses feeling that they are being blamed for budgetary shortfalls, as Mary comments:

… we’re always … being blamed because it costs a lot of money to have all you nurses and we’re always the budget blow-out everything is always nursing budget blow-out, it’s a shame really. (Mary RN, Interview transcript, p. 7)
The redesign of nurses’ work is evident in nurses’ job descriptions, as seen in the increase in nurses’ responsibilities. It reflects the kinds of accountability stemming from information-based management technologies such as performance outcome measures. Rankin and Campbell (2006), in their study of the impact of reforms to Canada’s healthcare system, note that nurses are expected to be responsible for how they (and other healthcare professionals/workers) use hospital resources. This is no more evident in this thesis than with discussions dealing with nurse staffing or their nursing hours. Management work to persuade, but also pressure, nurses into being held accountable for their working time using administrative strategies such as hospital forums and the generation of reports to shape nurses’ business mentality, so much so that their ‘nursing hours’ feature daily in their conversations:

They [manager] ... figure out the hours on the computer and so they [manager] will look at every day, how many hours of RN have you had how many hours of EN have you had, how many hours of ward clerking have you had? And they tally it up … I can’t think what else we talk about. It’s just, it’s there ... we all might be in the office and you hear, well girls our hours are over. You know, our hours are over for the month. We’ve really got to tighten up; we’ve really got to whatever. And most people just look at each other and roll their eyes because it’s like, well how? How do you want us to do that? You know. And this work smarter thing, we’re all smart. You know. We’re not dumb. (Linda RN, Interview transcript, pp. 14–15)

This is Linda’s account of the way the state of nurses’ hours is conveyed to staff at a ward level. The authoritative voice of administrators, asking nurses to ‘tighten up’ their nursing hours, indicates a shifting of responsibility of managing these ‘hours’ to the nurses on the ward. “How many hours of RN you had, how many hours of EN you
had“48 is represented not only within computer files but also in the nurses’ Daily Allocation Sheet, which indicates what ‘hours’ an individual is working, rosters or scheduling formats, enterprise bargaining agreements and industrial wards. Nurses’ ‘hours’ are also located in patients’ medical records as timed nursing entries in nurses’ ‘charts’, for example clinical pathways, and in nursing workload measurement/patient classification systems, euphemistically referred to as units of ‘care’.

While nurses and others may well attend these meetings, any authority to make comment on the state of the ‘nursing hours’ lies with the hospital executive. The executive and Unit Managers, with their trust in numbers (Porter, 1995), report on the state of the ‘hospital and budget’. The nurses’ ‘hours’, it seems, are always ‘over’.

Undoubtedly there is much reporting of the state of the organisation, as represented by the ‘budget’, be it at ward level or in meetings or forums with the Chief Executive Officer, although it appears that nurses cannot or do not speak because the “deathly long silence”49 of management says it all. Yet nurses do speak, if not verbally, as they “look at each other and roll their eyes”50 and question how this is so. Given budgetary constraints, nurses working on the wards take umbrage with popularised management-speak of ‘working smarter not harder’ when they are indeed working harder and longer (Beynon et al., 2002; Garling, 2008; Weinberg, 2003; White & Bray, 2003), and where nurses’ expertise gained through education and experience (Arbon, 2004; Benner, 1984; Duffield & O’Brien-Pallas, 2003; Lawler, 1991) is devalued – where nurses are considered to be “dumb and that it is nurses’ fault”. Nursing is numerically the largest group of health professionals providing direct patient care, and this, plus the imperative

48 Linda RN, Interview transcript, p. 14
49 Linda RN, Interview transcript, p.15
50 Linda RN, Interview transcript, p.15
for effective cost control, constitutes their costs as a legitimate study focus and policy
target (Newbold, 2008). That said, the challenge for the hospital executive, including
the nursing executive, is to not only maximise outcomes and minimise costs but to
maintain service quality in the most economical way. While some of these challenges
ultimately lie with the executive, we see from the preceding chapter that the object of
nurses’ talk is the hospital’s business. In this chapter, however, we see that it is nurses’
business to manage their working time for the benefit of the organisation. Whether it is
represented via in-house forums or in budget spreadsheets, the cost of nurses to the
organisation shapes how the organisation is managed. While this is neither new nor
surprising, participants revealed a level of cynicism and anger to what one nurse
perceives as the “usual conversation” of hospital administrators. According to Linda:

… with ANF when we’ve been negotiating our enterprise bargaining
agreements and things like that, and they [hospital executive] don’t say it
directly but you know darn well what they mean when it’s like, well you nurses x
number and you want a pay rise of so many percent over so long etc, etc. Usual
conversation. Well the hospital can’t afford that. And so you are pretty much
directly told that what you want is financially impossible unless you want to put
the hospital under and then it’s like, well then where do you go. I want to get paid
and I want to be paid what I’m worth, and so does everybody else. But you are the
fault for it, I feel is laid at our feet, most of the time. (Linda RN, Interview
transcript, p. 16)

Linda expresses anger with the hospital administrators’ inference that it is the fault of
the “x number” of nurses employed by this organisation as a reason for arguing against

51 Established in 1924, the Australian Nursing Federation (ANF) is the national union for nurses,
midwives, assistants in nursing and students. The ANF represents the industrial and professional interests
of nurses and midwives through the activities of a federal office and branches in each state and territory.
(ANF, 2011).
52 The enterprise bargaining agreement (EBA) is an enforceable document that covers the employment
conditions of group of employees and their employer. Awards contain minimum terms and conditions of
employment. Typically, workplace agreements cover an individual or group of employees. They can
include a broader range of matters than an award and, when in place, take precedence over an award.
wage increases in enterprise agreements, not only because it is purportedly “financially impossible” but because it will also “put the hospital under”; shifting the focus from the hospital’s administrators to nurses as being responsible for the state of the hospitals’ finances. Nurses’ burden of care (Fagin, 2001) lies not only with what they can deliver at a clinical level but at an administrative level as well, where the cost of nursing services is such that it threatens the organisation’s financial viability.

**Doctors and nurses**

Doctors are valuable and important contributors in the private hospital care market. Thus, despite hospital administrators’ talk of budgets and money, the visiting medical practitioners are positioned as having authority to comment on the hospital’s business. Doctors, by nature of their ‘visiting’ status, influence the competence level of nurses employed by the hospital, as noted previously in this chapter. Returning to nurses’ position descriptions (see Figure 5.1), we read that the hospital values the professional association with our visiting medical staff, even though visiting medical practitioners are not technically ‘staff’ – doctors work in private practice and are paid on a fee-for-service basis by Medicare and patient monies. O’Loughlin (2002) points to what is the clear difference between healthcare and other businesses; healthcare is highly dependent on the actions and motivations of individual doctors, who, because of their independent accountability and authority, hold a great deal of influence over hospital operations; most centrally, doctors control referrals to private hospitals. Thus, private hospitals provide the infrastructure such as beds, theatres, equipment, and other facilities, and importantly nurses to allow doctors to treat patients. That said, not all hospitals are the same. Many private hospitals target niche markets of doctors or specialities to differentiate their services (Productivity Commission, 1999).
It is this relationship between the organisation and doctors that is cultivated not only by the hospital executive but importantly by all hospital employees, no matter their roles. Doctors can and do move completely to other hospitals or take some of their better remunerated work to other hospitals (O’Loughlin, 2002). The potential of losing either a doctor or a profitable casemix of patients has an impact on the organisation’s financial performance. The impact of this is not lost on nurses:

I mean doctors get their money and they dangle carrots I guess to try and get people to stay here and promise them things so that you’re trying to entice business, and keep business, and keep doctors happy. For God’s sakes keep the doctors happy! (Leanne RN, Interview transcript, p. 40)

Keeping the doctors happy entails nurses ensuring that doctors who regularly use the hospital have privileged access to beds and they will work to make these available where and if they can, despite the occupancy rate. Sonia sums this up as follows:

A: … We have had a few new surgeons and we’ve had a few new doctors but then they get a bit put off because we get full and we can’t take [admit] their patients so it’s a merry go round isn’t it and I don’t think it’s any different anywhere else in any other private hospital.

Q: And as an After-Hours Coordinator do you sometimes feel pressured to take patients or not take patients …

A: If I can take them I'll take them, it’s as simple as that. …

Q: Yes.

A: If I can fit them in. Even if I can’t fit them in and it’s some of our surgeons who in fact operate with us a lot or some of our physicians who grizzle in my ear and say I can never get my patients in here, um you tend to try and make room for them if you can regardless. (Sonia After-Hours Coordinator, Interview transcript, p. 19)

While there is no disputing the integral relationship of nurses and doctors to the delivery
of quality patient care, in private health there exists this other dimension to the relationship where the doctors – and other visiting health professionals and service providers – are positioned as the hospital’s clients or customers. Again, the nurse’s position description (Figure 5.1) reflects this. We read in the document’s wording that it is heavily tilted toward business-oriented discourses of marketing and customer-service, and that nurses’ responsibilities and skills include public relations skills; nurses are to:

Demonstrate an appropriate level of written and verbal communication skills including problem solving and public relations skills;

As well as:

Enhance the hospital’s profile and reputation both internally and externally;
Consistent positive feedback from patients, carers and visiting clinicians regarding care and service provision. (Registered nurse/midwife position description, emphasis in original)

Nurses’ work is as much about promoting the hospital’s image, reputation, and services as it is about ‘care’, and thus nurses directly or indirectly contribute to building the hospital’s business. While the nurse: patient relationship is at the core of nurses’ work – the business of nursing – the ‘business’ orientation of private health adds another facet to that work. Currie and Brown’s (2003) study of narratives used by managers at hospitals in the United Kingdom picks up on this notion of marketing wherein nurses are encouraged to be market-aware in promoting the hospital services; nurses are co-opted into a set of systems geared toward achieving organisational objectives (Currie & Brown, 2003). The changing dimensions of the nurse manager role in the public healthcare sector (see Allen, 2001; Germov, 2005; Newman & Lawler, 2009) under managerialism or New Public Management means that for nurses in private health, this notion of marketing the hospital is not confined to nursing administrators; clinicians are
involved in it as well.

One of the study participants, Sandra, reflects on why the visiting medical practitioners do not, or will not comment about nurse staffing, given its impact on their patient’s care. Despite what she regards as a professional and amicable working relationship with many of the doctors, who are “our very good friends” and have known “each other for years”, she fails to comprehend why doctors do not support nurses to argue for better staffing to enable nurses to “provide better care” for their [the doctors’] patients:

Surprisingly enough, a lot of a medical officers [are] our very good friends, because we’ve all known each other for so many years. They treat us so well, they’re so kind, so, you have a few rotten ones, but on the whole, they are very concerned when they see us running around. But they themselves don’t go and report it, which is a real shame. I don’t know why they don’t say, ‘I won’t bring my patients here if you do not provide better care by allowing the nursing staff to have better hours’. They tend not to do that. Which is a shame. (Sandra RN, Interview transcript, p. 30)

Doctors “tend not to do that” because, quite simply, they can take their business elsewhere. The Australian financial press made much of doctors’ independence as the cause of the profit downgrade of what was at the time one of Australia’s largest for-profit group private hospitals – Mayne. A bad relationship between the company and doctors who worked at Mayne hospitals saw many doctors moving completely to other hospitals or moving their better remunerated work to other places, which resulted in falls in patient numbers at Mayne health units at a time when other hospitals were experiencing high occupancy (O’Loughlin, 2002). According to Gottliebsen (2002, pp. 19, 26):

The Mayne problem was caused by a simple mistake: not understanding
the power of surgeons who very neatly took them to the cleaners ... the word spread around the surgeons ... that Mayne no longer provided hot breakfasts during surgery; too often it rescheduled operations; the air-conditioning was turned down; and that the hospital employees that they liked had been ‘rationalised out’.

Again, nurses are acutely aware of the doctor’s position and the role of the executive in working to ensure the sustainability of the business and in turn their own employment.

As one nurse puts it:

I look at it that she’s [Nurse Executive] more trying to get ... known out there and get new doctors in and try and increase the profile I suppose of the hospital and where they’re looking to go in the future. Because I think things, I don’t know exactly, but I’d say, probably, doctors have left, and to try and get new doctors here is always difficult, and it’s a private hospital so it’s the doctors that really bring in the money. (Angela RN, Interview transcript, p. 3)

So far, this chapter, in providing an understanding that it is ‘really’ the doctors and health funds that bring money into the private healthcare market, has indicated some of the “various statuses, the various sites, the various positions that [nurses] can occupy or be given when making a discourse” (Foucault, 1972, p. 54). Identifying “who is speaking” (Foucault 1972, p. 50) in this chapter shows that insurers, doctors, and ultimately patients (it is patient revenue that is the main source of income for private hospitals) have authority to speak about the hospital’s business. Patients, as customers or consumers of healthcare services, speak in nurses’ job descriptions where nurses’ expertise is not only of a clinical nature but also where meeting the needs of ‘the customer’ – however these needs are defined – is important. Doctors also speak about their expectations for, and demands of, a certain type of nursing service for themselves and their patients. Then there are the “institutional sites” (Foucault, 1972, p. 51) such as
industry and professional regulatory bodies that regulate the kinds of statements that can be made about nurses’ work. Nurses’ positions are:

... defined by the situation that is possible for ... [nurses] to occupy in relation to the various domains or groups of objects: according to a certain grid of explicit or implicit interrogations. (Foucault, 1972, p. 52)

These grids are further interrogated in the process of negotiating an enterprise agreement. The hospital’s four-yearly enterprise or collective bargaining process coincided with the changing organisational milieu for staff as the nursing department was restructured. The discursive construction of the nursing workforce as costly has nurses constituted as a ‘problem’ for business, as the nursing budget or ‘hours’ are always spoken of as ‘over’. With the focus on the costs of the nursing hours, the dominance of this representation makes it difficult to appreciate the work nurses do in attracting business for the hospital. The following section considers how nursing is positioned to comment on the business of their working time in the process of negotiating an enterprise agreement.

**Enterprise bargaining**

In ensuring *the success of the hospital* (Registered Nurse/Midwife Position Description), what is written into the nurses’ enterprise bargaining agreement is a way of speaking that is broached in absolutes and certainty. Nurses’ working time is a source of much negotiation, with ‘flexibility’ being ‘critical’ for the hospital’s ongoing success. While I am unable to cite directly from the final document published for the hospital because of the ethical requirement for anonymity, data include records of some of the enterprise bargaining process. It is these working documents to which I refer – specifically minutes of two meetings held between the union and hospital enterprise
bargaining committee, and my fieldnotes. Nurses’ working time is at the foreground of
the enterprise bargaining discussions, particularly with the issue of numerical or
‘temporal flexibility’ through working hours (Hudson, 2002). Extracts from minutes of
meetings are presented in a table format written in italics to differentiate them in-text.
We read that the enterprise bargaining committee is on to the third draft of the
enterprise agreement. In the minutes presented below (Table 5.1), we read how nurses’
working time features in discussions, particularly around extending to 12 hours.

**Table 5.1 Nurses’ committee meeting minutes**

<table>
<thead>
<tr>
<th>[Hospital] Nurses EB Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting held: (Date) at 3.00 pm</td>
</tr>
<tr>
<td>Present: (Names)</td>
</tr>
<tr>
<td>Absent: (Name)</td>
</tr>
<tr>
<td>Minutes:</td>
</tr>
<tr>
<td>Draft No.3 document distributed by [hospital]. Agreed to work through the document. Amended clauses are printed in blue.</td>
</tr>
<tr>
<td>Clause 30: Shift length: Theatre and Mid staff are against extending shifts to 12 hours. Historically previous shifts of 10 hours had been removed at staff request. Staff consensus to continue with 8.5 hour shifts. [Hospital] wish to consider this further.</td>
</tr>
<tr>
<td>Clause 39: Shift lengths – not supported by staff</td>
</tr>
</tbody>
</table>

At the next meeting (see Table 5.2), the clause that dealt with shift lengths for operating
theatre suite personnel is not commented on, while another clause, Clause 39, which
pertains to shift length for nurses working on the wards remains a source for discussion
in the knowledge that it is not supported by staff. In another extract from the minutes,
the hospital’s position is recorded in so far that it still wish[es] to pursue up to a
maximum of a 12-hour shift for nursing staff on the wards, which has the union agreeing
to taking it back to members at the next meeting along with the latest draft document.
Table 5.2 Enterprise bargaining meeting minutes

<table>
<thead>
<tr>
<th>Nurse – Enterprise Bargaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Held on (Date) at 1000pm.</td>
</tr>
<tr>
<td>Present: (Names)</td>
</tr>
<tr>
<td>Apologies: (Names)</td>
</tr>
<tr>
<td>Chaired by (Name)</td>
</tr>
<tr>
<td>ANF to meet with members (Date) at 2.30pm</td>
</tr>
<tr>
<td>Clause 39: Shift lengths: [Hospital] still wish to pursue up to a maximum of a 12 hour shift. ANF: seek additional wording to this clause, eg. By mutual agreement and no lack of disadvantage. They will take it back to members.</td>
</tr>
<tr>
<td>ANF has not yet taken the latest draft – this will occur on Friday. It is noted that they [ANF] appreciate the offer of a fixed operative date.</td>
</tr>
</tbody>
</table>

Two months after the date of the above minutes, I record in my fieldnotes:

*It was on the desk in the handover room that I found a copy of an excerpt from the current EBA working document, highlighting sections dealing with hours of work. EBA still in progress it seems. There are three pages copied – pages 6–8, all one-sided, marked lengthways with blue highlighter pen indicating the areas of the document that are of greatest concern for the nursing staff: predominately those referring to hours of work and specifically those dealing with 12-hour shifts. By way of example... from the Final Document, highlighted under the heading of ‘Hours of Work’ is:*
15 Hours of Work

(d) Where specified in this agreement shift length may, by mutual agreement up to 12 hours. When an employee is rostered a 12 hour shift, overtime will accrue after 12 hours.

(e) The hospital may by mutual agreement provide shifts of variable length with a minimum of 3 hours, up to and including 12 hours. Provided that the number of shifts per week does not exceed 10 per fortnight. When an employee is rostered on a shift a duration shorter than 12 hours, overtime shall accrue after 7.5 hours on wards and 8 hours in theatre, where that employee agrees to work beyond the rostered shift length. Hours worked in excess of the rostered shift per day or 75 hours per fortnight shall be paid at the appropriate overtime rate.

(f) The hospital by mutual agreement, and provided that the number of shifts does not exceed 10 per fortnight, may provide shifts of variable length, with a minimum of 3 hours and up to and including 12 hours. Where this occurs provision for overtime will occur after 12 actual hours worked. (p.6)

Any reference to 12 hours is highlighted in other sections of the excerpt; a total of three areas. Firstly, as indicated above in the section dealing with ‘Hours of Work’, secondly, that dealing with ‘Part-time employment’ and thirdly the one dealing with ‘Shift Lengths’. From Section 17 of the document, under the heading of ‘Part-time employment’ I have indicated below what is highlighted.

17. Part-time employment

Unless otherwise provided for in this agreement a regular part-time employee who works additional hours (in addition to their regular contracted hours) will receive payment at ordinary time rates for all hours worked up to their expected shift length, in any one day or up to 75 hours in a given fortnight. When an employee is rostered on a shift of duration shorter than 12 hours, overtime shall accrue after 7.5 hours on the wards and 8 hours in theatre. (p.7)

(Fieldnotes #22, pp.2–3)

In reference to shift lengths of 7.5 hour shift in the wards and 8 hours in theatre, I understood that as referring to the usual shift times for these two areas, a standard shift
length being 8 hours for theatre and 7.5 hours for the wards. Another section, *Shift Lengths*, is small, but reference to *12 hours* also sees this section marked with the highlighter pen because this indicates the minimum and maximum shift length times. Reassuringly for nurses, it states that *there will be no disadvantage to employees who elect not to participate in 12-hour shifts*.

<table>
<thead>
<tr>
<th>39. Shift Lengths</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Shift lengths may vary with a minimum of 3 hours and by mutual agreement to a maximum of 12 hours per shift. Maximum ordinary hours worked will not exceed 75 hours per fortnight. Overtime will apply for work performed in excess of 75 hours per fortnight. There will be no disadvantage to employees who elect not to participate in 12 hour shifts.</em></td>
</tr>
</tbody>
</table>

Fieldnotes #22, p. 3

The issue of 12-hour shifts is of great concern to the nursing staff of this hospital. When I was speaking with one of the hospital’s union worksite representatives, Donatella, at the nurses’ station desk after she had worked a morning shift on Ward A, she told me how disappointed she was that the potential for nurses to work 12 hours had managed to creep into the hospital’s enterprise agreement. The previous enterprise agreement made no mention of 12-hour shift lengths, with the maximum length set at 10 hours for nurses on the wards. In her role as the union representative in her discussions with nursing staff, at union meetings, and meetings with the hospital executive, she believed it had been made very clear that nurses were adamant they were not prepared to work 12-hour shifts. Although she *was not a lawyer*\(^\text{53}\), her concern was with the fact that reference to 12-hour shifts had appeared in three different sections of the draft document. Donatella saw this as an indication of the importance the hospital placed on 12-hour shifts in relation to the management of nurses’ working time. Whilst she acknowledged that in

\(^{53}\) Donatella RN, Fieldnotes #22, p. 3
this round of negotiations nurses had managed to negotiate an agreement that was better than others currently available in the private sector – with this enterprise agreement being almost on par with that offered by the public healthcare sector\textsuperscript{54} and with meetings being the best attended by members and non-union members in the hospital’s history – she expressed a view that the union had failed nurses in some way by allowing provision for 12-hour shifts to find its way into the agreement.

The potential for working 12-hour shifts on the wards as a rostering strategy for nurses through an enterprise bargaining process was a decisive moment for many nurses working at this hospital. Now, whether this was reflective of the demographic profile of the nursing workforce of the hospital, with the average age of nurses mirroring national nursing workforce data as the age of a registered nurse at 44.1 years (AIHW, 2010a) and the majority of nurses working part-time, the prospect of working 12-hour shifts created much discussion and angst. Whether or not this angst was justified, it appears that for some nurses this was regarded as an erosion of their industrial conditions and that the union had somewhat failed them. Although ‘\textit{some staff are not averse to being able to work 12-hour shifts}’\textsuperscript{55}, other nurses certainly were.

Lily and a colleague discuss the issue as I observe them preparing a patient’s intravenous therapy in Ward A’s Treatment Room:

\begin{quote}
... 12-hour shifts, neither is happy to even entertain the thought of them and they do not believe that anyone wants to work them; Lily informs me that “no-one that I’ve spoken to wants to work them”. (Fieldnotes #18, p. 5)
\end{quote}

\textsuperscript{54} Historically, nurses working in private health have been paid less than those working in the public sector.  
\textsuperscript{55} Anita Nurse Unit Manager, Fieldnotes #18, p. 5
While nurses were adamant they were not prepared to work 12-hour shifts, nurses I spoke to perceived any authority on the union’s part to negotiate against this particular strategy in managing the roster as being unsuccessful, although the union managed to have the inclusion of the statement *with mutual agreement* inserted in the clause.

Industrially, nurses, positioned as employees, appeared to have limited authority to comment on how their work time was configured because the hospital’s flexibility requirements, such as that staff work 12-hour shifts to manage its workforce and budget, took precedence.

There is an expectation of, and demand for, a level of nurses’ expertise in this organisation that is beyond a mere ‘competent’ level of practice, as already noted.

Linda, in talking about the nurses’ hours, observes that:

> ... there’s actually some very experienced people who work here and I think if you can’t make [the nursing budget] with all the experience that we’ve got here, if you can’t make the budget work, the budget’s wrong. ... you know, it can’t always be the nurses’ [fault]. (Linda RN Interview transcript, p. 15)

While nurses may have little say over the budget, what is interesting in Linda’s observation is that she alludes to nurses’ expertise/skill as what nurses’ draw upon as they ‘pull’, to use Linda’s words, to rein in their nursing hours. The nursing workforce literature makes a great deal about nurses’ workloads, particularly showing the effects of nursing workload on patient outcomes, staffing, and quality issues (Aiken et al., 2001b; Needleman et al., 2002; Rafferty et al., 2007). While the issue of workloads remains at the forefront of the nursing workforce literature, in this chapter I have argued that statements about nurses’ expertise found in nurses’ job descriptions and interviews, for example, show it is this expertise that is drawn upon to manage the nursing budget,
thus minimising the hours needed for care delivery.

**Conclusion**

There is no doubt that the authority inherent within legislation, insurers, medical health practitioners, and patients – as clients/customers – determines the many business decisions and/or choices made by hospital administrators in relation to nurses’ work. In this chapter, nursing is answerable to the business concerns of the organisation/enterprise – it is a clear expectation of the job. It is an expectation that is present within all nurses’ position descriptions and in statements pertaining to the management of the hospital’s risk – financial or otherwise. Nurses impact on hospital finances simply because of their numbers. Consequently, the hospital’s business becomes nursing’s business.

This chapter aimed to explore how ‘the nurse’ is located in organisational texts and how this representation of nurses defines, limits, but also produces nurses’ work/practice. Nurses’ position descriptions, in-house forums, and minutes of meetings have been shown to shape nurses’ subjectivities within business or enterprise discourse so much so that the business of nursing, while perhaps always about patients, is indeed about ‘business’. A particular nursing subjectivity is produced that goes beyond that of nurses as ‘employees’ to that of an ‘expert’ nurse whose skill and experience combine to manage the cost of nursing care time for the hospital. The representation of nursing as ‘nursing hours’ impacts on nurses’ everyday working life. Nursing working time is constituted as problematic for the hospital, resulting in responsibility for managing the cost of that time accruing to nurses across all levels of the organisation. The problem of nursing working time can be understood as being represented by:
Numbers, and the techniques of calculation in terms of numbers, have a role in subjectification – they turn the individual into a calculating self endowed with a range of thinking about, calculating about, predicting and judging their own activities and those of others. (Rose, 1999b, p. 214)

In this and other chapters, we have read how nurses think about their work practices as their nursing hours are calculated, predicted, and judged. This theme is pursued further in the next chapter, which describes the way in which time as time management becomes central to nurses’ practice within discourses of business management and a changing conceptualisation of care.
CHAPTER 6
TIME AT WORK

In Chapter 5, I indicated how a particular nursing subjectivity or identity was demanded/produced within organisational texts, taking nurses beyond competent employee to expert professional with heightened business savvy. This was exemplified by nurses assuming a wider range of responsibilities that included marketing and business, with expectations that nurses had public relations skills and knowledge of private hospital performance indicators such as length of stay benchmarks. In this chapter, the centrality of the concept of time to the organisation of nurses’ work is demonstrated. I examine how the responsibility for responding to the hospital business imperatives becomes the nurses’ responsibility through ensuring the flexible delivery of their work. Points for consideration are how work flexibility plays out in the temporal and spatial locations of nurses’ practice as patients, doctors, and nurses exercise their ‘choice(s)’. I illustrate how the discursive practices of ‘flexibility’ govern nursing practice within the context of the hospital’s market position using Foucault’s (1972) archaeology to frame how the programmatic aims of the government of private health and the hospital articulate working time flexibility within various technologies such as ‘whiteboards and beds’ (Heartfield 2005) to (re)organise and (re)conceptualise nursing care.

The chapter begins by revisiting in some detail the hospital’s ‘Annual Review’ and ‘Enterprise Bargaining’ documents to illustrate how managerial rationalities of flexibility, along with excellence and quality, foreground these texts. How nurses go on to manage hospital-patient demand is explored through an analysis of textual
representations of nurses’ work, from a whiteboard to ward spaces. Although there may not be that much ‘new’ about work flexibility as an employment strategy in maintaining profitability in an increasingly competitive and global economy (Coyle, 2005), mapping the arena of time at work illustrates how discourses of flexibility play out in ‘modelling the space of government’ (Rose, 1999b, p. 37) in the business of private health.

**Designing care or defining the business**

Following Foucault (1972), an analysis to re-conceptualise nursing care considers:

The various rhetorical *schemata* according to which groups of statements may be *combined*, (how descriptions, deductions, definitions, whose succession characterizes the architecture of a text, are linked together).

(Foucault, 1972, p. 57)

In thinking about the ‘rhetorical schemata’ (Foucault, 1972, p. 57) of private healthcare, it is useful to return to, and define, what a private hospital is. The Australian Institute of Health and Welfare (AIHW), Australia’s national agency for health and welfare statistics and information, defines a private hospital as:

A privately owned and operated institution, catering for patients who are treated by a doctor of their own choice. Patients are charged fees for accommodation and other services provided by the hospital and relevant medical and allied health practitioners. The term includes private free-standing day hospital facilities. (AIHW, 2010a, p. 518)

Hence, what constitutes a private hospital is that it is privately owned and managed, charges for services rendered (inclusive of nursing), and offers patients their choice of doctor. Nurses’ invisibility is promoted by the incorporation of nursing within ‘accommodation and other services’, as argued in Chapter 4. The difficulty for
organisations is in defining, and therefore costing, just what the nursing component of care is, by default reducing the measurement of nurses’ work to their working time or ‘nursing hours’. The architecture of Australia’s healthcare system, and private health funding in particular, is such that nurses’ invisibility leads them to describe their work within discourses of business management and the ‘reality’ of private health and the market in which this hospital operates. In this instance, the market is about the hospital competing with other healthcare organisations, both public and private, in relation to the services it provides within a particular geographical location, doctors and the infrastructure that allow them to treat their patients, health insurers, and last but not least the patients. Nurses manage these market and/or business concerns daily in their work. They refer to, and use, management concepts such as quality in creating and promoting the culture of ‘excellence’ that defines this hospital. It is reflected in the organisation’s Vision, Mission and Values Statements, as discussed in Chapter 4, and illustrated in the following excerpt from the Mission Statement:

Our vision … achieving excellent outcomes, [hospital] will be the **first choice** private hospitals for residents of …
Our mission … [Hospital] provides **premier personalised** care.
Our values … the key values of respect for the individual, teamwork and quality are integral to [hospital] primary goal of achieving **sustainable excellence** in patient care and associated services. (emphasis in original)

Concepts of quality are also evident in nurses’ position descriptions, hospital marketing publications, and annual reports that frame nurses’ work, because the hospital competes with other healthcare organisations in the ‘business of caring’\(^{56}\). While ‘caring’ may be the hospital’s business, what underpins this concept is a need to create:

... a culture of business excellence to complement the hospital’s \(^{56}\)Hospital Annual Review, Hospital website
hallmark standard of clinical and service excellence\textsuperscript{57}

And

… it is the nature of the interaction between our key values, vision and mission that sets [this hospital] apart from its competitors\textsuperscript{58}.

It is the nurses’ ‘business’ within the organisation – an organisation defined by its hallmark standard of clinical and service excellence – that rhetorically frames how it ensures sustainable excellence in patient care and the preservation of our heritage\textsuperscript{59} in any one year. A reference to heritage in this statement alludes to more than the preservation of the heritage-listed building and gardens in which the hospital is located. It also refers to a need to preserve its prestige in the community it serves.

**Competing expectations**

Unsurprisingly, a discourse of competition or profitability through overcoming competition is present in the design of private hospital texts. In its 1999 report into the Australian private hospital industry, the Productivity Commission acknowledged the competitive market place of private health. Competition in this market is influenced by institutional arrangements, the nature of competition within the industry, and particularly the relationship between the hospital, doctors, and health funds. Private hospitals are in the business of providing services to patients, doctors generate much of that demand, and insurers pay most of the accounts on behalf of their contributors. It is these demands that place an onus on hospitals to provide an environment where doctors are willing to treat their patients and to supply their services at a price that is attractive to the health funds. It is this latter requirement that is increasingly important as hospitals

\textsuperscript{57} Hospital Annual Review, Hospital website

\textsuperscript{58} Hospital Annual Review, Hospital website

\textsuperscript{59} Hospital Annual Review, Hospital website
compete for contracts with funds (Productivity Commission, 1999).

These requirements remain pertinent over a decade later. While the hospital’s annual review publications speak of management concepts such as excellence and quality, they also refer to some of the other factors that impinge on service delivery. In one testing year for the hospital, indicated by poor financial results, the nurse workforce was implicated as a cause of this deficit. Unsustainable Agreements$^{60}$ with certain Health Funds and difficulties in the effective management of the nursing workforce were put forward as reasons for a loss in hospital revenue. Although the hospital activity level that year was on par with those of previous years, the problem has been exacerbated by insufficient flexibility of the nursing work force$^{61}$. The inference is that a connection exists between the health funds and the purported ineffectiveness of management of the nursing workforce, which undermines the sustainability of ‘business excellence’.

Understandably, nurses reading the ‘Annual Review’ took umbrage with this remark, leading to the hospital’s Chief Executive Officer writing an open letter of apology to all the nursing staff, explaining that the insufficient flexibility remark related directly to the fixed component of labour costs, the greatest of which relates to nursing, and that for a period of time this was unsustainable when matched against low patient occupancy$^{62}$. This letter was pinned up on each ward’s Nurses Station, located in a prominent position for all hospital and visiting medical and allied health personnel to read. While private hospitals have contractual arrangements with insurers and medical practitioners, which are fundamental to their viability (Munn, 2005), the nurses they employ are also fundamental and, at the risk of stating the obvious, as one participant commented

$^{60}$ As these Agreements are commercial-in-confidence one cannot presume anything about what these could be.

$^{61}$ Hospital Annual Report: Hospital website

$^{62}$Chief Executive Officer: open letter to all members of the hospital nursing staff.
previously, “It’s a hospital for heaven’s sake, what else do you expect to have here but nurses?”

One could argue that hospital administrators construe nurses’ ‘flexibility’, or more precisely their inflexibility, as problematic in statements issued in the context of competition, the private hospital market, and how efficiently these hospitals perform in delivering service quality to ensure their financial viability. Organisational flexibility is a feature of much of the workforce literature, with the requirement for a flexible workforce central to modern economies (Beynon et al., 2002; Burchell, Ladipo, & Wilkinson, 2002; MacEachen, Plozer, & Clarke, 2008). The literature refers to functional or internal flexibility – the ability of employers to redeploy workers from one task to another – such as personal service assistants doing the work of nurses (Spilsbury & Meyers, 2005), multi-tasking, multi-skilling, and/or up-skilling (Hudson, 2002). It also refers to numerical or internal flexibility where an organisation can adjust the size of its workforce (or number of hours worked) in response to fluctuations in demand by the use of temporary, casual, and short-term staff, and/or adjust the hours of people already employed by extending and/or reducing their working time, such as overtime or part-time – strategies making for a ‘flexible firm’ (Atkinson, 1984).

The management of numerical flexibility is a focus in much of the nursing workforce literature. Flexibility is attained through practices where nurses’ working time is adjusted by asking or requiring permanent/regular full-time and part-time nurses to work overtime and/or take time off (Duffield et al., 2007; Norrish & Rundall, 2001; Weinberg, 2003), limiting the duration of employment through the increased use of

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63 Linda RN, Interview transcript: 15
casual and agency staff (Allan, 1998a; De Ruyter, 2004; Fitzgerald, McMillan, & Maguire, 2007) and calling in nurses on their days off or on-call (Bard & Purnomo, 2005).

At the time of data collection, provisions of the federal Workplace Relations Act 1996 (Cth) legislated industrially for numerical flexibility, which is now covered by the Fair Work Act 2009 (Cth). In the same way that the Workplace Relations Act 1996 (Cth) made statements about workplace flexibility, this discourse is also evident in the more recent legislation, for example the object of the Fair Work Act 2009 (Cth, p. 4) is:

a) providing workplace relations laws that are fair to working Australians, are flexible for businesses, promote productivity and economic growth for Australia’s future economic prosperity and take into account Australia’s international labour obligations; and ...
(d) assisting employees to balance their work and family responsibilities by providing for flexible working arrangements.

The National Employment Standards (NES) contained within the Fair Work Act 2009 (Cth) underpin what can be included in modern awards and enterprise agreements. The minimum standards identified within this Act deal with matters of working time such as: maximum weekly hours and working ‘unreasonable hours’, also known as overtime; flexible working arrangements; parental leave; annual leave; personal/carer’s leave and compassionate leave; and community service leave, for example, jury service, long service leave, and public holidays. A reading of the above Act is illustrative of neo-liberal understandings of the nature of the workforce, with flexibility in business

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64 Modern awards are industry or occupation-based enforceable minimum employment standards which apply in addition to the National Employment Standards. These awards were created to establish one set of minimum conditions for employers and employees across Australia who work in the same industries and occupations and replace a large number of federal and state-based awards (FWA, 2011a).
and in work-life important “for Australia’s future economic prosperity” (Fair Work Act 2009, Cth, p. 4). Rose (1999b, p. 198) writes that:

... so many political decisions affecting our lives entail the deployment of numbers in their calculation and legitimation. Numbers, like other ‘inscription devices’, actually constitute the domains they appear to represent; they render them representable in a docile form – a form amenable to the application of calculation and deliberation. … the domain of politics is made up numerically.

The reality of people’s working lives becomes thinkable and calculable (Rose, 1996) with flexibility enshrined in legislation and represented as time. In being made thinkable, flexibility, as described in literature and legislation, emphasises the positive elements of this concept – it is ‘family friendly’ (Coyle, 2005) – or the choices in the infamous ‘Work Choices’\(^{65}\) legislation of the Howard Liberal-Coalition Government through:

(a) encouraging the pursuit of high employment, improved living standards, low inflation and international competitiveness through higher productivity and a flexible and fair labour market; and...
(l) assisting employees to balance their work and family responsibilities effectively through the development of mutually beneficial work practices with employers. (p. 3)

The rhetoric of choice, the promotion of flexibility as ‘family friendly’, and the idea that some form of ‘work-life balance’ can be achieved through flexible working is reflected in hospital practices where:

... some people start at 8.30 in the morning because they’re taking children to

\(^{65}\) Workplace Relations Amendment (Work Choices) Act 2005 (Cth) legislation came into effect in March 2006 and made changes to industrial relations and employment conditions. The Act rewrote the Workplace Relations Act 1996 (Cth). This Act sought to individualise employment relations and to limit the influence of trade unions and industrial tribunals.
school and that is the beauty of this hospital and that’s probably what I will like when I have kids, that it is adjustable to routines. (Angela RN, Interview transcript, p. 27)

However, working time flexibility in practice comes at a cost in terms of work-life balance:

... I got a lot of half shifts and that was really off putting. Like half night duty shifts, they only really want you for half a shift from 10:15[pm] to 2:15 [am] and that was a real, that was a real bummer, going home at that hour. Because you know, if you broke down or anything. (Joan RN, Interview transcript, p. 2)

Employment in private health may be attractive for nurses in terms of ‘choice’ in so far as:

… my whole concept of working here is because it is supremely convenient to my life, to my family and to where my children are at school. (Mary RN, Interview transcript, p. 8)

However, work-life balance is somewhat unachievable where, in an effort to maintain the budget, nurses experience work intensification through “unachievable workloads” that leave them exhausted, as Sandra tells:

I suppose nursing for 20 years, you know, you feel reasonably confident in your ability, and time management. I think most of the girls here are very good time managers, but you always get the impression that you’re not quite up to scratch and that somehow it’s really you, this is not working, and when you go home, and it’s funny, I asked a lot of the girls, what time did you go to bed last night? A lot of them are saying 8–8.30 [pm]. To me this is, and I was floored, why do we have to work to the point that we have no life afterwards, we’re just so exhausted. A lot of the girls even go home and have an afternoon sleep. To me that’s a sign of not an achievable workload. Because you are absolutely exhausted to have a life afterwards. (Sandra RN, Interview transcript, p. 7)
Any notion of ‘flexibility’ being family friendly and/or that any semblance of work-life balance can be achieved through flexible working is called into question in Sandra’s comments, which highlight some of the tensions with these practices where, at the end of the day, Sandra and her colleagues are “absolutely exhausted to have a life afterwards”. Employers’ flexible working strategies, alongside competitive pressures, intensify the pressures of work rather than diminish them (Green, 2006).

Managing hospital–patient demand: the whiteboard

Nurses’ flexibility in managing their working time (workload) is represented throughout organisational texts, such as the previously discussed executive forums, minutes of meetings, and rostering formats. Another textual space is the whiteboard. This location provides a visual and visible representation of the management of nurses’ work by drawing attention to hospital occupancy rates. The next extract from my fieldnotes, focusing on the whiteboard comes from an episode where I followed one of the Night Duty Coordinators. We are listening to the end-of-shift report. Rosemary, who has worked the night shift, is handing over the hospital to Anita, one of the Nurse Unit Managers who will be responsible for the hospital’s operational aspects that day:

*In the Admission Office, while Rosemary [Night Duty Coordinator] hands over the hospital to Anita I note that the whiteboard above my head is filled with calculations and numbers of what the hospital’s occupancy level has been. This is a new thing. The board carries the retrospective summary of the fortnight work, more particularly occupancy and numbers are up there for all to see at glance. ‘All’, here are the Admissions Officer, Clinical Managers/AHC and Executive. While I suspect some of these numbers are meaningless to the majority of the nursing staff that enter, or walk past the office, the board does provide a visual summation of the month’s/fortnight’s numbers …*
The whiteboard is highly visible, located just in from the sliding door that accesses the Admission Office. Stuck on the board is a small yellow post-it note also with some numbers on it. The top of the whiteboard, a sign/slip that ‘indicates the week that we are in’ for example, this week is Week A. Weeks B, C, and D slips are held on the small ledge at the bottom of the board next to the eraser 66.

<table>
<thead>
<tr>
<th>Targeted Occupancy</th>
<th>Actual O/N</th>
<th>Target</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month 1 81%</td>
<td>83</td>
<td>107</td>
<td></td>
</tr>
<tr>
<td>Month 2 77%</td>
<td>107</td>
<td>93 Births</td>
<td></td>
</tr>
</tbody>
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**Abbreviations:** OBS Occupied beds; O/N over night; D. Occ Daily occupancy; MN midnight; YTM Year to Month.

![Figure 6.1 The whiteboard](image)

Half heartedly listening to handover – my attention has now turned to the whiteboard – the Nurse Unit Manager–Maternity steps into the room, picks up the whiteboard eraser and adjusts the number of births from 93 to 94, even though the patient in Labour Ward has not yet delivered. The patient will have by the end of the morning. This manager is obviously getting ahead with managing her area. Apparently this visual representation of the hospital’s inpatient numbers, “helps

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66 Abbreviations: OBS Occupied beds; O/N over night; D. Occ Daily occupancy; MN midnight; YTM Year to Month.
with terms of overflowing upstairs”, that is, managing midwifery overflow to Ward A.

I take the ‘numbers’ down, hand-writing the content of the whiteboard in my notes. Again in order to de-identify the data, I have represented what was written on the board, written in italics, and have attempted to give an indication of the spacing, headings used, abbreviations and format of what is written as copied in notes.

All these calculations are impressive ... I ask Anita to clarify the sums for me. (Fieldnotes # 30, pp. 17–18)

Numbers hold unmistakable political power within technologies of government, mapping as they do the boundaries and characteristics of the spaces of population, economy, and society (Rose, 1999b). Here the whiteboard serves as a technology of government, mapping the work of the hospital and its nurses through numerical representations of its patient population in terms of its ‘occupancy’.

(Re)calibrating care

The invisibility of nurses’ work lies not only with it being ‘counted’ with the patient’s accommodation, that is ‘the room’, but also with the way that nursing hours are calculated. The administration of bed occupancy lay predominantly with the Admissions Officer who was also a nurse, the Nurse Unit Managers, After-Hours Coordinators and, to a degree, nurses on the ward. There remained a strong reliance on paper-based texts, such as the ward’s Daily Bed Allocation sheet to determine patient room allocation, despite the hospital using computer software packages to administer beds. Information was also provided in a number of template forms held in the After-Hours Coordinator folders and the ‘After-Hours Coordinator Management Report’.
Patient occupancy numbers were a concern to nurses on the wards and served to enrol nurses across all levels of the organisation into taking responsibility for some of the hospital’s financial and/or non-financial performance.

Understandably, ‘numbers’ would occupy the minds of hospital administrators because occupancy is fundamental to business, with nurses working on the wards well aware of this. They understand that administrators are:

... trying to get more doctors in. ... they’re trying to maybe canvass that more so they can actually umm have more bodies in beds basically. (Angela RN, Interview transcript, p. 4)

… if the bed’s empty fill it, we’ll worry about the staffing later. (Sandra RN, Interview transcript, p. 10)

Nurses’ concern with the hospital’s financial viability is again reflective of doctors’ central role in private health. It has already been identified in this thesis that doctors are the hospital’s main customers/clients and are pivotal to its viability. Only doctors can admit and discharge patients, and private hospitals work to secure doctors’ business/patronage to generate an income from their patients. Allan (1998a) notes that a single doctor can provide a hospital with tens of thousands of dollars of income a month and, in 90 percent of cases, it is doctors rather than patients who will nominate the hospital for a patient’s admission because doctors choose to operate from a small number of hospitals, often all within a defined geographical location. Allan (1998a) also comments that some of the business of private health is as much about “matching doctors to hospitals [as it is to] … matching patients to hospitals” (Allan, 1998a, p. 67). One could argue that this situation remains to this day. However, from the outset of my data collecting, what dominated in determining what patients, as customers of private
healthcare preferred (and their doctors for that matter), lay with the hospital facilities or, to put it another way, the characteristics of the physical environment or ‘servicescape’ (Bitner, 1992). This was an argument borne out by the Nurse Unit Manager Maternity who commented:

... *there has been a change in private health, where once patients would choose their doctor, now patients choose their hospital and from there select a doctor/obstetrician that goes there.* (Liz Nurse Unit Manager, Fieldnotes#3, p. 5)

It is with this view of patients choos[ing] their hospital that the hospital markets to the public, as shown in some very polished organisational texts. In one hospital informational brochure, for example, the question is asked: *If you have to go to hospital, which hospital would you have to go to?* The title page invites potential clients to consider the hospital as the one that they would go to. The brochure goes on to promote the hospital’s facilities and services. The operating theatre suites are equipped to meet the exacting standards of one Australian capital city’s leading surgeons and anaesthetists, and in the area of women’s health, obstetrics is heavily advertised as one of the hospital’s key services. A separate brochure for the Maternity Unit not only reinforces this notion of quality in care delivery in the tradition of delivering excellence, it also contains an A4 loose leaf insert entitled *Obstetricians who Deliver at [Hospital].* The brochure does not list all visiting obstetricians, but lists the names of the hospital’s Top-Providers.

The Maternity Unit was not one of the study sites, however Maternity services impacted

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67 Hospital Information Brochure, p. 2.  
68 Hospital Information Brochure, Title page.  
69 Hospital Information Brochure, p. 4.  
70 Hospital Maternity Unit Information Brochure, p. 1.
on Ward A because this ward accommodated Maternity overflow\textsuperscript{71}. Fieldnotes and interviews reflected just how much the Maternity Unit affected the organisation of this ward. During the course of fieldwork, one end of the ward was refurbished to replicate the Maternity Unit rooms that had been extensively upgraded and redecorated as part of the hospital’s redevelopment the previous year. Ward A refurbishment included gutting a patient bathroom to turn it into a nursery, installation of a door to demarcate this area from the rest of the ward, redecoration, and upgrading each room and its facilities. The attention to detail extended to the colour of the bed linen, where now we have mid[wifery] sheets, caramel coloured sheets for the mid[wifery] end of the ward\textsuperscript{72}.

At the time of the study, Nurse Unit Managers spoke of nurses’ concerns with maternity patients coming upstairs\textsuperscript{73}. There was a concern that patients will complain if the décor is not comparable at least to that of the Maternity Unit\textsuperscript{74} and an assumption that “patients won’t like not being upstairs\textsuperscript{75} as opposed to being located in the Maternity Unit. Consequently, these patients will not be cared for properly\textsuperscript{76}. This latter concern was unfounded because all Maternity patients that overflowed to Ward A were assigned a midwife to care for them, although this was not necessarily a midwife redeployed from the Maternity Unit to the ward. It was most often a registered nurse with midwifery qualifications working on the wards. Depending on the number of Maternity patients in the ward at any time, this nurse may also be caring for a number of ward patients. While patients might see it differently, one Nurse Unit Manager observed:

\begin{quote}
These patients are probably the best cared for in terms of nurse-to-patient ratios in the hospital, but for them [patients] this is not the issue, the room, how the
\end{quote}

\textsuperscript{71} Fieldnotes #3, p. 5.
\textsuperscript{72} Alice RN, Fieldnotes #31, p.8.
\textsuperscript{73} Anita Nurse Unit Manager, Fieldnotes #3, p. 5
\textsuperscript{74} Anita Nurse Unit Manager, Fieldnotes #3, p. 5
\textsuperscript{75} Fieldnotes #3, p. 5
\textsuperscript{76} Fieldnotes #3, p.5
Regardless of this statement, what matters in the end to the financial viability of the hospital is patient occupancy rates and hence the work done to achieve this.

**Occupancy and staffing**

Occupancy is important because it determines the base/minimum nurse staffing for the hospital, unit, ward, and all nurses. Doris explains that:

… we work on a ratio of 1 to 6 and then it’s also trying to get the staff mix to suit the wards so …it’s a matter of trying to have no more than 2 ENs on [Ward A] … ward because of its size so that means that you have one RN working with an EN and …over in the ... wing it’s a matter of trying to have only one EN to 2 RN’s over there um getting staff and getting that mix is not easy because uh the way in which our FTEs are worked out is on a ¾ occupancy of the wards so therefore if you’re full you’re always short before you even start the shift. (Doris CN, Interview transcript, p. 9)

In the above excerpt, the number of nurses needed stems from a base of “¾ occupancy of the wards” and working with a nurse-to-patient “ratio of 1 to 6”. What is also important about occupancy is the number of patients in the hospital, unit, or ward at midnight, which impacts the calculation of the ‘nursing hours’ and thus makes a difference as to whether wards meet their budget or not. This was expressed to me by Marcello, a Nurse Unit Manager, as he prospectively calculated one ward’s nursing hours:

... *what happens during “the business day” is not taken into account by the midnight census.* (Marcello Nurse Unit Manager, Fieldnotes #11, p. 8)
Although nurses may conceptualise their workload or staffing levels as a nurse-to-patient ratio of ‘1 to 6’, for example, the implication is that a single nurse will care for six patients at any given time. However, this is not the case. In my fieldnotes and interviews, nurses tell how they are:

… given 6 or 7 patients and 1 or 2 would be going home ... and then that you are expected to clean those beds and have them ready because if there’s any admissions then they automatically come to you as well cause you’re the one with the empty beds so some shifts you could start with …6 or 7 and you could lose 2 or 3 and then you could gain 2 so yeah, yeah it just depends. Usually though the average is around 6/7 possibly 8 patients. (Yvonne RN, Interview transcript, p. 14)

Emma reflects:

... certainly there are days when, if you looked back over it, you’d actually been caring for 9 patients during the shift, rather than the 6 that you thought you were caring for, because you’ve had admissions as well. ...it’s just one of those things. (Emma RN Interview transcript, p. 41)

These statements are indicative of what Duffield, Diers, Aisbett, and Roche (2009) call ‘patient churn’. Duffield et al. (2009) point out that analysis of a patient’s length of stay does not take account of where the minutes or hours of care occur on wards. Nor do they account for how many wards or rooms a patient might “touch” during their stay in hospital, for example ward transfers to accommodate patients’ conditions or requests, illustrating how “churn increases requirements for nursing but is rarely part of staffing formulae” (Duffield et al., 2009, p. 187). It is an “absence of ward level metrics” (Duffield et al., 2009, p. 191) that compromises the ability of Nursing Unit Managers and the Nurse Executive to describe and justify what nurses do. While Duffield et al. (2009) are undoubtedly highlighting the problems they have with the calculation of
nursing working time, these statements exemplify governmentality at work, where the “knowledges of human conduct are to be transferred to the calculative regimes of accounting and financial management” (Rose, 1996, p. 54), making churn no longer “one of those things”, to quote Emma.

The hospital experienced significant variation in occupancy rates, which may be attributable to any number of factors. The hospital’s ‘Annual Review’, and my fieldnotes and interviews make reference to how international and national medical conferences and school holidays impinged on the hospital’s revenue. Decrease in demand for hospital services because of medical conferences and/or school holidays resulted in patients and their doctors preferring to avoid elective hospitalisation. This in turn impacted on business and reflected the fragility of relating nursing hours to occupancy levels. As such, nurses were well aware that they would “at some stage have to make them back”. As Linda explains:

... there was one stage again, not that long ago, where there was an enormous conference on overseas ... we had doctors and anaesthetists away and our numbers dropped right off and it was dropped off at the end of school holidays or Easter or some other break as well. And so, we had an extended period of time of low occupancy rates. ... Then of course, you have to make that [nursing hours] back somewhere along the line. So, it’s not like it’s in excess, and we try and rein it back in. It’s like, well you have to try harder. So you then do without [staff].

(Linda RN, Interview transcript, p. 16)

And as Doris pragmatically puts it:

…we’ll make the numbers [nursing hours] up somewhere else”. (Doris CN, Interview transcript, p. 20)
While medical conferences, school holidays, and long weekends are put forward as explanations for why occupancy rates may be down, another explanation is:

... because a lot of the time, surgery’s during the week so then people go home on the weekend and it’s, ... you know, that decreases your number in the viability of the profit of ... actually the hospital I suppose, staying open or keeping wards open. (Angela RN, Interview transcript, p. 4)

Occupancy rates, daily, weekly, monthly, yearly, and even hourly are up for discussion and analysis at any given time by nurses and administrators. While hospitals may have a good understanding of historical patterns in occupancy rates, for example where there are seasonal dips such as increases in medical admissions or the above mentioned medical conferences, weekends, and school holiday times, there remains uncertainty in predicting and managing the level of demand despite the best efforts to do so. The imprecision in predicting patient occupancy, and therefore nurse staffing, impacts on the intensification of nurses’ work. Lily, a Level 1 registered nurse, who had returned to nursing after doing a re-entry course, expresses her frustration:

... they [management] decided in their infinite wisdom that we weren’t going to be busy in July, but a lot of people got sick, we had a lot of respiratory patients. Ok, the surgery was less, but the respiratory patients were heaps more, and they’re multiple IV antibiotics and what have you, and a lot of the staff got sick. And so we were really short staffed in July when we were meant to be quiet. You know, and they did that a few times, decided we’d be quiet on some such strange evidence, and always in retro[spect], well, same as January, that was going to be quiet. But then, they put everybody they possibly could on holidays and closed [Ward B]. And I ended up having to stay on until 3.30 [am] one night. We had no staff. It was just, and, so this trying to predict how busy you’re going to be, I think was a major factor in the staffing levels. (Lily RN, Interview transcript, p. 3)

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77 Australian winter
78 Australian summer
In Lily’s opinion, nurses’ ‘busyness’ was predicated on some “strange evidence” rather than on any sophisticated notions and/or methods of analysis and/or calculation. It was always calculated retrospectively. The hospital considered the periods when surgeons were away due to summer or winter holidays as a quiet time for business, however these periods did not translate as quiet for the nurses who were working. Nurses felt they were left ‘short staffed’ because the staffing was adjusted according to the surgeons’ presence or absence, making their time at work not ‘quiet’

**Places and spaces**

Given that healthcare organisations are ‘places of visibility’ (Foucault, 1977), an analysis of the geography of the ward and rooms was undertaken – its physical environment. I wanted to explore the contribution spatial arrangements made to how ‘nursing hours’ were operationalised to enable nurses to deliver ‘excellent care’. In my fieldnotes and interviews I describe in fine detail the location and number of rooms of each ward in relation to other ‘rooms’ or areas such as the pan-rooms, treatment rooms, hand-over room, and Nurses Station. The state of the patients’ ‘rooms’ – whether they were being prepared, tidied, cleaned, shifted, allocated, and re-allocated – and those of the nurses, particularly that of the Nurses’ Station and the ward corridor from where much of the observational data collecting occurred, feature heavily in fieldnotes as I followed nurses organising their work. In this case, it was clear that the hospital architecture impacted on the business of care delivery. Nurses spoke of the many structural changes to the hospital’s geography, where buildings are located and re-located, and to changes to the wards themselves:

> Geographically physically I don’t think there’s one part of this place that’s the same you know I mean it’s been upgraded and it’s been modified and it’s been
improved and it’s been re-modified you know, so those sort of the geographical changes I really don’t think there’s one part of it that’s the same as when I first started here so it’s been very dynamic in that aspect. (Mary RN, Interview transcript, p. 2)

No matter the ‘hours’ worked, the wards impacted geographically on how nurses were allocated to, and cared for, their patients. It was pivotal to whether nurses may or may not have a ‘good’ or ‘bad’ day or night. How nurse-to-patient allocations were sorted out essentially came down to ‘distance’. The geography of one of the wards was “terrible … it’s a long way between any two points”79, and having single rooms further compounded this:

… the problem with nursing at [hospital], because of the way that the organisation, that the ward is structured, long isolated rooms, single rooms. It is very isolated in its nursing. (Anita Nurse Unit Manager, Interview transcript, p. 17)

In private … the other downside is single rooms … I much prefer the bays but patients don’t like bays in private hospitals. (Joan RN, Interview transcript, p. 27)

One nurse, Angela, echoed this view and questioned whether a computerised patient classification or costing system such as Excelcare would even ‘work’ in this hospital:

I don’t know whether Excelcare that’s the only system I’ve worked with in the public sector. I don’t know if that would work here or not, with the, looking at the acuity of patients and how many hours you actually spend because of the type of hospital, being private, the fact that you have to walk in and out of rooms … (Angela RN, Interview transcript, p. 11)

Ward geography was taken into consideration when sorting out nurse-to-patient allocations. Anita, one of the Nurse Unit Managers, describes how allocations were

79 Joan RN Interview transcript, p. 4.
essentially determined by the location of the pan/sluice and treatment rooms:

Basically the way that the ward is spread out was, and where the pan rooms are situated, and where the treatment rooms were situated was how we sort of split the wards up. … it was a distance issue. (Anita Nurse Unit Manager, Interview transcript, p. 11)

… a lot of it is geographically determined … I try very hard to certainly make it geographically friendly for people so that they’ve got a good combination [of patients]. (Mary RN, Interview transcript, p. 22)

I thought that they just allocate on geography, and numbers. And I don’t think that they ever took into account the dependency of the patients. (Lily RN, Interview transcript, p. 8)

The above extracts from interview transcripts identify how ward geography determines care where the “physical workplace matters” (Parish, Berry, & Lam, 2008, p. 232) to how nurses go about delivering ‘quality’ care.

In Foucault’s (1972) ‘fields’ for analysis, the “field of presence” (Foucault, 1972, p. 57) is where an analysis outlines “statements formulated elsewhere and taken up in a discourse, acknowledged to be truthful” (Foucault, 1972, p. 57). Thus, determining what counts as ‘true’ requires looking to “what is criticised, discussed and judged” (Foucault, 1972, p.57), and what is rejected or excluded; what permits certain statements and not others to be made. What is permitted may be of the order of acceptance justified by tradition (Foucault, 1972) or, in the words of the Nurse Unit Manager, a certain “mindset”. Anita, Nurse Unit Manager of Ward A, explains some of the dilemmas she experiences with managing the budgeted “labour hours” in light of the geographical location of the Critical Care Unit [CCU] and Ward A, particularly when the patient
occupancy in CCU is low and where the one or two patients admitted to the unit are not necessarily ‘critical’. Anita believes CCU nurses could step out of the unit to care for some general ward patients if need be, however these nurses are resistant to doing so. The consequence of nurses remaining in the unit despite the low occupancy pushes the general ward nursing staff “harder” to “compensate for the hour” in CCU:

... always an issue in terms of acuity, when you had 2 patients in there [CCU] who weren’t airway managers\(^{80}\), they [nurses] could actually come out. But try to convince HTU staff that you can actually come out and care for general patients was also problematic. So that was another mindset. When you had an arterial line in there … or if you had an airway, I mean the safety was always the priority there so you ran one to one. But you knew that your hours was always going to be over. So, how I tried to compensate that was actually then, push harder, push the ward staff harder, knowing to compensate the hour in there [CCU], … in terms of, because that’s the way that they had always operated … the acuity of the patient in that particular workload was considered but not necessarily a priority. Because it was a more, it was about, do I hear the complaint about, well look how far I have to walk or deal with it? And the way we tried to deal with it was then how we allocated the beds at the beginning. (Anita Nurse Unit Manager, Interview transcript, p. 12)

In staffing CCU, while the issue ultimately lies with the ‘nursing hours’, as this manager points out, some of the issues with staffing the unit are as much about dealing with “the complaint … about, well look how far I have to walk”. It appears that the issue with nurse-to-patient allocation is with the geography of the unit and has little to do with patient acuity. Norrish and Rundall (2001) also noted this issue in their review of patient classification systems literature, where, while these systems are purported to be useful in determining nurse staffing requirements at a macro unit level, they have little to no effect in determining nurse staffing assignments. Patient care assignment is

\(^{80}\) Type of patient
based on the patient’s location in the ward.

Returning to Foucault (1972) to describe what nurses and their administrators criticise, discuss, and judge in regard to nurse staffing and how to best manage that within the context of this medical/surgical Unit, nurses discuss at length, and are often critical of, the nurse staffing configurations in the wards, particularly how staffing of the CCU impacts on their workload. The wards’ “spatial distribution” (Foucault, 1972, p. 56) constrains how nurses’ working time is organised; nurse-to-patient allocations are concerned with nurses’ workload, which is compounded further by a lack of recognition of the ‘intensity’ of their work. Mary reflects on how the CCU nurse staffing impacts on nurse staffing overall, particularly for nurses working on the ward:

… when you think about the intensity of it when you look at the 4 patients that you’ve got they’re beautifully located, all on monitors, all pretty much staying in bed or sitting next to the bed you know you think they and that’s something that they probably need to look at as well and that’s historical, that is historical in 1 to 6 you know, that means 3 patients regardless [of intensity] … so one equates to 2, the equation of 2, so historically they say ‘Yep you know they may have a 4\textsuperscript{th} patient in the unit that is not requiring anything and uh and yet they [CCU nurses] won’t take that patient on’ … interesting and we do have a situation where it’s very isolated in some situations down there … you need to look at that situation and think now you’ve only got 3 patients if none of them are requiring anything too, yeah sure there are some that you don’t get away from if they’ve got some sort of you know … you know that they’re needing fluids or whatever the situation is then there’s some that you are quite intense and don’t get away from it but there are many, many occasions when they may just be post-surgical and require a little bit more observation or they might have an art line\textsuperscript{81} or whatever, and I’m not denoting that but I was just thinking that’s not always the case, there can be a casemix in there yet one other person will have to look after one bed of

\textsuperscript{81} Art line abbreviated term for Arterial Line. This is a thin catheter inserted into an artery, often for real time monitoring of blood pressure and for taking arterial blood gases. The use of these lines is primarily confined to use within Critical Care Units.
that unit because you know that’s 4 patients.

Q: … so one person from the ward will take the other patient in CCU?

A: Mm and then have a patient load outside. Now there are times when that needs to happen because the 3 are intense, there’s one left over and geographically sometimes it works out very nicely. (Mary RN, Interview transcript, p. 37)

The play of a legal discourse weighs heavily in nurses’ staffing conversations, whether or not staffing works out geographically “nicely”. Nurses practice in accordance with legislation affecting nursing practice and healthcare (ANMC, 2006). It is incumbent on nurses to be aware of the legislation governing practice, for example adhering to the legal requirements of medications. In their actions, nurses need to demonstrate an awareness of legal implications of their practice, and identify and explain the effects of legislation on the care of individuals/groups and in the area of health (ANMC, 2006).

While some nurses did not have a problem with how nurse staffing was managed “as long as the patients were within hearing distance”⁸², particularly in regard to the CCU, these same nurses had qualms about the practice and the precariousness of their legal position. In the following excerpt from an interview transcript, Emma expresses her misgivings:

I didn’t have a problem, as long as the patients were within hearing distance of the unit. But if I have somebody in CCU that had had surgery on their head or neck, I prefer not to be out of viewing distance of the unit … legally, we were supposed to be in view of the patient at all times, somebody had to be there at all times … there’s nothing you can do, and particularly, I used to find that if you had somebody in there that had had jaw surgery and you had to be in the unit, I could be sitting up in CCU keeping an eye on this perfectly fit well patient, and everybody else is frantic. And there’s nothing I can do, because if I step out of the unit, and this person has respiratory difficulties, then I’m liable. So while it’s, I would also complain about having people you know, to look after too far away

⁸² Emma RN, Interview transcript, p. 14
from the unit, but yeah, if you’ve got somebody with head or jaw surgery you just can’t do that. As I say, it’s a legal requirement that they are in view. (Emma RN, Interview transcript, p. 15)

How nurses are placed in potentially risky situations as the nursing budget is stretched to manage the nursing hours in light of the physical layout of the wards and CCU is not lost on some nursing administrators:

The other concern that I know …is a very heavy factor for our CCU staff is that not infrequently they are expected to care for CCU patients as well as … ward patients by the very physical layout of the unit, … that’s not always easy … and I have great concerns that that actually … breaches the requirement for high dependency nursing because if high dependency nursing is 1 to 3 [one nurse to three patients] at about maximum … which most other high dependency units run, we very often have … and that’s a difficult statement to be making too because there are times we will only have one patient in CCU and if they have got an airway management problem, arterial lines etc, then that CCU nurse can only have one patient and that ratio is difficult in the opposite scenario that they’re carrying one patient while the rest of the staff are carrying a huge load. There’s nothing we can do about that because of the very nature of that high dependency patient and again the layout of the system. (Rosemary, After-Hours Coordinator, Interview transcript, p. 15)

Nurses on Ward B also spoke of how geography impacted on their workload. While there is no doubt that geography was a determining factor with nurse-to-patient allocations across and between units, and at a ward level, nurses did not assume that this was always the reason why some of the nurse-to-patient allocations were done the way they were:

People will say, ‘Gee they allocate patients and things and they’ll allocate them so that geographically it means they don’t have to walk as far’. And that will be their reasoning, and yet when you look they’ve got the ones that are quite independent
or minimally demanding, to find that you’re in fact the one that’s got the ones that are all, you know, far more complicated and so geographically it’s wonderful and I can understand that reasoning, but not at the expense of your work mate and their workload. (Linda RN, Interview transcript, p. 25)

It is in working through the different ‘fields’ identified by Foucault (1972) that centres ‘time’ at work, where:

... [s]tatements that concern quite different domains of objects, … and belong to quite different types of discourse, but which are active among the statements studied here, either because they serve as analogical confirmation, … or because they serve as models that can be transferred to other contents. (Foucault, 1972, p. 58)

Statements about allocations, occupancy, and flexibility are reflected in marketing concepts of ‘place’, and how the ‘servicescape’ impacts on nurses’ working time because the design of the facility or ‘the place’ is important for meeting the hospital’s business goals.

Conceptualising nurses’ work as ‘nursing’ hours lies in the “field of memory” (Foucault, 1972, p. 58), which considers those statements “that are no longer accepted or discussed” through which “relations of filiation, genesis, transformation, continuity and historical discontinuity can be established” (Foucault, 1972, p. 58).

As noted in previous chapters, the halcyon days of nurses having 4 patients are long gone; there are changes in care delivery and expectations. In Chapter 4, I established what constituted “excellent nursing care” for nurses in the past. It was through a focus

83 Emma RN, Fieldnotes #7, p. 2.
84 Emma RN, Fieldnotes #7, p. 2
85 Laura RN, Interview transcript, p. 2.
on the personal, intimate knowledge of care delivery and/or expectations of the organisation and its nurses, and where patients were “very grateful for any care and really appreciative of time”.

Outcomes potentially sensitive to nursing’ (Needleman et al., 2001, p. 6), in other words, ‘nursing sensitive outcomes’ and/or time involved in achieving those outcomes, are now “no longer discussed” (Foucault, 1972, p. 58). The International Council of Nurses defines a nursing sensitive patient outcome as changes in patient health status where nursing care has a direct influence (ICN, 2009). Nurses accept that “it is a business and is [not] you know for illness”, although the hospital is still regarded as having a “reputation of being a good hospital and good patient care; old fashioned proper care”. Yet, how that old-fashioned proper care was being delivered was being re-written as I observed and talked with the nursing staff. The ‘contemporary’ nursing care demanded by the nurse’s position description was being delivered via business and private health market discourses, as one registered nurse explained:

I think a lot of us are holding on to those … old standards you know where you do straighten their bed when they get out of it and … just do the little extra things … but it’s getting harder and harder to do that because of patient loads and … I would say, ‘Yeah I guess things are slowly slipping by … that we don’t do any more. … it’s harder now because we find time is short yet we still want to do all those things that we were made to believe were important you know, and I think it’s because of that the hospital gets the people saying you know the care is excellent because we try and do that. (Yvonne RN, Interview transcript, p. 27)

Anita explains nurses’ ‘thinking’:

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86 Sandra RN, Interview transcript, p.2.
87 Commonly used indicators of nursing sensitive outcomes include urinary tract infections, skin pressure ulcers, hospital acquired pneumonia, pulmonary embolism and deep vein thrombosis; sepsis and shock, complications of surgery such as wound infections, patient length of stay and ‘failure to rescue’ that is failure to respond to urgent conditions such as shock, cardiac arrest, which can potentially result in increased morbidity and/or mortality.
88 Sandra RN, Interview transcript, p. 3.
89 Lily RN, Interview transcript, p. 2.
… when it comes to having a lunch break, a meal break, their patients come first but it’s about them making sure that the I’s are dotted, everything’s crossed, that the patient’s sitting out of bed beautifully, that they’re perfect, the bed’s made before they go and have a cup of tea. And that’s the internal culture. … how to explain that elsewhere is different … [nurses in other hospitals] would have a coffee first before the bed’s made cause it’s 10 o’clock. Majority of them there [at the hospital] don’t think like that. (Anita Nurse Unit Manager, Interview transcript, p. 25)

In articulating their commitment to a certain level of care, despite persevering with something that is perceived as ‘old-fashioned’ but certainly marketable, nurses maintain a strong commitment to working at a hospital where the “core business is the provision of optimum quality patient care and services” (Hospital Policy Manual). Understanding the hospital’s core business resonates within nurses’ statements, which hold remnants of particular conceptualisations about nursing; what nursing is or should be, and what was, for many, what they went into nursing to do.

**Conclusion**

In this chapter, I have indicated how nurses’ working time is constituted as a problem for the hospital despite certain expectations of care. The rationality of business management is privileged not only in textual representations of the firm but also in representations of nurses’ work. I have argued here that the nurses’ work is re-conceptualised through economic and business management discourses, with choice of working time flexibility integral to how business is run to be successful. This chapter points to the “optimistic discourse of flexibility” (MacEachen et al., 2008, p. 1020) as a programme of government. Miller and Rose (1990, p. 11) remind us that whilst ‘governmentality’:
... is ‘optimistic’, government is ‘a congenitally failing operation. ... ‘Reality’ always escapes the theories that inform programmes and the ambitions that underpin them ... Technologies produce unexpected problems, are utilized for their own ends by those who are supposed to merely operate them, are hampered by underfunding, professional rivalries, and the impossibility of producing the technical conditions that could make them work – reliable statistics, efficient communication systems, clear lines of command, properly designed buildings, well framed regulations. (Miller & Rose 1990, pp. 10–11)

The hospital’s programmatic aims were translated into new ways of understanding care through a number of technologies and practices, whether whiteboards or patient allocations. The communication and information technologies on which I have focused in this chapter are not those of sophisticated information and communications technologies, as found in computer-mediated texts, but are more mundane technologies such as a ‘whiteboard’. This technology serves as well as any computerised strategy to communicate the state of the hospital’s occupancy rate.

Similarly, the ward design impacts on how nurse-to-patient allocations are thought about. Governmental and industry regulations, as well as individual nurses’ care ethos, frame nurse staffing practices. Yet these practices present difficulties for how staffing is done, given the spatial layout of the wards and budgeted nursing hours.

Nurses’ work is increasingly represented as time as nurses account, and are accountable to the hospital for, business outcomes. How the firm taps into and uses nursing care to enhance those outcomes is discussed in the following chapter, where time and care intersect.
CHAPTER 7

PRIVATE HEALTH: INTANGIBLE NURSING CARE?

In Chapter 6, I argued how nurses’ working time became a concept central to the organisation of nursing work when the economic and business discourses of private health dominated nurses’ talk. In this chapter, I take the analysis further to demonstrate how nurses appropriate business management discourses to speak about and practice the ‘excellent’ care for which the hospital is renowned; how nurses are enrolled in the interests of the business through “text based practices of accountability” (Rankin, 2003, p. 57). These texts exemplify the governmental rationalities in play to “make up” (Hacking, 1986) private healthcare. The political realities for/of the hospital are expressed in technologies such as the hospital’s ‘Annual Review’ and the ‘Organisational Chart’, and in calculations of nurses’ working time, which illustrate how nurses’ work is presented and represented.

In previous chapters, I have identified how management concepts of quality and excellence locate nurses within numerous discourses – clinical, business, and economic – and how intersections between these competing discourses set up a number of contradictory positions for nurses in providing such a thing as ‘excellent care’. These discourses are embedded within calculations of nurses’ working time – their ‘nursing hours’ – a strategy that hospital administrators use to measure and manage business. It is the tension between the clinical and economic that impacts on how nurses think about their work. Where nurses strive to provide a certain level of care to patients on the one hand, job insecurity and protecting their employment is also important for them on the other hand. Nurses’ resistance is also evident in this chapter when nurses use these same
business discourses for their own ends to define ‘excellent care’ while at the same time watching out for the business. Drawing upon the rules of formation of Foucault’s (1972) archaeology, this thesis has so far traced how these rules constitute particular “themes and theories” (Foucault, 1972, p. 64), which he calls “strategies” for discourse (Foucault, 1972). In this and the following chapter, I illustrate how the ‘problems’ with the cost of nurses for organisations has nurses choosing a ‘business’ discourse and, in doing so, (re)constituting ‘care’ in the interests of ‘the business’ or firm.

**Nurses as workers in a service industry**

Chapter 4 demonstrates the extent to which nursing discourses are dominated by ideas of excellence and provision of quality care within a set of discourses about health, productivity, and healthcare reform. In the following data extract, Emma identifies a number of points of incompatibility or contradictions (Foucault, 1972) for how nurses manage care in this setting. She observes:

... everything’s dollar driven and some people just can't see the benefits of giving good quality care. The thing is, if the care isn’t good quality, the patients won’t come back, and I think one of the big things of the hospital is their readmit, that patients will say I had my last operation at [hospital] can I go back there, because the staff are wonderful. And the letters that the nurses do get from some patients thanking them for the care that they’ve got, was beyond what the person expected to get. ... that’s something that we need to maintain is that people do ask to come back because of the nursing care and it is the nursing care that you know, that people are coming back for. ... it’s because, you know, they’ve enjoyed their stay. And if you can have somebody enjoy their stay when they’re sick, then they’re going to come back. And if they don’t want to come back, if you’ve got a lot of people out there saying, ‘Oh, I had my operation at [hospital] I’m not going back there’, then that will get around, and so you need to maintain that standard, ...
that’s something that took me there in the first place, and certainly kept me there … was the standard of care that we provided. (Emma RN, Interview transcript, p. 43)

Emma and her colleagues need ‘time’ to deliver that standard of care. In the above excerpt, Emma voices the contradictions that exist in nurses’ understandings of the business of private health. While she acknowledges and is resigned to the fact that “everything is dollar driven”, and is aware also that as a nurse she has little authority over how some of those dollars are spent, Emma maintains the belief that it is the quality of the nursing care delivered at the hospital that will distinguish this hospital from its competitors. After all, a requirement for nursing care is the main reason that patients are hospitalised and this constitutes nursing as one, if not the core, service for this and other hospitals. Nurses are engaged in all aspects of care, often alongside other health professionals, which makes it difficult to disentangle their specific contribution to an episode of care (Needleman, 2008), hence the naming efforts discussed in Chapter 2.

The “readmits” to which Emma refers are not about patients readmitted to the hospital as a result of complications post-discharge, such as hospital-acquired infections or deep vein thrombosis, but to those patients who time and time again choose to return and/or recommend this hospital to others for care. What Emma is talking about has to do with some serious brand loyalty; imagining the hospital as a ‘brand’ providing a “service experience” (Pine & Gilmore, 1999) to its customers, to use the words common to marketing and management.

Brand loyalty is a foundational corporate asset and an increase in customer loyalty is thought to increase profitability. Although customer loyalty is in, and of, itself no
guarantee of a company’s financial position, from a business perspective investing in
customer loyalty is assumed to build tradeable assets (Crosby & Johnson, 2004).
Indeed, as the hospital’s business plan puts this:

... premised on the Hospital being able to conduct its business as an
[independent] acute care facility, on the basis that it continues to have
sufficient brand and reputation to do so. (Annual Review # 4, p. 5)

Customer satisfaction depends on perceptions of what was delivered and how; the
customer’s expectation of the service and the company delivering it. Chase and Dasu
(2001) state that ultimately the only thing that matters is the customer’s perception of
what occurred.

As argued throughout this thesis, patients’ increasingly demanding expectations of the
private hospital experience result in nurses delivering care that goes beyond
expectations. According to Pine and Gilmore (1998; 1999), as services have
increasingly become commoditised, the economic value for companies lies at the level
of customer service experience. A company intentionally uses services [nursing] as the
stage and goods [facilities] as props to engage individual customers in a way that creates
a memorable event, such as that of care delivery in a hospital. In Pine and Gilmore’s
(1998, p. 98) words, commodities are “fungible, goods tangible, services intangible and
experiences memorable”. While business management literature uses notions of
tangibles and intangibles as key in differentiating businesses from one another, nurses
also draw upon an ideal standard of care; one that may be possible to meet within this
arena. Thus, in terms of recruitment of nurses to the organisation, it was the “standards”
of nursing care for which the hospital is known that brought Emma and many of her
colleagues to seek employment there, and in the end was, as Emma says, “what kept me
there”. Well may Emma refer to the standards of care as the “thing” that made the difference (Bowen & Ford, 2002) to keeping her at the hospital – the assumption being that companies need a ‘thing’ to differentiate them from one another –and it is what the hospital markets itself as to its customers, visiting external service providers, medical and allied health practitioners, employees, and patients. Some of these ‘things’ are found in nurses’ statements, in the hospital’s ‘Annual Review’, and hospital promotional material indicating what makes for a different hospital experience in private healthcare. This experience, according to Pine and Gilmore (1998), occurs through organisations engaging their customers in a personal, memorable way. What could be more personal and often memorable than nursing care and some of the things that nurses do to/for people when in hospital (Lawler, 1991)? Nevertheless, it is the focus on a ‘personal’ experience of care delivery that the hospital promotes amongst other things as key words in its organisational texts; the hospital’s ‘Mission Statement’, written into the preamble in a number of policy documents, nurses’ position statements, brochures, and in the ‘Annual Review’, for example:

… [hospital seeks to] achieve a high level of sensitivity to the needs of our clients. We [hospital] expect to achieve excellent clinical outcomes at all times whilst always providing premier, personalised care for all of our patients. (Annual Review #2, p. 3)

… reputation for personalised high quality care … [the hospital] continued to expand its services and has developed its patient care facilities to provide a level of comfort and privacy unequalled in [one Australian capital city]. (Annual Review #3, p. 3)

While the purpose of the ‘Annual Review’ is to report what the hospital has achieved over the past year and to indicate its goals and strategies for the future, there is no single
The review contains statements by the Chairman of the Board, Chief Executive, and those pertaining to the hospitals’ financial position. Scattered throughout these reports are statements, presented as quotes, attributed to various hospital personnel, including nurses. Although an organisation’s ‘Annual Review’ is not about any one department or service but about the enterprise as a whole, it is interesting that there is little that specifically discusses the work of nurses in “preserving the [hospital] difference which our patients, staff and visiting clinicians value highly and have come to expect”\(^9\). While the ‘Annual Review’ acknowledges the virtues of all of the hospital’s workforce, analysis of the data collected shows that reference to the nursing service presents more often than not as a cost to the organisation. The following extracts from annual reviews over a period of four years, for example, show that it is nursing, along with health insurance funding, which impacts/concerns the hospital’s financial viability:

Besides being busier, private hospitals also faced escalating costs related to nursing wages and [the hospital’s] professional indemnity insurance. (Annual Review #1, p. 4)

The maintenance of the 30% private health insurance rebate, the continuing difficulties in securing a reasonable reimbursement from all health funds and the seemingly ever present recruitment shortfalls for all categories of nurses sit clearly and consistently on our drawing board. (Annual Review #2, p. 13)

Much of the turnaround can be attributed to notable improvements in the levels of patient activity, particularly in the maternity area, structural improvements, the improved management of labour costs and better health fund negotiation outcomes. (Annual Review #3, p. 5)

\(^9\) Hospital Annual Review #2, p.12.
Nurses, along with other hospital personnel, are represented in some of the hospital’s organisational texts, as noted previously. Texts include the ‘Annual Review’, hospital promotional publications, and in-patient directories held in patients’ rooms. Nurses are pictured in their uniforms or dressed in operating theatre suite attire – scrubs – and are often depicted standing next to patients’ beds or chairs. In one year’s ‘Annual Review’, a nurse is photographed with a comforting hand on a patient’s shoulder, captioned with the statement ‘compassionate care’. This particular photograph, minus the caption, is also used in a number of the hospital’s promotional documents. In another year’s ‘Annual Review’, photographed in black and white, the Nursing Executive is holding a baby and informs the reader that “our mothers are delighted with the improvements in our neo-natal nursery”91. This particular full-length feature photograph followed a page that described the hospital’s Mission, Vision, and Values. In the same ‘Annual Review’, a nurse working in the hospital’s oncology unit is photographed gowned, gloved, unmasked, standing in front of a seated patient holding a ‘cold cap’92. The patient’s face is turned away from the camera and is looking up at the nurse. This photograph is also presented as a full-length feature page with a nurse stating that the hospital “offers more support than a large public hospital. There is great team work and a sense of pride in the hospital”93.

Whether the hospital does or does not offer more support for nurses than its public hospital counterparts is not the focus of this chapter. Similarly, the thesis is not about adequacy or inadequacy of the public or private healthcare system. What I am endeavouring to illustrate in this chapter is how particular organisational texts, such as

91 Hospital Annual Review #2, p. 4.
92 Cold cap is as the name suggests a cap worn by patients to reduce hair loss during chemotherapy treatment. It involves continuous application of a number of precisely cooled caps to the scalp before, during and for a period of time after intravenous chemotherapy.
93 Hospital Annual Review #2, p. 11.
the hospital’s ‘Annual Review’ and ‘Organisational Charts’, which I discuss later, participate in producing organisational life (Cooren, 2004). A business management discourse is manifested and perpetuated within these texts, serving to inscribe nurses’ working practices. Participants allude to the differences between the two sectors in the data collected, particularly in relation to differences in wages, casemix, and working conditions. One of the hospital coordinators describes the differences like this:

... well there has been a wage difference \(^{94}\) ... we’re hoping to attract more people ... but it is, it is repetitive type nursing that we have here there’s not a lot of challenge, there’s not a selection of whether you do surgical or medical because we’ve got combined, as most private hospitals have on their floors, they have a combination and ...and in the government hospitals some people prefer to look after surgical patients or they prefer to look after medical patients or respiratory or whatever it might be. ... I think a lot of them [nurses] have worked in the government sector so they decide to stay with the government sector and I think they’re probably better off in the long run, now looking at it, I think they probably won’t be because they have to do a certain amount of night duty in the government sector whether they like it or they don’t, they don’t have a choice of when they go on nights, they get put on the roster and told that they will do their set of nights then whereas we’re able to well hopefully look after them a lot better. (Iris, After-Hours Coordinator, Interview transcript, pp. 16–17)

In this example, the organisation of the Unit and/or wards has nurses caring for a “combination” of patients with “the floor” not limited to a particular medical or surgical speciality. Ward A accommodates the Critical Care Unit (CCU) and has provision to accommodate Maternity overflow. Nurses do not refer to patients as ‘outliers’ from other wards or Units in the context of this hospital because the wards are not organised along strict speciality lines. This, as well as the fact that there are no doctors on site and

\(^{94}\) As noted previously, historically nurses working in private health are paid less those working in the public sector.
a perceived lack of specialisation, sees the hospital demand a greater and broader set of
skills from its nursing workforce. As we have read in Chapter 5, a broader skill set is
reflected in a demand for a higher level of nursing expertise. Rose (1999b, p. 52) writes
that “technologies of government are those imbued with aspirations for shaping of
conduct in the hope of producing certain desired effects and averting certain undesired
events”.

The hospital’s ‘Annual Review’ is one such technology, interfacing with, and
representative of, the political realities of the organisation and the external environment
within which it operates. Two of the four annual reviews collected during the course of
fieldwork are published in a simple black and white colour scheme. One could perhaps
argue that the depiction of the hospital in simpler format is representative of the
challenges experienced by the organisation during that time and conveys a picture of the
seriousness/difficulties of the past year(s), so much so that the hospital was not
spending money on colourful, bright, glossy booklets. The cover of one of these two
publications has a serious-looking, mature operating theatre staff member, dressed in
scrubs, holding linen. This staff member may or may not be a nurse, and may represent
other operating theatre personnel such as those working in the Central Sterile Supply
Department. The cover for the following year’s review, although still printed in black
and white, depicts a young child playing on the hospital’s lawn. While the previous
year’s review was titled “caring for generations”, this review sees the hospital moving
forward and refocusing on “our future”.

The relationship between the perceived quality of care and the hospital’s continued
financial viability is emphasised in each year’s ‘Annual Review’ as the hospital seeks to
preserve its business edge while:
… remaining cognisant of our responsibility to ensure [the hospital’s] continued viability, we will energetically embrace whatever challenges come our way. Equally important is maintaining our independence which we believe is critical to preserving the [hospital] difference which our patients, staff and visiting clinicians value highly and have come to expect. (Annual Review #3, p. 12)

This statement encompasses many of the marketable points for private hospitals that are both tangible and intangible “things” such as ‘care’. The management literature defines tangibles as “something that can be seen, touched, held” (Bowen & Ford, 2002, p. 447) and intangibles as what “is perceived, sensed and experienced” (Bowen & Ford, 2002, p. 447), such as the care patients experience in private hospitals. While not using a vocabulary of tangibles and intangibles, this is what Emma commented on when she said, “If you can have somebody enjoy their stay when they’re sick, then they’re going to come back [to the hospital]” (see page 189).

Chase and Dasu (2001, p. 82) note that “last impressions not first impressions – endure” in service encounters. It is this sort of marketing thinking that nurses are talking about, as in Emma’s comments, and they work very hard to ensure that patients “enjoy their stay’, all the while ensuring that care occurs in a timely manner. That said, what an analysis shows is that there are divergent discourses present about what nursing is, for example in terms of their job descriptions. Clearly, the hospital relies on more traditional discourses of nursing as caring work, and what Gordon and Nelson (2006, p. 7) refer to as nurses’ “virtue script” to market the hospital. What is evidenced here is how discourses of caring and marketing converge in the behests of the business. It is these ‘things’ that are not captured in workload measurement methods, and patient and nursing classification systems. They are simply not factored in as part of nursing work.
This is the location where the contradictions for nursing exist; between the clinical care and business of private health. It is these discourses that enrol nurses into marketing the hospital and its services; nurses do this consciously, knowingly, and actively. Moreover, nurses are not passive dupes; they invest in the business, and there is a strong sense of ownership and pride in the organisation and indeed of the work that they do – a “sense of pride in the hospital”.

It’s a reflection of the commitment of the staff though, the staff here are very good, they’re very committed ... and they really want to see the hospital work well. (Doris CN, Interview transcript, p. 6)

… the relationship that the staff have with the doctors there is quite strong. … They really know the idio’s [idiosyncrasies] of all of them, which is a good thing in terms of caring. (Anita Nurse Unit Manager, Interview transcript, pp. 25–26)

Thus, despite the tension for nurses with what the organisation expects of them and with what they can actually deliver, and although they struggle to work at this hospital at times, nurses choose to do so.

In previous chapters, I have argued how the discourse of business management becomes central to nurses’ talk and governs practice. To exemplify discourses and their operations, one goes on to “describe the specific authorities that guided one’s choice” (Foucault 1972, p. 66). There is no doubt that the authority inherent within legislation, insurers, medical and allied health practitioners, and patients – as customers – determines the many business decisions and/or choices hospital administrators make in relation to nurses’ work.

Registered Nurse, Annual Review #3, p. 11.
As I have argued throughout this thesis, nursing is answerable to the organisation’s business concerns – it is a clear expectation of this location. It is an expectation that is present within all nurses’ position descriptions and in statements pertaining to the hospital’s risk management. Simply because of nurses’ sheer numbers, nursing impacts on hospital finances and consequently the hospital’s business, including its viability, becomes that of nursing. On one level, the authority of hospital administrators will determine what business choices are made, for example determining the budget. However, on another level, it is nurses themselves, individually and as a group, who privilege these choices as they manage care.

The following section considers the ways in which organisational documents operate as a “strategy of regulation” (Rose, 1996, p. 37) that links “political” rationalities with “apparatuses that shape and manage individual and collective conduct in relation to norms and objectives but yet are constituted as “non-political” (Rose, 1996, p. 38). Texts, such as the hospital’s ‘Organisational Chart’, shape nurses’ practices by governing through the:

... regulated and accountable choices of autonomous agents – ... consumers ... employees, managers, investors – and to govern through intensifying and acting about their allegiance to particular “communities” (Rose, 1996, p. 61)

**Charting success: the author(ity) of organisational charts**

Texts within organisations are usually directed toward specific areas or specific people within that organisation. Organisational texts such as memos, budget spread sheets, and policy documents, or in this case an organisational chart, are designed to initiate
actionable and more often than not textual responses (Rankin, 2001). Text will always perform something (Cooren, 2004). Texts have particular readers and authors; particular interventions.

I now describe in detail the ‘Organisational Chart’ in relation to nurses’ location in the organisation – their “author(ity)” (Rankin, 2001) – and the chart’s audience and intent.

The ‘Organisational Chart’, or in the case of this study chart(s), are a visual, graphic representation of the organisation’s formal relationships. The chart(s) depict the hospital structure, show relationships between personnel and departments, and identify reporting lines of authority and responsibility. The chart(s) are presented here to give an idea of how they changed. Fundamentally, all versions of the chart ranked staff according to their position. Textually, the chart(s) have much in common with many organisational charts in that they are hierarchical, with rectangular shaped boxes representing people’s positions and/or departments. The two interim organisational chart(s) saw the names of individual staff used, whereas the chart that was in place at the completion of my data collection used position titles only. The size of the boxes indicates the relative authority of the position or job title-holder, for example the Board of Directors sat at the top in a large rectangle. In the level underneath sat the Chief Executive, with finance, nursing, and corporate services executives all on the same level underneath that. These executives also sat in large individual rectangular boxes. Solid lines and inverted arrows depict the formal and direct relationships between positions, with right-sided arrows and dashed lines depicting the flow of communication between departments and positions of the same level of hierarchy in the organisation.
Figure 7.1 Organisational chart
Figure 7.2 Interim organisational chart
The ‘Organisational Chart’ is important for organisations in that it identifies for itself and outsiders, the organisational structure and key personnel, delineating clear lines of authority and responsibility so that people understand their roles within the organisation to help them meet organisational goals. The chart does not reflect individual relationships or managerial styles and, as seen during data collection, quickly became outdated. The chart changed three times during a six-month period of data collection, reflecting a level of ‘change’ and confusion in the organisation’s structure at the time.

Nevertheless, the organisation of nurses’ work, as depicted within organisational texts such as the ‘Organisational Chart’ and industrially written into enterprise bargaining agreements, for example, identifies textually the various roles nurses play within organisations. The location of these roles, represented visually in these documents, identifies who has the right to comment on nurses’ working time at an institutional level. While this document represents line, lateral, and functional organisational relationships, it fails to capture the social relationships between staff no matter their hierarchical location.

Chapter Four has shown that individual nurses such as Mary, a Level 1 registered nurse, while perhaps having little line authority according to the ‘Organisational Chart’, are positioned as an authority in the organisation to comment on hospital matters. In Mary’s opinion, some “things need to be looked at” with regard to staffing configurations of Ward A and the CCU. Although she says this is in many respects out of her “field of responsibility” and “not within my capacity to address”, Mary will, and does, comment:

... they’re things [CCU staffing] that need to be looked at, that’s out of my field of responsibility although I am interested in it and that’s not to say that I don’t say...  

96 Mary RN, Interview transcript, p. 37
something about it because I do, but it’s not something that I’m, that’s within my capacity to address ... it [CCU] has a huge impact on what the rest of [Ward A workload] is like. I think whenever you’ve got an area like that, a more acute area that is linked so closely to another area you do need to have a look at that. (Mary RN, Interview transcript, p. 37)

The ‘Organisational Chart’, as already mentioned, was literally a moving document during the course of fieldwork as the hospital dealt with significant organisational change. The redundancy and reinstatement of the Nurse Executive position and the reconfiguration of reporting channels left many nurses feeling quite insecure; insecurities arising from structural issues that were about power relationships within the organisation, as Mary observes:

... we’ve gone from you know having someone [nurse manager] covering both wards, to one in each ward, to someone covering both wards and you’d think with such a small institution it wouldn’t be that difficult to maintain but it is, it just seems I don’t know whether that’s geographical, or I don’t know what drives that there should be such a problem with having to you know maintain not necessarily huge areas [the Unit] but quite different areas [the wards]. (Mary RN, Interview transcript, p. 5)

I found that very hard to come to terms with because I’ve always known a Director of Nursing, someone there for the nursing staff …where it seems to be more … management now … business management type … just in the recent couple of weeks ... we have …a clinical person back again that we can identify with. (Yvonne RN, Interview transcript, p. 3)

Participants identified the organisation of the nursing department in light of the financial business concerns put forward by the hospital as an issue for them. These concerns are reflected in a number of organisational texts, for example Memorandums to staff, draft copies of collective bargaining or enterprise bargaining agreements, and in amendments
to the ‘Organisational Chart’ for inclusion in Policy Manuals. Nurses’ concerns also featured in interviews and were observed in nurses’ organising practices, particularly around the lack of clinical safety and increased accountabilities brought through working with enrolled and agency nurses, illustrated as follows:

... these days I often come on [duty] and there are 2 enrolled nurses [rostered] on and 2 registered nurses and they seem to get the same [work]load as I get and we all set off happily running around doing our own 6 patients. And at the end of the shift I think, now, who was actually, who has actually been responsible for the enrolled nurses’ patients? Was it me? Was it the other registered nurse at the other end of the corridor? ... I have no idea ... the enrolled nurse introduction is something quite new again to the hospital because we haven’t worked with a lot of enrolled nurses ... for years and years. And at the moment they’re asked to work like a registered nurse virtually. Because they [enrolled nurses] don’t get somebody to supervise them ...we all seem to have the same [work]load. And I know they will come to me when an intravenous drug is due and say can you do that for me. ... but I’m actually relying on them to come to me to ask me. There is no way I can fit in looking through another 6 patients’ ... medication sheets and make sure that I remember all their medication as well. ... I tend to organise life more when I work with an agency enrolled nurse. There’s no way I’m going to let them go off and look after their 6 patients and I look after mine and wait for them to come to me when there is a problem. Then it becomes a real, real stress factor because a) I don’t know how experienced they are, so I try and find that out and then ...I actually will go through their notes and their charts at the beginning and at the end [of a shift]. ... So I virtually take them under my wing so to speak ... because I don’t know their level of expertise. (Laura RN, Interview transcript, pp. 24–25)

Nurses were cognisant of their position within the hospital and their vulnerability to effects emanating from its business concerns as a result of legislative and industrial changes and the vicissitudes of the private healthcare market. Indeed, over the years, many of the participants had experienced changes to the reconfiguration of the hospital
organisational structure that saw the creation of new nursing positions within the hospital and the redundancy of others. Nurses relate such instances as follows:

...when I first started … I was sharing the clinical nurse role with one other full-time person on the ward and that position has been made redundant so that I am the only clinical nurse on this ward. (Doris CN, Interview transcript, p. 3)

... over the last few years [hospital] had had a number of people being made redundant and walk[ed] off site. ... my position was created as business manager role, initially was created by a redundancy of two people. Therefore, it had huge implications from staff that had been there for years ... I mean they had seen early in the years when the EN’s were made redundant. When Clinical Educators were made redundant. Nurse Managers were made redundant. So they had seen all that. ... this was the final straw basically ... not having a Director of Nursing. (Anita Nurse Unit Manager, Interview transcript, p. 4)

... every patient here will be looked after by an RN, that’s what they need, that’s what they get, that’s what we [hospital] do. ... and it changed and we actually let some enrolled nurses go, well actually didn’t let them go, they were made redundant basically. Their positions were made redundant and there was some wonderful girls. (Linda RN, Interview transcript, p. 35)

It is interesting to note from the above extract from Anita’s interview that the hospital did, for a time, have a clinical business manager position within the structure of the nursing department. This role was defunct by the time I started my fieldwork and although short-lived was perhaps reflective of shifting organisational expectations of senior nursing administrative roles to a more business-oriented focus. My point here is that despite discussion in the literature of a nursing shortage (KPMG, 2009; Productivity Commission, 2005), nurses working at this hospital across all levels or grades of nurses historically have always understood that their positions/jobs were not necessarily secure; that they could be made redundant at any time. This sense of job
insecurity stemmed not only from the hospital’s implementation of the redundancies that heightened nurses’ uncertainty about their future employment prospects and the stability of the organisation, but also from changing work arrangements (Beynon et al., 2002). That is not to say that individuals were rendered unemployable to work as nurses in other organisations or at the hospital in a different capacity for that matter. However, in the context of this organisation, it meant that their positions/roles, as represented in organisational documents such as the ‘Organisational Chart’, for example, or as shown in Chapter 5 in the nurses’ position description, are determined by the economic value or cost of nurses to the hospital as co-producers in the business. Thus, nurses have a vested interest in ensuring the viability of the firm to protect their employment. They are responsibilised in this endeavour of keeping the hospital within budget, as well as being aware that their value to the organisation is figured as a cost for which they are responsible (see Rose, 1999b).

It is nurses’ economic value to healthcare organisations that is discussed in the nursing literature in relation to how healthcare organisations can go on paying for quality nursing care (Kurtzman, 2010; Needleman, Buerhaus, Stewart, Zelevinsky, & Mattke, 2006; Spetz, Donaldson, Aydin, & Brown, 2008; Unruh, Hassimiller, & Reinhard, 2008). Needleman (2008), for example, examines the argument for determining quality nursing care by making a business case for nursing, asking: “Is what’s good for the hospital good for nursing?” According to Needleman (2008), the difficulty with showing a business case for nursing is that incentives for doing so at an institutional level are low. He draws a distinction between the business, economic, and social cases. The business case is where an intervention is valued from a financial perspective of the organisation that will bear its costs. The economic case is where financial returns do not
need to accrue to the hospital bearing the costs. The social case is where the value of the intervention is considered without weighing its costs. The issue is that a quality initiative may meet social and/or broad economic goals because it improves outcomes and/or saves money, but if the cost savings are not captured by the organisation it may not meet the business case goal of the institution bearing the costs (Needleman, 2008).

**Managing control: nurse staffing**

If the ‘Organisational Chart’ was a moving document during my fieldwork, it is perhaps no more dynamic than how nursing roles play out industrially. Interestingly, participants considered the introduction of the nursing career structure as a moment of discontinuity (Foucault, 1972); a moment where some of the changes to the organisation of their work occurred:

.. when that career structure\(^\text{97}\) came in you know everyone was encouraged to apply for an appropriate position but of course there weren’t enough positions in their structure to give a job to everybody and so actually people were offered a lesser position or they left the building and we did have a few that left the building because there just wasn’t a position for them and that created a bit of an angst. (Mary RN, Interview transcript, p. 6)

While some of this angst was viewed as inevitable at the time, ongoing organisational restructuring continued to mark nurses’ working life/employment at the hospital, which participants viewed negatively. Mary reflects:

I think one of the other things from this place which is probably one of the negatives that you know there’s a lot of exit left stage door in this joint, there’s a

\(^{97}\) The career structure was introduced in Australia in the 1980s to provide a framework for career progression and remuneration for nurses based on an individual nurse meeting defined criteria of skill, competence, professional expertise and education. It was based on the clinical ladders system in the United States. Here in Australia it was influenced by the ‘Dreyfus Model of Skill Acquisition’ adapted to nursing by Benner (1984).
lot of DCM you know don’t come Monday. Now, from an outside looking in it always looks like, ‘Oh my god what are they doing?’ ... some things are quite justifiable but it does create a bit of an ill feeling and I think it probably started then you know and it has just simmered, boiled, simmered, boiled simmered ... but um that I sort of do look back and I think [the] career structure probably started things you know, sort of that was the start of the way it went, and the way it probably still is a little bit here but I don’t know. (Mary RN, Interview transcript, p. 6)

In relation to the most recent episode of organisational restructuring that would have resulted in changed reporting lines, data reveal a high level of anxiety for participants – it was a ‘huge issue’, as Anita tells:

... the way that the interim structure was to take place was that the clinical division was going to be split, that the medical surgical wards, so [Clinical Manager Ward B] and myself [Clinical Manager Ward A] are going to report to the Quality Manager who was not a nurse. And that Theatre and Maternity were going to report to the Director of Support Services who has a HR [Human Resources] background and obviously not a clinician, and there was not going to be any clinical representation at executive level, and that was a huge issue from a nursing point of view. (Anita Nurse Unit Manager, Interview transcript, p. 4)

This and the previous accounts in this section show how the hospital played a major role in shaping nurses’ employment/work despite the discourses about the external as opposed to the internal nursing labour market as ‘in shortage’.

The following section examines “the rules and processes of appropriation” identified by Foucault (1972, p. 68), where the:

Property of discourse ... the right to speak, ability to understand, licit and immediate access to the corpus of already formulated statements, and the capacity to invest in discourse in decisions, institutions, or practices – is
in fact confined (sometimes with the addition of legal sanctions) to a particular group of individuals. (Foucault 1972, p. 68)

The hospital regularly reviews national, state, and local government requirements through its Quality and Risk Coordinator to comply with legislative requirements. The hospital’s ‘Policy Manual’ states that the hospital relies on a number of sources that highlight changes in legislation and standards to ensure new legislation is flagged for attention. Some of the sources or ‘authorities’ referred to include the Australian Private Hospitals Association (APHA), Australian Industrial Relations Commission (AIRC), Australian Nursing and Midwifery Council (ANMC), state and territory nursing and midwifery regulatory authorities, Australian Council Health Care Standards (ACHS)\(^{98}\), Australian Commission on Safety and Quality in Health Care\(^{99}\), and Acts of Parliament that impact on the hospital at a Commonwealth, state, and territory level. State and territory regulatory authorities, for example, have the responsibility for determining nurses’ scope of practice and ensuring standards of practice within legislative frameworks. Professional organisations, both nationally and internationally, such as Australia’s Royal College of Nursing (RCN) and the International Council of Nurses (ICN) also define nursing roles in ways that are consistent with regulatory legislative standards.

The hospital confers to the Quality and Risk Coordinator the authority to administer the dissemination and incorporation of legislative and standard changes into policy and practice. The hospital’s ‘Policy Manual’ indicates the process for change from the requirements for introducing and/or updating policies, review via relevant hospital

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\(^{98}\) Australia’s leading health care assessment and accreditation provider.

\(^{99}\) The Commission was established in 2006 by the Australian State and Territory Governments to develop a national strategic framework and work program to improve safety and quality across the Australian health care system.
committee and subsequent authorisation by the Chief Executive, and communication of new and revised policies via email to managers who are responsible for ensuring staff are aware of changes. When legislative changes impact on practice, this information is brought to the attention of the relevant committee and its implementation is in accordance with the committee’s directions. Staff awareness of, and compliance with changes is monitored via the hospital’s Incident and Adverse Event monitoring systems and performance development program, all of which are components of the hospital’s risk management strategy. While the Quality and Risk Coordinator is responsible for administering changes to policy and practice within the hospital, there is an expectation that all managers maintain a watching brief on industry change and that they inform the hospital of any changes relevant to the organisation.

Legislation and standards also govern the hospital committee structure, with the hospital authorising a number of committees with the purpose of managing corporate and clinical risk to the organisation to ensure safety and quality of care. Some of these committees have a clinical focus, such as Patient Care, Infection Control, Operating Suite, Quality, and Perinatal committees. While there may be a number of committees or sub-committees in operation throughout the hospital at any one moment (for example the Enterprise Bargaining Committee), the hospital’s Board gives authority to a number of committees to direct policy and practice changes, although the Board will determine what those changes are. Yet, while some nurses will sit on various committees, not all nurses do. Data did not indicate who these nurses were, their role or position, however all nurses working on the wards also assume authority to determine care delivery. Professional codes of conduct (ANMC, 2008b) and Occupational Health and Safety
legislation based on a principle of duty of care\textsuperscript{100} and the Nurses Acts of each Australian state and territory\textsuperscript{101} in which they are registered govern individual nurses’ daily conduct. Nurses have a right to speak (Foucault, 1972) about the conduct of care (Latimer, 2000) and speak they do. Rosemary, discussing night duty staffing, reflects:

…whilst hierarchy can say you know they are the ones that worry about an unsafe situation …and the people on the floors … that’s not in their job description … as very experienced professional nurses …. each, each individual senior nurse is very, very aware of their responsibility and their professional accountability … and there is [workloads] that you know out of, out of acceptable, or you know limits that will in fact place them in a situation where potentially they could make an error which has a significant impact on their professional life … I see the concern that they have, to run with you know [unacceptable workloads] when that occurs. (Rosemary After-Hours Coordinator, Interview transcript, p. 8)

Where nurses have genuine concerns about their workloads they voice their complaints using the hospital’s risk management processes to do so strategically:

**A:** I had 3 patients on triple antibiotics one night and they were ones that just couldn’t go through with a push, they had to go over an hour. So it was just constant going back, and you just felt like you were handing out your care to 3 people. And the other 9 just got neglected, and that was the night, that was another night I filled out a hazard form.

**Q:** And why did you do that?

**A:** Because I thought if anything happened, like seriously, to any of my patients that I was caring for, I wanted some back up. Because it was only me, really, at the coalface. I mean I’m accountable for them or responsible for them but if I

\textsuperscript{100} In Australia, each State and Territory is responsible for Occupational, Health and Safety laws. Each State and Territory has an Occupational Health &Safety Act and Regulations, setting out requirements for ensuring the health, safety and welfare of people at work.

\textsuperscript{101} The State and Territory Nursing Acts that were in place at the time of data collection. These Acts were repealed by the National Health Practitioner Regulations laws in 2010.
didn’t say something and something happened, the Nurses Board would say to me, ‘Now why didn’t you get help?’ Or ‘Why didn’t do you do whatever you have to do?’ So I fill in this hazard form, so I want to let the hierarchy know ... that all is not well with having 12 or 13 patients with triple antibiotics. (Joan RN Interview transcript, p. 11)

The above excerpt may be read as an example of nurses’ resistance. On one hand, Joan has accepted an allocation of “12 to 13 patients” and is undoubtedly unhappy about the workload for the night. On the other hand, she is also ‘watching out’ for the hospital – for herself and her registration –as she uses the hospital’s official processes to challenge nurse staffing for the shift. While Joan is challenging staffing in relation to patients’ best interests, she frames inadequate nurse staffing as a risk management issue for the hospital. The potential of an adverse patient event occurring due to insufficient staffing poses a costly and significant risk to the hospital, not only in terms of medico-legal costs incurred by the organisation but also risk to its reputation and therefore business. Joan is well aware of her legal position and that what she is doing is no more than what her job requires; practising in accordance with the standards of the profession, those of the broader health system, and laws relevant to the practice of nursing (ANMC, 2008b). Not only are Joan’s standards being compromised in terms of workload where the “other nine patients are neglected” but there are implications for service delivery.

If we are to conceive of healthcare services as an intangible product, then what Joan expresses with the neglect of the other nine patients, as customers, is a failure by the hospital to meet care expectations. If we are to think of nursing care delivery in terms of tangibles and intangibles, as Levitt (1981, p. 100) states, the most important thing about intangible products is “that customers usually don’t know what they’re getting until they don’t get it”. Joan, in effect, in management and business parlance, is safeguarding
service quality. While the Quality and Risk Coordinator is given authority to determine quality processes, the hospital relies on nurses to be “the quality inspector, primary complaint handler and rework expert” (Bowen & Ford, 2002, p. 454).

**Conclusion**

Analysis reveals how the hospital uses care as a business strategy. It is an ‘ethos of enterprise’ (du Gay, 1996), of business, that enrols nurses within the private sector in the strategic goals of the firm through their shared goal of delivering quality care. In Rose’s (1999a, p. 56) words:

> The path to business success lies in engaging the employee with the goals of the company at the level of his or her subjectivity, aligning the wishes, needs, and aspirations of each individual who works for the organization with the successful pursuit of its objectives. Through striving to fulfil their own needs and wishes at work, each employee will thus work for the advance of the enterprise; the more the individual fulfils him or herself, the greater the benefit to the company.

This chapter has highlighted how this ethos operates through a nursing rationality of care where the organisation markets nursing care as one of its defining features. This ethos ensures that nurses are responsible for the health of the hospital as well as the patient’s experience, effectively enrolling the nurses in the hospital’s aims and mission. It is also this enterprise ethos that affects nurses’ work because their sense of job insecurity, “as measured by the fear of job loss” (Burchell et al., 2002, p. 2) rather than job stability, has nurses working and working hard to ensure the future of the firm – with the possibility of their own (un)employment in play, nursing values such as ‘care’ are transformed into neo-liberal forms of enterprise governance in which market relationships and values govern nurses’ work. Enterprise as a neo-liberal rationality of
government ‘(re)problematises’ the nursing ‘problem’ for organisations as one of care; as a ‘new’ political rationality that:

… involves “offering” individuals and collectivities active involvement in action to resolve the kind of issues hitherto held to be the responsibility of authorized governmental agencies .... This might be described as a new form of “responsibilization” corresponding to the new forms in which the governed are encouraged, freely and rationally, to conduct themselves. (Burchell, 1996, p. 29)

As such, this chapter extends conventional understandings of nursing as caring work, highlighting the entrepreneurial facet of that work. Nursing’s traditional values and care are commodified – but this work is not acknowledged. Rather, it is regarded as an expectation of the firm. The management, without proper recompense or acknowledgement of its worth alienates this work to the fungible in the hospital’s budget lines. Unlike in the public sector, where the competitive advantage between institutions for customers is perhaps not such an issue as in private health, nurses in the private sector, specifically those participating in this study, are well aware of the implications of the market on their work and employment. That said, this study shows how the hospital also plays a role in shaping nurses’ employment through its staffing policy and practices, which shape nurses’ working time. The hospital frames care as a dominant business goal to avoid commoditisation and ensure its viability within a private healthcare market. In the process it enrols nurses within business management discourse. The nurses in this study use ‘care’, as one of nursing’s central tenets, to argue for the maintenance of standards through protecting staffing levels as represented in their working time. The hospital in this study uses ‘care’ as a marketing tool and a commodity, and in doing so commodifies nurses’ work. The next chapter discusses how nurses’ care makes nursing hours ‘work’.
CHAPTER 8
SORTING THEMSELVES OUT

Calculating routines are rarely self-contained practices. What is counted usually counts, and the counting of it has effects. (Miller, 1992, pp. 70–71)

Building upon the analysis in Chapter 7, this chapter considers the ways in which nurses organise themselves in light of the prominence of business management and marketing discourses in shaping private healthcare delivery. Here, I provide a more detailed account of how nurses do this. Drawing upon my observations, interviews, and organisational texts, I illustrate how nurses go about sorting out their work in light of their budgeted nursing hours. Chapter 7 demonstrates an uneasy tension between the hospital’s business management and nurses, particularly around cost and importantly around reducing nurse labour costs. The hospital resolves this issue by drawing upon nursing’s care ethos to make nurses’ nursing hours ‘work’. This chapter demonstrates how this occurs in practice through the way in which nurses allocate patients, ‘buddying-up’ with each other, and handover practices between nurses about the patients under their care. The translation of nurses’ work into a “single figure” (Miller, 1992, p. 68) such as the ‘nursing hour’ has nurses, as “calculating selves, rendered responsible and located in calculable spaces” (Miller, 1992, p. 69), illustrating how accountancy’s calculative technologies represent and intervene in social and economic life (Miller, 1992).

This chapter focuses on a calculable space – a space both abstract and real – because the organisation of nurses’ work is tied to the hospital’s performance, financial or
otherwise. It is organised as follows. First, I describe how the spectre of nursing practice, as represented in the calculable space (Miller, 1992) of the ‘nursing hour’, affects the ways in which nurses work. Second, I analyse the various ways in which nurses’ working time is organised as a result of staffing policies and practices, focusing on nurse-to-patient allocations or assignment, the organisation of nursing work in relation to skill mix, and the many instances where nurses handover their work. The effect of these policies and practices on nurses and their managers when managing their ‘hours’ ensures that the hospital’s business occurs in a seamless manner.

**The spectre of nursing practice**

**Allocating time: managing the numbers**

There remains an (in)visibility about the work of nurses despite the purported visibility of the nursing labour force in national data bases such as population statistics and in government reports, as described in Chapter 2. The problem of nurses’ invisibility for the profession sees a proliferation of literature dedicated to outlining classification systems and methods designed to measure nursing workload as a means of identifying nursing contribution to healthcare delivery to inform practice and policy with a view to improving patient care (see for example De Groot, 1994a; ICN, 2010; Malloch & Conovaloff, 1999; Rauhala & Fagerstrom, 2004; Trend Care Systems, 2011; Van Slyck, 1991a, 1991b; Willis, 2002). Classification systems are a management ‘solution’ that assists in “optimising efficiency in work practices and the utilisation of human resources” (Trend Care Systems, 2011).

The reviewed literature continues to debate issues of identifying just what the nursing component of healthcare delivery is, how best to go about classifying it, and even why
nurses should do so (Beswick, Hill, & Anderson, 2010; Duffield et al., 2006; Finkler, 2008; Ginsburg, 2008; Kurtzman, 2010; Welton, Zone-Smith, & Bandyopadhyay, 2009). Recent debates arise from a push to recognise nursing care in inpatient prospective payment systems in the USA, for example, with funding healthcare delivery based on pay-for-performance (P4P) initiatives that tie ‘nurse sensitive’ quality indicators to payments (Aiken, 2008; Clarke, Raphael, & Disch, 2008; Needleman, 2008). While much work has been, and will continue to be, done in the profession’s desire to make nursing ‘visible’, the hospital’s day-to-day management of nurses’ working time ensures the “phantasmatic representation” (Foucault, 1972, p. 68) of nursing within the abstract spaces of organisational accounting techniques.

In this study, these techniques see nurses’ working time literally written out in/to the margins or visually off the page as people are metaphorically taken ‘out’, as I recorded in my fieldnotes:

For this afternoon’s staffing Marcello has cancelled the ward clerk for Ward B and assigned her to Maternity, leaving 2 Registered Nurses for 12 patients on the ward. Even by doing this, as he calculates his nursing hours for the day, he comes in at “4.879, with 12 in Ward B by 2400”. Marcello shows me his ‘Monthly Report’ and demonstrates how the nursing hours for his unit will “always be over” even if he takes himself and the Ward Clerk [hours] out. We go through some sample ‘sums’. ... Further discussing nursing hours he states that his “performance appraised about this as KPI”. After a few calculations with some imaginary patient numbers and subtracting himself & the ward clerk hours he demonstrates how he “can’t get anywhere near 4.5” with the occupancy that the ward has. ... he says, in the end you are “working with figures”. (Fieldnotes # 9, p. 9)

Marcello is pragmatic about the reality of managing the ward in light of the figures and
well aware that his performance as a manager is tied closely to how he manages/controls the nursing labour hours in the interests of reducing organisational cost. Interestingly, no matter how Marcello works the figures, his calculations show he is unable to come in within budget; his nursing hours will always be over because he staffs the ward to the midnight patient census. The only time he comes within budget is if the ward is full at midnight. Staffing decisions are related to the cost of care. These decisions are made on the calculation of the nursing hour based on the midnight patient census and calculation fails to take into account nurses’ business day\(^{102}\). This is illustrative of how “governing by numbers” (Rose, 1991, p. 673) rules managerial thinking, where:

> The calculative technologies of accounting have become intrinsic to the activity of management, according to objectivity, neutrality and legitimacy to decisions that otherwise appear subjective. (Miller, 1992, p. 72)

In the discourses about the management and concerns facing private hospitals, the emphasis is on funding and competitive pressures, with a correlated focus on the reduction of nursing (and other) labour costs. In this study, a number of strategies were used to reduce the total nursing wage cost, including changing the skill mix from what had been for a time all registered nurse staffing to an 80/20 percentage ratio of registered to enrolled nurses:

> Other things that come up this morning, include, that the hospital is aiming to have an 80/20 percent skill mix of RNs to ENs. This is part of the Business Improvement Initiative. (Fieldnotes # 9, p. 8)

In practice, however, this often resulted in a greater proportion of enrolled nurses to

\(^{102}\) Marcello Nurse Unit Manager, Fieldnotes#11, p. 8
registered nurses:

… now we have … gone to a system where they’re looking at an 80 to 20% [registered nurse to enrolled nurse ratio] mix but some shifts we actually find we have a lot more ENs on than that. (Doris Clinical Nurse, Interview transcript, p. 4)

Another aspect of the ‘Business Improvement’ strategies discussed was that managers should limit the use of agency nurses to fill staffing shortfalls where possible because this was identified as a source of possible financial risk for the organisation:

Anita reports that at the hospital’s ‘Business Improvement Meeting’, the hospital identified that some of their “risk is with amount of Agencies” used. (Fieldnotes #9, p. 4)

The temporary nursing workforce at this hospital includes their own ‘casuals’ and agency nurses. The hospital’s preferred means of staffing the wards was with their own staff – full-time, part-time and casuals. Managers spent considerable time arranging and changing rosters to balance nurse staffing requirements, asking nurses to change rostered shifts, work additional shifts and/or work longer shifts, for example. While people helped out where they could, this practice was also a source of consternation:

… our casuals have been used to maximum capacity, our part-timers are picked up as much as they want to pick up you know you can’t make people do what they don’t want to do you know, I mean there are those that have a sort of commitment and they’ll certainly pick up where they can and I think there’s a core of people where we do that. A lot of people, you know the girls that work the double shifts or the girls that swap to do the nights … I think everybody has the philosophy that they try and help out where they can but sometimes you just reach your point and that’s all you can do and that’s hard because then you, you know you, I mean I look at that and I think ‘Well you know you sort of hate to think that any of your colleagues are being compromised’, yet I know that some of them do feel very threatened and that’s not good. (Mary RN, Interview transcript, p. 29)
Controlling nursing’s hour in Mary’s example was achieved by drawing upon nurses’ professionalism and goodwill, which left some feeling “compromised” in so far as they were not only working harder at work, but in some cases they were working longer hours as well.

An additional strategy saw the reduction of handover or the change of shift report time. Here, the objective was to reduce nursing labour costs through reorganising nurses’ working time:

**Q:** You’ve spoken a little bit about the handover time being cut back, and the shift times being cut back, what do you think that was all about?

**A:** Oh, that was taking it back to a 75-hour fortnight, rather than an 80-hour fortnight. (Emma RN, Interview transcript, p. 33)

Taking handover time “back to a 75-hour fortnight” saw a change to the standard shift pattern for nurses at the hospital. The shift pattern was a 7.5-hour morning/afternoon shift (0700 to 1500) followed by a 7.5-hour afternoon/evening shift (1430 to 2230) and a 9-hour evening/night shift (2215 to 0715): a total of 24 hours of nursing cover in one day. A short overlap of time was allocated for handover, being half an hour between the morning and afternoon shift, and 15 minutes between an afternoon and night shift, and the night and morning shift – a total of one hour in a day for nurses to handover their patients. The following data extract indicates the time changes and their implications for practice, as Emma recounts:

... lap over of shifts has decreased. …it used to be that the morning shift didn’t finish until 3.30 [pm], now it finishes at 3.00 [pm], so you’ve only got a ½ hour of overlap in the afternoon. You’ve only got ¼ of an hour overlap in the evening,

103 The actual change to ‘handover times’ had occurred some years prior to my commencing fieldwork. However in their conversations nurses referred to the reduction to handover time as a factor that influenced how they organised their work.
going on to the night shift, the night staff come on at 10.15 [pm]. The day staff are supposed to be gone at 10.30 [pm]. Now, that’s … the really tough time. In that, particularly if you’re listening to handover for 27 patients out on the ward, even if you keep that brief, it’s still going to take longer than 15 minutes, most of the time. It shouldn’t. But it does, and sometimes you’ve got you know, the night staff are still in there listening to handover at 10.45–10.50 at night, and it shouldn’t be happening like that. So it’s a difficult situation … (Emma RN, Interview transcript, pp. 32–33)

Handover time is clearly a calculable space in the organisation of care; a space where nurses’ working time was evaluated “according to a financial rationale” (Miller, 1992, p. 76), and in the process was arranged and rearranged, made visible, and in being made visible made manageable. Tightening of handover time was one approach to managing the nursing budget, but as we read in Emma’s account the amount of time nurses spent giving the change of shift report was often exceeded, taking nurses (over)time. How nurses manage handover practices is described in more detail later in this chapter.

A final strategy was the use of the practice of ‘acting up’104, or performing ‘higher duties’105. In the words of one participant:

... where we’re all running by proxy at the moment we’ve got a proxy Clinical Manager in Mid[wifery], we’ve got a proxy Admissions Officer, we’ve got a proxy Discharge and Admissions Coordinator you know, so we’re all looking after each other I suppose and I think a good day is you know when we’ve all just helped each other and at the end of the day thought we’ve done the best we can

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104 ‘Acting up’ is an arrangement whereby an employee agrees to temporarily fill a vacant position at a higher grade or classification. This benefits the organisation by keeping costs down, by not providing replacement for the person that has acted up in a senior/ supervisory position, and sometimes not compensating fully the person taking on extra duties. It allows staffing decisions to be deferred by management where there is uncertainty over future staffing or resource levels and future downsizing (Beynon et al., 2002)

105 Industrially, the Nurses Award 2010 (FWA, 2011b) states that where an employee is relieving another at a higher classification than that which they are ordinarily employed they will be paid at a higher rate provided it is for 3 days or more. Registered nurses employed at Levels 4 and 5 are ineligible for higher duties allowance.
do, we’re doing it because we’ve been asked, perhaps not because we choose to do it. (Mary RN, Interview transcript, p. 9)

Beynon et al.’s (2002) exploration of the changes in work and employment in seven large organisations in Britain in the late 1990s found that no matter the industry – banking, retail, telecommunications, or the National Health Service – the practice of acting up led to work intensification, with people working harder, often for longer hours and for less cost to the employer. In the case of this hospital, nurses often acted up to cover clinical management roles, covering for people who were off sick or on leave, or to cover unfilled positions such as those described by Mary. This strategy was used regularly to manage the cost of the nursing budget, with the time spent in the role accounted for on an hourly basis, as illustrated in the following excerpt from interview transcripts. Anita, working as the Acting Clinical Operations Manager, was responsible for clinical issues in the hospital in the absence of the Nurse Executive position. She tells her story:

I was left in a position where, well I can’t even make a decision because I had no, I had the title but no authority, which was quite frustrating. And it put me in a position where you are a middle manager from 9 to 10, from 11 to 12 you became an exec[utive] person, and then you went back down again. So it was very difficult. And trying to keep everybody happy was hard, so I was torn constantly. (Anita Nurse Unit Manager, Interview transcript, p. 6)

‘Acting up’ is a staffing management strategy used to manage temporary position vacancies, often for extended periods of time. In this study nurses were asked to act up and/or relieve one level or grade to manage the nursing budget for short periods of time. This strategy was used extensively, making for fluidity in between nursing positions. This extract from my fieldnotes describes how, in the course of handling their ‘nursing
hours’, the ward managers deal with “getting round” the staffing through flexible working practices. Anita is handing over the wards to Gloria, one of the After-Hours Coordinators, who has commenced her shift for the afternoon:

*From Anita we hear that “Ward B 16 [patients]” with “3 staff” and there is “no ward clerk” this evening. ... For my benefit Anita clarifies that when staffing the “rule” is that when a ward has “12 patients and above, they have a ward clerk, but because 3 [nurses] are rostered on [Ward B] the ward clerk [has been] cancelled ... Moving onto the staff allocations for the morning she notes that Ward A has “3 to 4 [registered nurses] on morning. Query shift one to the Late shift.”*

*Handing over Ward A one nurse is working “1730–2230”, and “one to [relieving to] Recovery. The Hilton is not used” [though this name is now not often used it refers to the end of Ward A that has just been refurbished and is now known as “the villa” end of the ward because of the wooden shutters in the windows and its pseudo-tuscan look. When this part of the ward was refurbished in the 1980s it saw the establishment of solely single rooms with ensuites for patients, hence the Hilton. ... We laugh at the names of the sections of the ward, and how the names have changed over the years. Returning to handover ... Anita remains seated at her desk and Gloria is standing, the ‘Resource Folder’ is on Anita’s desk, opened out, the page now turned over onto tomorrow’s staff allocation sheet. A: “We have lot of 0700 admissions” G: “You’ve got six staff” A: “Don’t need them cancel [name of RN]” G: “Cancel [name of RN] ... No CCU [Referring to that at present there are no patients in CCU nor are there any planned admissions to unit in the morning] ...she says to ‘ask [name of CN-CCU] if able to work Thursday ... cancel [name of another RN]’. She flips through the allocation sheet, looking ahead to Thursday. Anita calls out to the CN-CCU who she has spied walking past the office door and asks if there is “possibility of you having tomorrow off and working Thursday instead?”*

*CN-CCU: Have an ANF [union] meeting [Hospital is currently negotiating a new*

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Enterprise Bargaining Agreement] ... Anita picks up the phone and rings one of the registered nurses, discusses and confirms that she will be not on roster Thursday and asks the CN-CCU who is still in the room, standing next to Gloria if she can “TL for her” on Thursday. The CN-CCU was rostered to/or planning to have a “management day” and Anita is also looking for a day off and this is one way of ‘getting round’ the staffing. Looking up at the CN-CCU Anita asks “can you be me on Thursday?”. CN-CCU clarifies if she is to start work at “7 or 8[am]?” Anita confirms “0700 start”. Anita and Gloria return to the staff allocation sheet. The CN-CCU will now have LWOP tomorrow. (Fieldnotes#14, pp. 3–4)

Where some of these strategies at an executive level are about meeting organisational service delivery goals, the central issue is containing costs, with nurses being made well aware of how their work fits into the hospital’s wider performance. Thus, managing nurses’ working time, or in the words of one of the Nurse Unit Managers, “your numbers”, was at the foreground of nurses’ talk:

You knew always in the back of your head what your numbers were of how many staff you had and what you actually had to do to be able to get there. There was no, I mean you knew you had a set 1 to 6 ratio and you endeavoured to meet that. And whether or not that became 2 to 12 or 1 to 6 or whatever, or even half shifts, we would manipulate a half shift. ... Or if I knew that the numbers were going to go over I would not ask the overtime and so from 3 [pm] to 6 [pm] staff would be looking after 10 patients. Which was heavy on patient [workload] but that was the only way a) you can manage your staffing, and b) the labour hour. (Anita Nurse Unit Manager, Interview transcript, pp. 9–10)

The above extracts illustrate how managers think about reducing labour costs through rescheduling work to increase productive hours and/or reduce overtime by tightening their control of nurses’ working time. While Anita kept what her “numbers were” in the back of her head, all nurses engaged in the practice of manipulating the staffing
requirements to a greater or lesser degree.

Models of care: buddying-up and babysitting patients

Nurses at this hospital drew upon two ‘classic’ (Duffield et al., 2010) modes of care delivery to sort themselves out; ‘team nursing’\textsuperscript{106}, and predominantly ‘total patient care’\textsuperscript{107} or patient allocation. Each of these modes comprises its own distinctive set of practice features related to work focus, continuity of care, division of labour, and individualisation of care, all shaped by different management ideologies (Adams, Bond, & Hale, 1998) and where work allocation lay with assigning tasks or assigning patients (Tiedeman & Lookinland, 2004). Although nurses in the hospital drew upon ‘total patient care’ as the preferred mode of care delivery, the re-introduction of enrolled and graduate nurses and an increasing use of agency staff had implications for the organisation of work, specifically concerned with increasing the flexibility of times nurses worked. Laura relates:

… the historical system is you give total care to the amount of patients you get for that shift. And … because we’ve been working with experienced staff and all of them registered nurses for quite a few years now, it meant, like we gave total care to our group of patients and just helping each other as the need arise. And to come away from that and now be introduced again to having enrolled nurses needs … a new programme … needs a new organisation. We can’t just work like that anymore. (Laura RN, Interview transcript, p. 26)

Nurses could no longer afford to “work like that anymore”. The ideal of delivering total

\textsuperscript{106} Team nursing, is a model whereby a team of nurses provides all the care to a specified group of patients, often allocated geographically. This model allows for supervision of aides and enrolled nurses by a smaller number of registered nurses. In this model the RN team leader supervises lesser-trained care providers and performs direct patient care that lesser-skilled staff are not qualified or licensed to perform. Other team members provide direct patient care to assigned patients (Duffield, Roche, Diers, Catling-Paull, & Blay, 2010; Tiedeman & Lookinland, 2004).

\textsuperscript{107} Total patient care or patient allocation has one nurse taking responsibility for the complete care of a group of patients. It does require an almost all registered nurse staff (Gullick, Shephard, & Ronald, 2004).
patient care with an all registered nurse workforce was no longer feasible – if indeed it
really ever was – within the discursive framing of the competitive business and
performance pressures for private hospitals. Given the budgetary constraints and
changing nursing skill mix, nurses and their managers were reconsidering past practices
of organising work around traditional modes of care delivery, such as total patient care.
How nurses go on to sort themselves out on a shift-by-shift and at times hourly basis in
light of changing modes of care delivery is discussed in the next section, which focuses
on patient allocations.

**Allocating care**

Nurse-to-patient allocations were crucial to how nurses approached their work. How a
shift was ‘set up’ for them by Nurse Unit Managers, After-Hours Coordinators and/or
colleagues determined whether or not nurses chose to accept or change their allocated
patient load. Anita describes how she rostered staff, bearing in mind the model of care:

> … the model was predominantly registered nurses running a 1 to 5, 1 to 6 ratio
> earliest and latest and a 1 to 10 on night duty. That was the model. [now] … 80/20
> RN mix with the buddy system. One RN to EN, either 2 to 10, 2 to 12, no more
> than that. So that’s where the model had changed. So what I tried to do when I did
> the roster is ensure that there was only, there was only 1 EN on per shift on an
> early and a late. And certainly the way then I rostered the RNs was to make sure
> that in terms of personality and skill mix was that there was somebody whom I
> could buddy that EN with, and that’s how I had to do the roster. ENs did work on
> weekends but I didn’t roster an EN on a Sunday night because I knew my
> numbers were going to go down, and so I had to be mindful of Sunday afternoon
> on [Ward B] ... Sunday night you could go down to 10, you know, [Ward B]
> could shut by Friday afternoon, Saturday afternoon. So I really had to be mindful
> of my numbers. And so that’s when, so I used to roster with about 3 staff on a late
> on a Sunday on [Ward A] and 2 on a late on Sunday afternoon on [Ward B]. So I
> reduced that by 1 on the [Ward B] because I’d roster 3 and 3 or something. And
on [Ward A] oh and out of those 3 [nurses rostered] on [Ward A] one of them had to be CCU trained. (Anita Nurse Unit Manager, Interview transcript, p. 18)

Despite the planning that went into rostering, what determined whether nurses would or would not continue to ‘buddy’ with a colleague was more often than not dependent on the grade and skill of the individual working with them, identified in this study as being enrolled and agency nurses. Mary explains:

… if I wasn’t happy with how they [nurse managers] set it up I’d probably change it and … if it was an agency enrolled nurse and me I would probably buddy up with that agency enrolled nurse and work as a directive, find out what her capabilities are, where she’s happy at what she’s done and then just go through and work through them together … whilst we don’t tend to do that as much, I think there are some times you just have to do that and that would be for my own peace of mind as well. I’d prefer to have 12 patients under my wing and direct someone than I would have my own 6 and put my head in the ground and not know what those other 6 … and then find out retrospectively that those other 6 were compromised or weren’t happy with their care or whatever, it’s easier you know, that’s me. (Mary RN, Interview transcript, p. 30)

Another nurse told me that she also preferred to buddy-up when working with enrolled nurses as a means of having greater control over care delivery:

… if I had an EN to work with, I used to try and find out what I needed to do for them, and what they needed to do. I found it actually better if we worked as buddy/buddy. (Lily RN, Interview transcript, p. 21)

While many nurses would take up this mode of organising work, not all nurses did. Sandra, like many of the participants, has worked on and off at the hospital over the course of twenty years or more and for varying lengths of time. Sandra was aware of this practice of ‘buddying up’ but was resistant to do so, although she conceded it may
be a useful strategy when working with agency staff, particularly enrolled nurses:

Q: And would you buddy up? Use that system at all? People have talked about that a little bit.
A: I don’t really like no, I wouldn’t.
Q: No. You don’t like it?
A: Umm, maybe if it’s, if it’s an agency enrolled nurse and you buddy up and you’ve got a total of 12 patients, that’s just impossible to care for, and that’s what I’m overseeing, is 12. I can’t do that. Some girls like it, I don’t (Sandra RN, Interview transcript, p. 33).

Yet, when questioned further as to whether she would consider buddy ing up with an enrolled nurse employed by the hospital, Sandra stated that this would not worry her:

Q: Would you buddy up with an enrolled nurse that’s a [Hospital employee] nurse?
A: Yeah, yeah, that wouldn’t worry me. (Sandra RN, Interview transcript, p. 33)

While Sandra did not elaborate as to why this would not worry her, there is an assumption that these nurses were familiar with the hospital’s mission and policies. Nurses would have attended the hospital’s orientation or induction programme and have acquired information about the hospital’s expectations and standards of care delivery. Nurses would be deemed as competent to work in the hospital, having met not only professional nursing registration standards but those of the hospital as well, integrating business discourses around quality, safety (Occupational Health and Safety), and risk management. Hospital policy demands that staff complete yearly mandatory competencies, which include but are not limited to cardio-pulmonary resuscitation, drug calculation, manual handling, and fire safety. These competencies would have to be met during the hospital’s orientation process.
Participants identified working with agency staff, and in particular enrolled nurse agency staff, as problematic because they were expected not only to orientate nurses to the ward but also find time to teach these nurses what they considered to be basic nursing and organisational skills, compounding their work intensification. Mary explains:

I know that ... there’s been some issues where the agency haven’t been up to speed and that makes it very difficult and that does certainly put a huge pressure on the others that are working on that shift because you feel like you have a responsibility to make sure that they’re providing adequate care and safe practice for patients as well as your own patient load and that’s huge. (Mary RN, Interview transcript, p. 28)

These sentiments are supported by Angela:

If it’s our [hospital employee] ENs, which is as I said, 99% of them are really good, they’d have their own 6 [patients] and I’d have my own 6 [patients] and they come up to me and say I need an IV drug or something like that. Agency, yeah, I kind of try and suss them out. … usually at the commencement of the shift, I would always find out where they’ve often worked too, because some may say, ‘Oh, this is my first shift in the acute care setting, I’ve just been working at nursing homes’, and so maybe I wouldn’t give them the post-op[erative patients], so usually that has a bearing too.

Q: And so given that scenario, what would you do. Would you buddy up together?
A: Yeah. (Angela RN, Interview transcript, pp. 32–33).

However, in Doris’s opinion, some of the problems with agency enrolled nurses stem from the Agency provider:

… most of the EN problems though stem from agency because they are an unknown quantity and you don’t know exactly what they can and can’t do and that’s more of an agency point of view of not knowing the staff member rather
than being an EN … but also, it takes a while to get to know who your ENs are and what their capabilities are, and I find I am very reliant on the ENs telling me what is happening to their workloads. It is only if I suddenly find that they are asking or there is something that is not quite right that is drawn to my attention that if that happens then I immediately change the allocation and we are both working together … if I have doubts about the ability of the EN that I am working with we will share a double workload and … that way it is my way of keeping an eye on what’s happening. I find that a lot more work to do that … because it means I have to check on them all the time but normally I wouldn’t have done that system in the first place unless I had to check on them so I’m already aware that things are not as good as they should be, so from my point of view it increases my workload and it has to increase my level of vigilance in order to ensure that things are happening like they should be … it also increases the paperwork a lot because it means that I do all the notes then. (Doris CN, Interview transcript, p. 16)

Like Doris, many participants identified working with enrolled and agency nurses as an issue, identifying that their capacity to manage their workloads lay with these nurses’ level of experience and skill. Whether an enrolled nurse was medication competent\textsuperscript{108} or not, and/or whether they were employed by the hospital or agency determined the extent of nurses’ control over how they organised their work:

I actually will go through their notes and their charts at the beginning and at the end and counter sign them and everything. So … if we do get enrolled nurses here, [and] they have not a lot of experience, then I’m set for a rotten shift. (Laura RN, Interview transcript, p. 25).

A perceived lack of enrolled nurse experience and skill was further compounded by the sense of not being able to adequately supervise these nurses due to the geography of the

\textsuperscript{108} Following the completion of relevant in-house education and competency assessment, under the supervision of the registered nurse, enrolled nurses at the hospital were able to administer medications; oral, intramuscular and subcutaneous medications (excluding Dangerous Drugs of Addiction or DDAs) and able to check oral, intramuscular, subcutaneous and intravenous medications. They were not allowed to administer intravenous medications nor were they able to carry the DDA keys.
wards and lack of time to provide support. Nurses felt that they were overseeing the care of a significant number of patients. In responding to changing the skill mix of the hospital’s nursing workforce, the data did not indicate that the hospital gave nurses any further formal training in working in teams or delegation, other than:

... we had some forum here a few weeks ago ... That was about just that, the responsibility for enrolled nurses and their role and how much they can or can’t do. So they’re obviously looking into getting it a little bit more organised. (Laura RN, Interview transcript, p. 28)

Vestiges of past practices, such as counter-signing enrolled nurses’ entries in the patient medical record, remained as nurses adapted to changing organisational employment policies and practices:

A: ... there are still staff that are resistant towards being responsible for the work that the ENs do, um I’ve only become aware of this because on my last shift I asked my EN to put out her notes so that I can sign them and she was surprised that I would do that and I said, ‘Why are you surprised?’ and she said, ‘Some staff are refusing to sign my notes because they don’t see what I do um’, and so that to me indicates that there’s still ongoing problems. (Doris CN, Interview transcript, p. 16)

Confusion surrounding the practice of countersigning enrolled nurses’ notes may have been why staff may refuse to do this:

A: ... look, it’s nothing personal [name agency enrolled nurse], but I’m not going to sign your notes because I have not seen not one single patient, and I haven’t got time to see one single patient, and I can’t go over all that you’ve done, and he said ‘Fair enough’. And I felt very strongly about that. But when I said that, I hadn’t signed the notes, I got told that I had to, but I didn’t. And they said, ‘It’s not legal’, and I thought, ‘Well why are we signing then? So?’

Q: Is there documentation about that?
A: I don’t know. It’s all up in the air, you can never get a straight answer, you get one thing from somebody, and one thing from another, and I just decided, if I wasn’t buddied up with them, I wasn’t signing their notes. I didn’t. So [name]… did and she wasn’t even on duty. How stupid’s that? In a court of law, you would be responsible. There’s just two ways about it. (Lily RN, Interview transcript, p. 22)

There were no hospital policies or protocols in place at the time of data collection that related to enrolled nurses’ documentation in the patient’s medical record. Indeed, legislation does not indicate that this is a practice requirement. Practice is also governed by professional codes and standards. All nurses are personally accountable for the care they provide (ANMC, 2008b). All registered nurses were well aware that they remained responsible for the nursing care delegated to enrolled nurses regardless of how the organisation chose to regulate this. While enrolled nurses are personally accountable for the care they provide to patients, it is the registered nurse who retains overall responsibility. Hence, their reluctance to countersign enrolled nurse entries in a patient medical record without any clear indication by the hospital – in its policies and/or protocols – of what countersigning the notes represents, making for another ‘thing’ to do. Nurses’ resistance to something as innocuous as countersigning the enrolled nurses’ notes was seen as problematic for some nurses in the hospital, the inference being that these nurses were being irresponsible in not doing so. This problem was shaped by arguments about changing models of care, as discussed earlier in this chapter, to a model that increasingly saw fewer registered nurses on shifts and assumptions made about registered nurses’ (and enrolled nurses’) knowledge:

… we went to changing the model of nursing or care, to then get people to, RNs to think that there is now 2 of you for 10 patients, the mindset of the registered nurse was still that they had 10 patients to care for. Didn’t think that the EN was
actually part of it at all. That’s all they focused on. ... The registered nurses couldn’t get their head around it and trying to teach people who are not under par, who was with what I would consider a very good EN, even though junior, to get them to think about splitting those 10 [patients] and run 1 [nurse] to 5 [patients] with you [registered nurse] overseeing, they couldn’t get their mindset around that. Very fascinating. And whether or not that was because of their insecurity, which I think the majority it was. It’s like, well how can I trust somebody? Well you have to learn to trust yourself in your own skill before you can trust somebody else. They couldn’t see that ... So to be able to then trust somebody whom you’re meant to be responsible for, and they always couldn’t differentiate between accountability and responsibility, they struggled, some struggled with that, was difficult with the ENs being introduced. Yeah. (Anita Nurse Unit Manager, Interview transcript, p. 17)

As a matter of fact, nurses did “get their heads round it”. They were cognisant of their professional and legal obligations. Nurses’ issues were structural; they related to the nursing skill mix allocated to the wards in light of patient numbers, acuity, turnover, and business expectations – in short, nurses’ workloads. That said, nurses were not prepared to compromise their standards or those they considered central to the hospital’s mission. Australian Nursing and Midwifery Council ‘Code of Professional Conduct for Nurses in Australia’ states that nurses are to practise in a safe and competent manner in accordance with the standards of the profession and broader health system, and conduct themselves in accordance with laws relevant to the profession and practice of nursing (ANMC, 2008b). It was this perceived shifting of standards coupled with a lack of consultation with nurses working on the wards about staffing numbers and/or issues with managing numerical and functional flexibility that was a source of tension for them:

... what happens is you just look at the [allocation] book and they’ve [nurse managers] written down whoever, whatever it is that’s going to be on for the
afternoon. It’s not, ‘Well what do you think you need or you know, what do you think, what’s this and what’s that and what are your staffing requirements for the day do you think? Have you got any special issues of, you know, that mean you need more staff than you think? Or in fact, do you think that you can make do with less? ... do you think you’d be alright until someone came on and then just have a 4 [pm] to 8 [pm]?’ Yeah, that would be great. So it wasn’t that we also hadn’t been prepared to give back the other way, because we most certainly have. But as I say, now it’s, no one says anything and it’s almost like the hospital coordinator scuttles in and sort of writes something down, then scuttles back out the door again ... it’s gone from a consultative sort of, ‘What do you think? Yeah this will be okay. Yea, everyone happy? Okay’, to, ‘This is it’. And not even this is it, it’s just nothing said and you just sort of look and discover for yourself what’s going to happen. So, umm and then chase [the nurse managers] if you’re not happy. (Linda RN, Interview transcript, p. 20)

Whether or not consultation about staffing issues occurred, as noted previously one way managers could manage the nursing hours was with the use of varying shift lengths to accommodate shortfalls in staffing establishments, increase productive hours, and/or reduce the nursing hours when the wards were quiet. As I have argued throughout this thesis, changes to nurses’ working time were not limited to nurses employed on casual contracts; they extended to those employed on full-time and part-time contracts. Nurses were not necessarily working their contracted ordinary or ‘standard’ hours; “all times of the day or night are now considered ‘standard’ working time” (Beynon et al., 2002, p. 248). In my conversations with nurses, the use of this strategy to manage nurses’ work time was met with a mixture of responses:

We used to have a lot of 7–11s, ages ago. ... but really it’s the 9–12 where you think people are coming and going that you need that help. (Sandra RN, Interview transcript, p. 9)
... half night duty shifts ... that was a real bummer. (Joan RN, Interview transcript, p. 2)

... I thought that was a very bad way to do things, bring people in at 6.00 [pm]. … On the other hand it’s better having someone come on at 6.00 [pm] eh, than no-one. (Lily RN, Interview transcript, p. 7)

This strategy, as an approach to reducing the nursing hour or labour costs, often left nurses ‘babysitting’ patients. Nurses used this term to describe the times they spent caring for patients that were not ‘theirs’. Nurses understood the many reasons why this may occur, such as sick leave or unavailability of agency staff:

... sometimes they [managers] do throw around [numbers] and say, ‘Do you think this is feasible?’ and often I will say, ‘Yes, that sounds feasible because I know you’re looking at the money cost and staffing accordingly’ … there are some shifts that aren’t staffed very well and that could be for a whole lot of reasons due to late sick leave, you can’t get any agency staff. (Angela RN, Interview transcript, p. 11)

Nevertheless, for whatever reasons managers put forward as to why some shifts were staffed they way they were, nurses begrudged babysitting patients because this added to their workload:

I just used to get angry when we’d get left holding the baby for 4 hours until somebody came on at 6.00 [pm]. (Lily RN, Interview transcript, p. 4)

A: Probably till 6.00 [pm] has been the latest I’ve had to babysit, so we’re looking at 3, 4, 5, 6–3 hours, and that can impact terribly on your workload, and then particularly if they’re [nurse] coming in at 6.00 [pm], you will have most likely have done their pre-tea observations, because we do them about that time, and their drugs … I really hate, if there’s no-one to cover, and sometimes … I just think, ‘Stuff it, I’m not going to do it’, because time wise, you can’t.

Q: So, is there an expectation that you’ll do the 6.00 [pm] medication and obs or
not? If you’re babysitting a patient?

A: I think there is an unwritten expectation because we’re nurses ... (Angela RN, Interview transcript, p. 30)

Managing nursing working time by demanding that nurses ‘babysit’ patients for a period of time diminishes the value of caring work for the hospital. The Oxford Dictionary of English (2010) defines the verb ‘babysitting’ as “to look after a child or children while the parents are out”. Using this term to describe nurses’ work reduces that work to no more than ‘minding’ patients as one would a child; an assumption being that nurses may only have to go and check on these patients and that care is limited to “just answering bells”109. However, the reality in practice is that nurses are carrying an increased, and at times significant, workload:

... we often babysit patients until staff can get on later in the shift ... and therefore we handover [to] them as well, there’s lots of communication between us usually ... you can come on to a shift and be allocated your workload and possibly up to 3 or 4 of somebody else’s who ... we start at 2.30 [pm] and they may be coming on usually at 6 o’clock [pm] um for a short late shift so we’d look after their patients, answer bells, give medications ... do observations, do whatever they need until that time so those 4 patients is added on to your workload.

Q: ... you’d be looking after how many patients when that occurs?
A: ... well I guess if you’re given 6 or 7 patients, yeah, that would take you up yeah to 10 or 11.

Q: And does that add to your workload?
A: ... it can do, hopefully they would have allocated ... some of the easier patients ... but that’s not always the case and yes it can add a lot of stress ... depending on what type of patient it is, if it’s a new surgical patient that’s having trouble with nausea or ... whether it’s a confused patient or palliative care or something ... that can prove quite busy yeah ... during the day they would do ... 7

109 Lily RN Interview transcript, p. 6.
till 11 or 8 till 12 yes … usually they do all the morning care for a patient, and just hand over to you at lunchtime so … some of their patients may have gone home and that happens sometimes but … otherwise yes the staff remaining on the ward have to pick up those patients. (Yvonne RN, Interview transcript, pp. 13–14)

Interestingly, nurses themselves make assumptions about what constitutes their work and just what has to be done for when the next person comes on duty – irrespective of time assigned – such as observations and medications. A business management discourse of ‘flexibility’ in the workplace, associated with changes in skill mix and an expectation of delivery of the ‘excellent care’ for which the hospital was known, made for strong feelings of acrimony for nurses left ‘holding the baby’. Lily describes her frustrations:

A: Well, it happened to me a lot because I worked a lot of lates, and [nurse] used to come on at 6.00 [pm] because she had children. Somebody else used to come on at 4.00 [pm] that’s no problem, really, you know, by the time the morning staff leave, that’s an hour, that’s answering bells, that’s nothing. But till 6.00 [pm] is a different thing. They need care. You’ve got tea break to cover, you’ve got patients going to and from theatre. One day, there was only 2 of us actually on the ward, until she came on at 6.00.

Q: So, how many patients?

A: … it must have been about 18 or more, perhaps we both had 7 each and she had 5 or 6 when she comes on. Well, that’s hairy, when one of you is in recovery and when you take someone to theatre and they take 15 minutes to come and take over from you, and you’ve left someone back at the ward on their own, with the Ward Clerk. You know, and that is, and I don’t see why we should have to look after 9 patients and go through 9 lots of notes, and sometimes, by the time that person came on, you hadn’t even caught up with what you were doing for your own patients. Yet by the time each, if you took over from 3 morning girls, quite, depending on who they were, quite often they’d leave all the 3.00 [pm] things for you. Quite often they’d say, ‘Oh, I hadn’t had the time to take the tray out, can you do it?’ They seem to have this conception that you know, that you had more
time than they did. So, by the time, and then certain girls, just used to omit things. So by the time you’ve checked up whether the antibiotic and Clexane\textsuperscript{110} were given at 2.00[pm], and they weren’t and you gave that, and took a couple of people to theatre, you haven’t even gone through your notes at 5.00 [pm]. You haven’t got time to go through her [patients] as well. ... I hated it. And then she gets on at 6.00[pm], and she’s got to get handover, and she’s got to get her head together, and no-one’s been to tea. (Lily RN, Interview transcript, pp. 6–7)

While accommodating some staff personal preferences so they can “come on at 6 [pm] because they have children”, the organisation’s flexible working time practices have implications for others such as Lily and some of her colleagues who experience work intensification in that time. In response, some nurses are choosing not to finish tasks that are allocated. As an After-Hours Coordinator reveals:

\[...\] there are a number of them[nurses] now who I think are just being very proactive in their management of their load and just saying well now I will just have to say to the morning staff I have not been able to perform this task. I have not been able to physically do this, my workload has been such that I could not achieve that but I know that they do that with a sense of, I would have much rather have completed my work, or I don’t like leaving, nurses don’t traditionally like leaving unfinished work. We are told that that’s what we have to do, that, we sometimes can’t achieve what we would like to do, that, that’s the way um that you just have to be able to be prepared to hand things on, but we’re all very conscious that each task we hand on to another shift means that that burdens that shift just that much more.

Q: And who would say that about leaving things? Is that actually said?
A: I think it's an inference. (Rosemary After-Hours Coordinator, Interview transcript, p. 25)

Whether or not the term ‘babysitting’ is used in my fieldnotes and interviews, I record

\textsuperscript{110} Medication used to treat blood clots, to prevent blood clots forming after an operation, during hospitalisation or extended bed rest. It is administered by injection under the skin usually daily.
the many instances where nurses are managing patients and indeed the hospital for short amounts of time across, and at either end of, shifts. The ‘flexing’ of nursing hours up, down, and across shifts as an organising strategy to ensure the flexibility needed for the hospital’s efficiency and productivity demands led to work intensification for nurses; intensification due to constant interruption of their working time due to fluctuating patient occupancy and/or nursing hours. Like the nurses in Waterworth, May, and Luker’s (1999) study on “clinical effectiveness” in nursing, the nurses in this study also aspire to not having their direct work with patients interrupted. Interruption is unremarkable for nurses – it is part of the job, a given – but because nurses do not deal with individual patients but groups of patients, patients’ individual needs are easily subordinated to organisational goals. While nurses deploy the notion of interruption, as discussed in Waterworth et al. (1999) and others (Allen, 2001; Gaudine, 2000; Latimer, 2000) in terms of nurses’ responsibilities to prioritise particular tasks, in this study what makes for interruptions to nurses’ work is the fragmented temporal organisation of their working time (Waterworth et al., 1999). The following extract from my fieldnotes highlights just how fragmented nurses’ working time can be as I describe one morning staffing configuration with staggering of work start and finishing times, and one nurse’s movement between roles/positions:

Staffing this morning is interrupted ... there are five nurses rostered to work on Ward B. Of these, one RN is to commence work at 0900, and will then be off the ward from 1000–1100 for ‘Emergency Training’. CN Oncology will commence her shift on Ward B from 0700–0900 and then remainder of her shift in Oncology unit. An EN is working a full shift [7.5 hours]. The CN Ward B is also rostered to work, however she is on a “management day” – that is, where she will not be doing any clinical work, busying herself with administration work – and Doris, who is rostered for a full shift. Doris is the CN Ward A and is relieving on Ward B this morning. She is allocated as “TL” for the shift and has a patient load:
initially caring for patients of the RN who is starting at 0900 then later will take over from CN Oncology, caring for those patients when this nurse leaves the ward at 0900. Doris will also supervise/be responsible for EN’s patients and drugs. Number of patients on the ward this morning is 13. Of these, there are three that are new admission. Two at 0715, one at 0830 all for theatre this morning. There are two expected discharges ... At morning tea, Doris and I sit together, going through my notes ... We discuss the morning’s work, and more particularly staffing. She acknowledges that this has been very much an “interrupted morning”. Much of that interruption because of ... inconsistency of staffing with nurses starting and leaving the ward at various times and made “harder, [as she] did resource [Hospital Coordinator] for an hour”. Not only was staffing “interrupted” but also the skill of the staff rostered on this morning for Doris was an issue, as one of the nurses was an enrolled nurse. (Fieldnotes #27, pp. 1, 16)

This is not unusual for nurses working within the context of this hospital. A glance at the ward’s *Daily Allocation Sheets* indicated just how few shifts were not adjusted in some way to ensure that nurses’ work time was closely matched to the structure of patient demand. The above extract shows that whereas the organisation’s work is made up of a series of financial flows at an administrative level – budgets, cost centres – nurses’ work is not a ‘flow’ but a set of disjunctures or disconnections made into a ‘flow’.

**Sorting out the work**

Nurses provided some detailed descriptions of how they went about sorting things out (Bowker & Star, 2000). As we will read in the next transcript, nurses classify their work as “really heavy” or not, and nurse-to-patient allocations are determined by “who is best suited to look after each patient”, again in light of the geographical restrictions of the ward and a consideration for their colleagues’ welfare:

I try to do the allocations … so that I can see who is best suited to look after each
patient, but there are geographical … restrictions because of the way in which the wards are spread out and so unfortunately in order to keep the walking distance down often patients are allocated, they’re all in one area rather than on what their needs are, and that’s not a very good way of staffing and allocating but sometimes we have to do that. I try to keep consistency so that people are looking after the same patients all the time unless they’re really heavy, then every couple of days I will shift them into another area so that they’re not always lifting the same patients but the difficulty lies we’re now at a stage in our ward well, we have several palliative patients and several heavy ones that it doesn’t matter where you get allocated you will always end up with some heavy patients. (Doris CN, Interview transcript, p. 10)

While nurse-to-patient allocations will be determined in part by the skill and experience of the nurse, the above excerpt shows that the geography of the ward is what determines allocation. It has little to do with patient acuity, as we have read in Chapter 7, and it is not always possible to avoid having “heavy” patients; “no matter where you get allocated you will always end up with some heavy patients”\textsuperscript{111}, that is, patients who will need two nurses to help them. In this scenario, while a nurse is allocated to care for these patients, no matter their skill and/or grade, two people will always be required to provide care or, to put it another way, it will not matter who is caring for these patients. In sorting themselves out, nurses will look beyond the skill and/or experience of an individual to care for patients, with allocations determined also by the nurse’s “personality”; ideally, they would be someone “that was reliable or who would help”:

... other thing that we try to do, which didn’t work very successfully, is that if you knew your workload was going to be harder and obviously dependent on the type of team whom you were working with, try to then say to the next person, well look I know you’re going to be a bit quiet tonight, such and such is going to be a bit busy, I’d like you to give her a hand. They couldn’t really, some could, some

\textsuperscript{111} Doris CN, Interview transcript, p. 10.
can depending upon the nurse, would go and help and offer. Others don’t. And that would happen. So, part of my allocation ... was about who was on. So if I knew that, you know, X block of work was going to be heavy, I would make sure that a person who I know is reliable or who would help would be closer to that person with the heavier workload.

Q: And that would be part of your allocation?
A: And that will be how I would structure my allocation as well. So you had to take in the personality of the clinician as to against who would care for X amount of patients. (Anita Nurse Unit Manager, Interview transcript, p. 14)

Nurses put a lot of thought into allocating patients, taking into account not only the skill and experience of individual nurses but their ‘personality’ as well as the geography of the ward. While patient intensity or acuity is undoubtedly taken into consideration when allocating nurses to patients, it did not order how nurses’ work was done. It was the hospital’s flexibility practices that ordered nurses’ work and increased the work intensity for nurses who remained committed to the caring ethos of the profession as well as the hospital’s mission.

**Handover**

Nurse-to-patient allocations order nurses’ work, but it is in nurses’ handover practices at each change of, and throughout, a shift that allow nurses to further sort themselves out to get through their allocated workload. Nurses’ working time is represented not only in their ‘nursing hours’ but also in nurse-to-patient assignment or allocation documents held on the ward, those held by administrators, nurses’ rosters or scheduling formats whether computerised or hand-written, in nurses own ‘scraps’ of paper, and in the ubiquitous handover sheets. The data highlight nurses’ handover practices and many instances of nurses handing over their work. Nurses order ward life through nursing handover as they classify or ‘grade’ patients and their care. It is handover that “relays
to nurses not just what aspects of the patients and nursing work have more significance than others, but *how significance is accomplished*” (Latimer, 2000, p. 31). In Laura’s words:

You look at your calibre of patients and you grade them immediately from handover onwards, you grade them. And that grade might change during your shifts but they’re all graded. And I have a picture, what every patient is going to require from me as a nurse, from very little to a lot. And so I prioritise the workload around that. I might find that with one patient I will need somebody else to help me, so I immediately talk to the person who works next to me. What is your workload like and when will you be able to help me? That would be probably the first thing I have to organise. (Laura RN, Interview transcript, pp. 12–13)

Varying shift lengths make handover a report that is not simply limited to the standard change of shift time. That is not to say that the rosters/schedules are not configured around these ‘standard’ times, but with nurses’ work time being constantly manipulated to manage the nursing hour, handover was a practice that occurred throughout the day and night, and also served as a source of industrial regulation.

Much is written in the nursing literature about what occurs at handover, what is said or not said, handover styles, whether handover occurs in an office, tea-room, or at the bedside, as well as handover methods such as whether it is written, taped, or spoken (Allen, 2001; Anderson & Mangiano, 2006; Cahill, 1998; Lally, 1999; Lamond, 2000; Latimer, 2000; Parker, 1996; Sexton et al., 2004; Tucker, Brandling, & Fox, 2009; Webster, 1999; Wiltshire & Parker, 1996). Care plans have been proposed as references during handover and as replacements for it (Clemow, 2006; Wallum, 1995). While change of shift handover is regarded as pivotal for the continuity of patient care across
shifts, some authors such as Sexton et al. (2004) have questioned whether this practice is “really” needed. They argue that the majority of information presented in handover could or should be available in formal organisational documentation sources; medication charts, nursing care plans, and patient medical records. These authors advocate for the development of concise guidelines regarding the process and content of handover, arguing that these would reduce the amount of unproductive time spent on this task “by ensuring that only essential information is ‘passed on’”. (Sexton et al., 2004, p. 42). Reasons put forward as to why handover may not be required include a lack of a formal structure compounded by a lack of guidelines for nurses giving the report and that the information presented is irrelevant, repetitive, speculative, and/or contained in other information sources, thus rendering the time spent on handover as wasted (McKenna & Walsh, 1997; Sexton et al., 2004). Others have noted that handover is a much more complex phenomenon than simply communicating clinical information. It involves elements of socialisation, debriefing, containment of anxiety, and ritual (Evans, Pereira, & Parker, 2009; Kerr, 2002; Manias & Street, 2000; Parker 1996; Wiltshire & Parker, 1996).

In both the observational and interview data – watching nurses sort themselves out in their work and talking about nurses’ work organisation strategies – it became apparent that nurses used handover, or the practice of handing over, as a dominant organising strategy. As Emma says:

I don’t think you can start a shift without it. It’s just, it’s ingrained in nurses I think that we have to have a handover. And it is essential to highlight any problems, so, yeah. (Emma RN, Interview transcript, p. 31)

And
... a good handover is important because it gives me a general idea where the trouble spots are, who is not very well and who is doing quite okay and is a bit the norm. So in handover I already prioritise certain patients that I want to have a look at first off because I’m not very happy with the way they’re going. ... yeah, it gives me a general idea what my work is going to be like, that sets a little bit the, the scene as it were. (Laura RN, Interview transcript, p. 9)

While these nurses refer to handover as the change of shift report, from my observations handover was a constant; it was certainly not an occurrence confined to change of shift report time and occurred across all levels of the hospital’s organisation. Nurses hand over to each other numerous times throughout their shift, bearing in mind that for some nurses their scheduled/rostered shift may be short – a minimum of three or four hours. Occasionally, nurses may work their rostered hours as split shifts, and where nurses are ‘relieving’ from other areas of the hospital to cover meal breaks, for example, their time spent on the ward is calculated to the minute.

In my fieldnotes, I recorded handover as being taped or spoken. Some nurses will tape, others do not or will not. Why some will not tape handover is never explained. Certainly, in my fieldnotes, I recorded the many occasions when taping did not occur, often attributed to the busyness of the ward. Then there are the many quick handovers with Nurse Unit Managers and the After-Hours or Hospital Coordinators – although the length of time spent on this varies – and numerous ad hoc handovers, such as those to cover meal-breaks or where nurses are taking patients to and from the operating theatre suite. Quite some time is spent handing over, with data collection marked by nurses’ use of ‘handover sheets’, also referred to as ‘cheat sheets’ or ‘task sheets’.

Some nurses will use these sheets. Others will not:
People … have their little cheat sheets and things I don’t think I’ve used one ever since I’ve been here. (Mary RN, Interview transcript, p. 13)

Yeah, and if I haven’t got it, it’s yeah, disaster. Oh, not disaster, but you know, it’s like my security blanket. Yeah. (Angela RN, Interview transcript, p. 27)

Some nurses will use both sides of the page and write copious, detailed notes; others will write very little. Nurses may make use of only one sheet, being the one prepared by the Ward Clerk or by the team leader of the outgoing shift in the absence of a Ward Clerk – document titled ‘Daily Sheet – Dependency Sheet’. Others will go on and draw up a second sheet by hand or print off from the template document held on the computer. This sheet, with additional information noted as information that comes to hand during the period of time a nurse spends on the ward, serves as the principal source of information for all nurses’ handovers and for recording patient care in the medical records and/or ‘blue folders’. The blue folder is a plastic, blue coloured folder that holds nurses’ charts or records and is separate from the patients’ medical record. Some nurses see these sheets as no more than a shopping list; a checklist.

There was nothing ‘scrappy’ about these pieces of paper. This was a carefully crafted document, prepared for nurses to use. Its preparation was regarded as part of the ward’s organising work and, for many nurses, organising their work depended on organising these ‘sheets’. The “scraps” (Hardey, Payne, & Coleman, 2000) that nurses used – paper towels, small bits of paper – to record information only saw nurses transfer this material to their ‘sheets’ in readiness for handover, to care plans, and to the patient’s medical record. Watching these ‘sheets’ and how nurses used them to organise their work featured heavily in fieldnote writings, which reflect nurses’ organising work around

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112 Sandra RN, Fieldnotes #20, p. 4.
time and the tasks they had to do.

Nurses constantly handled their handover sheets and blue folders during the course of the day as they sorted themselves out. An extract from the fieldnotes describes how Doris used her sheet to organise her work:

*Doris’ sheet is not overly different to that of the other nurses. It is filled with abbreviations, medications names, written in full are noted ... the times that medications are due for administration are noted in more detail than the other nurses as are patients’ medical conditions or previous surgical history. ... she writes on her sheet in one colour only – blue biro – nothing is highlighted using highlighter pens or different colours or any other indication of what may be considered to be of importance. What she does do is use codes. Asking Doris about this, she explains, a “w” next to patient names means “to do wash”, “OT” though self explanatory would indicate that a patient is for theatre ... For Doris “OT” next to a patient’s name means “get them ready for theatre”. Finally a tick, “✓” means that she has “actually finished them” [attended to patient’s care]. With regard to medications she explains that the medications written down identify “who, what and [that] they’ve been done” ... she “always writes abnormal never writes normal”. ... “if anything abnormal will always write that down on my sheet”. She says, “that’s my additions, I should say in the morning when we have handover I write down what they [nurses] tell me” – that is, what is reported by the nurses on the previous shift. “Although sometimes it’s all running in my head rather than somewhere else”. (Doris Clinical Nurse, Fieldnotes# 27, pp. 5–7, 16)*

That *somewhere else*, be it in nurses’ handover sheet, care plans, and/or patient’s medical records says much about the elusiveness of being able to capture nurses’ work (either textually or arithmetically). In the case of the handover sheet, it is shredded at the end of a shift and lost, thus contributing to the (in)visibility of nursing work.
The loss of these sheets is of concern for nurses, for example, one nurse “feels lost, unorganised” without hers and Angela tells how:

A: (Laughs) I kind of feel I am renowned for placing them in places and finding them half way through the shift. Sometimes if I really can’t find it, I will write another one out. And once again, I think that goes, no, I like writing it out. I was saying if I lost it, yeah, I usually do have to go and do another one. Because I think it’s stupid but I think it’s like my little lifeline to what I’m like doing, and that, obsessiveness of having to cross things off when I’ve done them. So at the end of shifts, sometimes I haven’t even crossed off because I know what I’m doing. But yeah, no, I, yes, it’s a need for me, that I’m lost without it. So it’s a funny thing. (Angela RN, Interview transcript, p. 26)

Nurses’ concern with losing their handover sheet not only takes into account the amount of time spent turning it into a useful and meaningful document (Allen, 1998; Hardey, Payne, & Coleman, 2000) but also relates to patient confidentiality. The risk of potentially breaching legislative and hospital privacy rules sees nurses being careful about what sort of information they write:

Q: … What sort of information do you note on that sheet?
A: Very basic information. …if they have an intravenous going, they’ve got an indwelling catheter in draining … if they’re incontinent, if they’re not for resus[citation]. So very, very basic.
Q: Right.
A: If somebody hands over …this is stroppy patient or a very demanding patient, I do not write those things down. The chances of losing those bits of paper are always there and I do not want anybody to see that kind of remarks on my bit of handover paper. It’s bad enough that somebody could see a list of all the people that are on the ward on that particular day. (Laura RN, Interview transcript, p. 10)

Indeed, hospital inpatient listings were not on public view. All documentation pertaining to inpatient management was retained in a folder held at the nurses’ station
desk that was accessible to nurses, doctors, and allied health personnel only. This A5 ring-bound folder contained the ward’s ‘Daily Sheet – Daily Roster’ and replicated the ‘Dependency Sheet’ in terms of patient information. In addition, it held the names and shift start times of the nurses rostered to work for the day. Nurse-to-patient allocations were indicated on this document. The hospital did not use bed or name cards at the head or foot of patients’ beds, nor were cards used outside patients’ doors. When looking for patients, doctors and allied health personnel would either ask at the desk and/or refer to the documents themselves to find a patient’s room.

Organising the text and handing over

Organisational texts, whether job descriptions, the hospital’s ‘Annual Review’, what is written on a whiteboard in the Admissions Office, or handover sheets all contribute to organisational processes. This section explores how something as ordinary as nurses’ handover sheets, as a particular type of text, perform in ordering nurses’ work. The sheet I describe below was taken from a period of participant observation during an evening where I followed Lily, a registered nurse, through to the end of her shift. Lily is caring for six surgical patients, all post-operative. Her workload for the shift consisted of two patients who had undergone major uro-gynaecological surgery that afternoon. She was also caring for a patient who had had their varicose veins done that evening. One patient was a day post-operative following sinus surgery. The other two patients were a couple of day’s post-operative, one following a total knee replacement and the other breast surgery.

Lily’s handover sheet was photocopied at 2000 – when I came on – and again at 2200 before she was to handover her shift. At 2000, the sheet was noticeably different, a lot less ‘filled-in’ than the document used to tape the change of shift handover at 2200.
Nurses use these sheets to organise work around the time work is to be done. It is these sorts of things that are handed over; what nurses consider important to hand over. In other words, what nurses need to know or what they think their colleagues need to know about the time of the tasks they have to do. The handover I received when I came onto the ward at eight o’clock that evening was different in that it was filled with Lily’s more personal view of her patients. One patient was described as a gem while another was not catching onto anything, referring to a patient being unable to perform post-operative exercises. The extract from my fieldnotes below describes some of my reflections and from the outset it structures Lily’s work. The sheet is structured as a grid with eight columns across the top with headings that indicate the patient’s room number, new admission, diagnosis, age, admit date, doctor, current length of stay abbreviated to ‘Cur LOS’, and a large space for comments. Rows counting down indicate patient room numbers, including the CCU beds. Reading Lily’s sheet, I note:

One of her patients is hand written in, all the others are typed, I expect this sheet was printed off the computer prior to the ward being made aware of this admission. Again, what is noted has very much a clinical focus – wound care, types and number of drains, amount of drainage and medical conditions. Lily notes that 2 patients in the ward are “deaf”, another is “NIDDM” [diabetic], and one also suffers with “chronic back pain”. Lily notes any post-operative complications such as deep vein thrombosis “DVT” and who is for theatre that afternoon ...

Some of the notations are extremely brief, limited to an indication whether a patient is for theatre or has returned, for example “OT” was written for 3 patients on the ward and nothing else. Of her allocated load, Lily notes for one patient “OT 1345. Survac IVT”. This patient returned to the ward from theatre at 1345; has wound drain and intravenous therapy. Another patient has “Ad 1600

113 Lily RN, Fieldnotes #19, p. 1.
114 Lily RN, Fieldnotes #19, p.1.
115 Type of wound drain
“OT” jotted down next to their name. This patient was admitted at 1600 for surgery later that evening. Again, what emerges is this notion of time, perhaps less specific to what is written on the back of the page, certainly in terms of organisation of time for care, a broader overview of what is happening in the ward, but time nevertheless. Time ... when a patient has returned to the ward, or when patients are due for discharge “?D/C in am” or noting patient’s admission time “Admit 1600 OT” is recorded.

... patient’s age is noted, again a discourse of time. ... “Admit Date” and “Cur LOS” ... Under the “Cur LOS” heading, time is constituted as the number of days a patient is in the ward for. The days range from zero, being day of admission and often the day of surgery for the majority of the patients admitted to the ward. On this particular day, 11 patients had been admitted and gone to theatre that day. Five patients were a day post-operatively, seven were two days post-operatively, two were day six, one day nine, one a day 16, 1 patient was day 25 and one had been an inpatient for 146 days. (Fieldnotes#19:10 – 11) An analysis of the reverse page of ‘the sheet’ I photocopied at 2000 o’clock and again at 2200 shows what sort of information is noted and added in a two-hour time period.

The page is neat. There is some crossing out or scribbling, but overall neat (see Figures 8.1 and 8.2). Lily categorises her work around three aspects of care – observations, (Obs), medications (Meds), and handover (H’Over). The sort of clinical information included in these categories varies from what medications the patient is taking and/or is due to take, to management of wound care, and noting the type and amount of loss, if any. Observations are recorded for temperatures, Blood Sugar Levels (BSL’s), and oxygen saturation levels (Sat O2). Medication administration times are noted, for example the administration times for various intravenous antibiotics are due at midnight and six o’clock in the morning. There is “Clexane stat 0100”.
Figure 8.1 Handover sheet at 2000

<table>
<thead>
<tr>
<th>Obs</th>
<th>Meds</th>
<th>H’Over</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td><strong>NP, 1600</strong>&lt;br&gt; OT?&lt;br&gt; 1/24 →</td>
<td><strong>RTW</strong></td>
</tr>
<tr>
<td>101</td>
<td>QID</td>
<td>Prn</td>
</tr>
<tr>
<td>118</td>
<td>OT.&lt;br&gt; RTW.&lt;br&gt; 1645 →&lt;br&gt; 2045</td>
<td></td>
</tr>
<tr>
<td>119</td>
<td>QID</td>
<td>1800 [line through]&lt;br&gt; 2200</td>
</tr>
<tr>
<td>120</td>
<td>1/24 → 1745&lt;br&gt;&amp; once.</td>
<td></td>
</tr>
<tr>
<td>121</td>
<td>BD.&lt;br&gt; 2100</td>
<td></td>
</tr>
</tbody>
</table>

Figure 8.2 Handover sheet at 2200

(Fieldnotes #19, pp. 8–9)

---

<sup>116</sup> Refers to use of the Continuous Passive Movement (CPM) machine. It is used in the immediate post-operative period following knee surgery to gently flex and extend the knee joint with the aim of minimising joint stiffness, reduce inflammation and pain. The surgeon prescribes the range of motion, speed and duration of usage. Two people are required to handle the machine as it can be quite heavy and awkward to position in the bed.
The sheet highlights how time governs nurses’ work, for example the time observations are due and how often these are to be done, with time abbreviated to ‘QID’ (four times per day), ‘BD’ (twice a day), and ‘1/24 → 1745 & once after that’ (hourly until 1745 and one more time after that being 2200). Hourly until quarter past midnight, recorded as ‘1/24 → 2415’, makes for less time spent writing ‘things’ down.

While Lily used her sheet extensively, other nurses did not use their sheets as much, if at all. Reflecting on my fieldnotes, it was only after observing one of the nurses, Sandra, that handover, and particularly the handover sheet, came to be ‘watched’ more intently. In my fieldnotes I record how this nurse used her sheet differently to the ways other nurses on the ward used theirs – she did not use one. I do not know whether that reflected this nurse’s professional expertise (Allen, 1998) or that she was simply blessed with an excellent memory, but she did not appear to rely on her sheet to organise and manage her work as some of the others had done. This left me reflecting on the importance of the handover sheets as one of nurses’ organising strategies.

Fieldnotes show that a nurse’s handover sheet is very much a crafted, idiosyncratic, personal text – filled with abbreviations, codes, and/or marked with different coloured pens. This text may be very prescriptive or contain the barest of detail. Nurses will work with it, using it as a running task sheet when buddying-up with enrolled and/or agency nurses. This rather mundane text is central to how nurses sort themselves out to ensure continuity of care. Nurses’ discourses of ‘care’ are inscribed in something as ordinary as a handover sheet.
**Conclusion**

The implication for nursing is this. Attempts to reduce nurses’ working time, or ‘nursing hours’ at an industrial level by reducing the wasting of time in ‘handover’ have led to the demise of the ritualised handover practice of giving a ‘report’ (Evans, Pereira, & Parker, 2008). The ritual escapes, as it were, in the many instances where nurses are handing over their work as part of the seamless blend of the way they organise their work on the unit. While allocation achieves organising in one form, handing over – to another nurse about a patient, to another nurse about a unit or hospital – is another form of organising that disappears through managerial processes, or industrially through enterprise bargaining, only to resurface in other more distributed and less centred locations and practices.

Nurses’ handover sheets are a textual tool that order the activities of nurses, by nurses, “(pre)organising” (Winsor, 2000) their work from moment-to-moment, hour-by-hour, shift-by-shift, and indeed from one day to the next.

This chapter has outlined the strategies adopted by nurses within this hospital to manage rostered working hours to ensure that the programmatic aims of the business are met. Nursing’s hours make for a “calculable space” (Miller, 1992), linking the hospital’s financial performance to nurses. The focus on ‘nursing hours’ emphasises their role as a technology of government that gives nurses “spheres of discretion” (Miller, 1992, p. 77) about how they manage their work. As management subtract the nursing labour cost in their accounting practices, nurses manage their work by changing understandings of care delivery modes. Changing staff skill mix, limiting ‘handover’ time, and ‘flexible’ working practices shape and (re)configure the nursing hour. Nurse-to-patient allocations
are sorted out by taking into account the nursing skill mix, by ‘buddying-up’, and by ‘babysitting’ patients. Handover and nurses’ handover sheets emerge as a space that shapes nursing knowledge in this context. It is a space that also protects nursing knowledge. In terms of governmentality, nurses’ handover practices may be considered a point of resistance to accounting and formal nursing documentation technologies. In restricting time of, and/or for, handover through flexing ‘hours’, the requirement for handover seeps into other moments where care for patients requires communicating with other nurses.
CHAPTER 9
CONCLUSION

… is not what was “meant” … it is not what has remained silent … [but where] discourse is constituted by the difference between what one could say … and what is actually said. (Foucault, 1978, p. 18)

As I begin this chapter by once more quoting Foucault, I think about ‘what is being said’ in the thesis. My goal in this study was to consider what it is to work in private healthcare if you are a nurse, by examining the kind of thinking or mentalities that nurses working in this sector draw upon. In the process, I have endeavoured to extend understandings of the organising work that nurses do, as I consider the discourses that govern their work. Throughout, I have exposed how discourses of business management or enterprise are far more extensive in nursing in the private healthcare sector than currently reported.

An understanding of the context of nursing, its issues, debates, and the discourses used to shape knowledge about nursing and its ‘problems’ are central in this thesis. The constitution of nursing as a labour force for governing through enumeration of any kind dominates representations of the workforce in the academic and professional literature, and in parliamentary documents. Specific understandings of nursing as a workforce in ‘shortage’ underpin discourses about the profession. Government programmes centre on “bringing nurses back into the workforce” (DoHA 2010a) as the uncertainty of a sufficient nursing workforce presents difficulties for governments, employers, and the profession alike in determining how many nurses are needed for care delivery. The profession’s response to economic issues of supply and demand as a measure of nurses’
work is to justify nurses’ worth to the health care system, as understood in official statistics and epidemiological databases as well as models of workload measurement and classification systems for nursing practice. Yet nurses in this study did not talk about shortages as such; theirs was another discourse altogether. This is not to say that there was not some talk about ‘shortage’ or being ‘short-staffed’, or indeed being part of an “an ageing breed”\textsuperscript{117}. However, these were not the discourse that nurses were privileging. Their talk lay with the business of managing care with regard to their working time – ‘nursing’ hours. In this final chapter, I discuss the findings of the previous chapters, which indicate that nurses’ care ensures business success. Finally, I discuss the implications of this study for healthcare policy and organisational governance as well as for the profession. I also consider some of the limitations of the study and make suggestions for further research.

**Re-imagining nurses’ work: ‘nursing’ hours and the business of care**

In the preceding chapters, I have explored the business of nurses’ work in relation to neo-liberal governmental rationalities in which “to govern better, the state [is to] govern less” (Rose, 1999b, p. 139) and where “the fulcrum of governability [is] financial” (Rose, 1999b, p. 151). In this thesis, nursing ‘care’ is a technology of government in a neo-liberal political rationality of private healthcare, which is premised on minimal state intervention to protect the ‘free’ market and individual choice. Rose (1996) argues that this plays out in practice through ‘devolution’ of regulatory functions to quasi-governmental organisations such as the ANMAC, and in the codification of standards. Neo-liberalism as a form of government is also associated with a mode of citizenship that sees individuals as “actively responsible” (Rose, 1996, p.57), fulfilling their

\textsuperscript{117} Emma RN, Interview transcript, p. 35
political obligations to the “health, wealth and happiness of the nation” (Rose, 1999b, p. 166) through a variety of micro-moral domains or ‘communities’ (Rose, 1996) such as the family and workplace. Rose (1996, p. 57) notes:

… the problem is to find means by which individuals may be made responsible through their individual choices for themselves and those to whom they owe allegiance, through the shaping of a lifestyle according to grammars of living that are widely disseminated, yet do not depend upon political calculations and strategies for their rationales or for their techniques.

In this study, the government of nurses taps into ‘care’ as one of the profession’s central tenets, or one of nursing’s “grammars of living” (Rose 1996, p. 57), as the means through which the hospital’s business concerns become those of nurses.

**Nurses’ invisibility problem**

Government statistics and reports about nursing in this study are framed around, and draw upon, the language of economics and management in outlining the perils of a health professional workforce shortage to the health care system and in identifying the nursing shortage as ‘a crisis’ – a ‘crisis’ requiring a government response. Stories in the print and electronic media, and government and research reports dealing with nurse staffing issues, specifically workloads, highlight nurses’ ‘moral domain’. This makes the profession and individual nurses responsible for the workforce problem facing the healthcare system and their workplaces. The profession translates this problem as one of nurses’ (in)visibility. Responsibility for managing nurses’ (in)visibility problem returns to the profession. The onus is on nurses to identify what they do through technologies such as classification systems for nursing practice and in models of workload measurement in their workplaces. Miller and Rose (1990, p. 7) write that “it is through
language that governmental fields are composed, rendered thinkable and manageable”, for example, the International Council of Nurses work with the ICNP®, which seeks to articulate nursing for the WHO’s “vocabulary of health” (Maddern, Sykes, & Ustun, 2007, p. 6). The ICNP® acceptance into the WHO’s Family of Classifications (WHO-FIC) links nursing – as a specific population or group – to other WHO classifications pertaining to the health system, such as the International Classification of Diseases (ICD-10), International Classification of Functioning, Disability and Health (ICF), and the developing International Classification of Health Interventions (ICHI), further making them a ‘field’ for government.

Furthermore, nurses’ invisibility is constituted as a problem of failure to identify what nurses ‘do’ in hospital reimbursement/payment systems, which, as Rose (1999b) points out, is at the fulcrum of the ‘field’ of government. Nurses’ contribution to hospital care is subsumed as part of the hospital’s accommodation rate. Given that nursing is a large part of a hospital’s costs in terms of personnel and that different patients will consume different amounts of nursing resources (read time and skill), this constitutes nursing as a risk to the ‘firm’s’ financial viability; a risk that shifts the burden of care (Fagin, 2001) to nursing and sees individual nurses and the profession as a whole take responsibility for the hospital’s financial problems, and more broadly those of the healthcare system – in this case, private health – in accounting for their work.

Tension is reflected in policy on the nursing workforce. Federal government policy focuses on the development of strategies around nursing regulation, financing, recruitment and retention, and education. On the one hand these strategies promote self-management by nursing, and on the other hand surveillance, as they reflect tension
between the construction of nurses as “active citizens” (Rose, 1999b, 164) and a population of vulnerable healthcare professionals. The ‘solution’ to nurses’ invisibility problem for hospital reimbursement systems is found in managerial work and research that seeks to incorporate ‘nursing intensity weights’ into hospital payment systems (see Laport et al., 2008; Welton & Dismuke, 2008; Welton, Fischer, De Grace, S., & Zone-Smith, 2006) to account for the cost of nursing. I contend that such work, rather than rendering nurses visible, reduces nurses’ care to a working hour by focusing on time. This process amplifies “new grids for visibilities for the conduct of organizations and those who inhabit them” (Rose, 1996, p. 55).

Flexible work practices

In this thesis, nurses’ talk privileged discourses of business management and marketing, as the programmatic aims of government of private healthcare and the hospital articulate ‘flexibility’ to re-organise and re-conceptualise care in times of financial constraint. The hospital influenced this focus by engaging in policy and practices of working time flexibility. It did so through the use of functional and numerical flexibility of work practices. Functional flexibility practices saw nurses’ time at work adjusted to meet changing staffing and inpatient demands; for example, nurses went relieving to other wards and/or areas of the hospital and rosters were adjusted to accommodate quiet periods when surgeons were away. Numerical flexibility practices were evident in the high use of part-time staff. Although casual or temporary staff were increasingly employed during the course of my fieldwork, their use was not a feature during the study. What was a feature was the constant adjustment of the contours of nurses’ working time, as and when required by the hospital, although not always at the peak times identified by nurses or in this study. Clearly, there was no ‘idle time’. While these
management strategies provided increased efficiencies in terms of managing the nursing budget, they resulted in work intensification for nurses. The seductiveness of the discourse of ‘flexibility’ in terms of its family friendliness and the notion that nurses, similar to many in other occupations, were in some way free to ‘choose’ the hours they worked, reflects neo-liberal ideals of ‘choice’; ‘choice’ that saw nurses working and working hard in the interests of the firm.

**Eliciting quality**

In light of the private healthcare market in which the hospital is located and their own professional expectations of care, nurses also drew upon management concepts of ‘excellence’ and ‘quality’ alongside a discourse of ‘flexibility’.

Nurses’ talk illustrated their understandings about business or enterprise, and norms about care that were changing from “those of service and dedication” (Rose, 1996, p. 56) to “those of competition, quality and customer demand” (Rose, 1996, p. 56). Such a movement sees a reconfiguration of the flows of accountability and responsibility about key indicators of the business (Rose, 1996), resulting in a business mentality governing nurses’ work. The reconfiguration of these flows is illustrated in fundamental organisational texts, such as nurses’ job descriptions, organisational charts, in-house forums, and ‘whiteboards’. Such mundane texts enrol nurses in management and business discourses that see them taking up the hospital’s business concerns as their own, eliciting a particular nursing subjectivity where nurses in the study hospital are expected to be business savvy, know the firm and industry, and, importantly, be clinical experts. Nurses become the “calculating selves” that Miller (1992) writes of as they think about, and judge their and their colleagues’ capacity to, manage workloads in light
of a nursing budget that is always ‘over’. Yet it is nurses’ expertise the hospital draws upon to manage the nursing budget, thus minimising the hours needed for care delivery. Understanding that “organizations, of whatever kind, usually have some sort of governing ethos” (Hirsch & Gellner, 2001, p. 4), nursing in this hospital is governed through a nursing rationality of care in which nursing care is marketed as a defining feature of the quality and differentiation of this organisation from other similar hospitals and public hospital settings.

Discourses of business, along with assumptions about the hospital’s flexible working policies and practices, leave nurses’ work organised around ‘babysitting’ patients and ‘buddying-up’ with colleagues. They present challenges for nurses in terms of work-life balance and work intensification. Nurses who are left ‘holding the baby’ for any length of time, no matter the shift or part of the shift worked, experience work intensification because they are expected to care for, and attend to, the routine work of the ward not only for their allocated patient load but also for those of their colleagues. Thus, flexibility, as an attraction for staff, becomes a way of life for the organisation as well as being necessary to maintain its viability in a competitive market.

**Handing over**

This study shows that flexible working policies and practices promulgated as a way of giving nurses, as employees, some ‘choice’ over how much, when, and where they work, result in work intensification. How nurses organise their work in light of flexible working practices sees ‘handover’ and the many instances where nurses hand over their work emerge as a space/spaces where nurses hold their own. Handover and nurses’ ‘handover sheets’ hold and shape nursing knowledge and practice, given the way nurses
‘nursing hours’ are managed. This space protects nurses’ knowledge. It is a private space; a space where nurses create and construct their working time as active citizens to manage to ‘care’ for their patients. Although a private space, I have shown in this study that nurses will occasionally ‘hand over’ their sheets to colleagues so that the care they have planned is uninterrupted. In terms of governmentality, nurses’ handover practices may be considered a point of resistance to accounting and formal nursing documentation technologies as nurses engage in the realities of their work:

‘The real’ always insists in the form of resistance to programming; and the programmer’s world is one of constant experiment, invention, failure, critique and adjustment. (Miller & Rose, 1990, p. 14)

The description of how the hospital sought to reduce its nursing labour costs through changing staff skill mix, limiting handover time, and in its financial accounting practices was made evident in a focus on nurses’ ‘nursing hours’. While these changes are not without critique, it is nurses’ expertise and ‘care’ that the hospital draws upon to protect its market position and financial viability. It is nurses’ ‘care’ that ensures the hospital’s business occurs in a seamless manner despite the interruptions to their everyday working time manufactured by flexibility practices.

A different mentality governs nurses’ work in private health; a mentality that is very much focused on the enterprise (see also Barnes, 2000). Nonetheless, nurses are not passive dupes and artfully manage the hospital’s business concerns through something as mundane as a ‘handover sheet’ and their allocation practices, minimising the work they do by using expressions such as ‘babysitting’ patients and ‘buddying-up’ with colleagues as management strategies. Such practices are undertaken mindfully and in line with an ethics of care (Barnes, 2000) that is shown by their efforts to maintain what
they see as ‘qualities’ of private care. This thesis stands as a record and
acknowledgement of such efforts.

**Limitations**

This study was conducted in a small, acute care metropolitan private hospital in
Australia. This limits the study in so far as it was conducted in a specific location and
within a particular context. However, a significant proportion of private acute (and
psychiatric) hospitals in Australia are small; 72 percent of hospitals have fewer than 100
beds while less than 10 percent have more than 200 beds (ABS, 2010). Therefore, there
are many nurses working in settings similar to this study. It will resonate with those
working in this currently under-researched area.

Another limitation is the research methodology used, because:

> ... ethnography is first and foremost a social practice concerned with the
study and representation of a culture (with a distinctly small c). It is an
interpretative craft, focused on more ‘how’ and ‘why’ than on ‘how
much’ and ‘how many’. (Van Maanen, 2011, p. 219)

As a “distinctly small c” study of a culture of nurses’ work in a hospital’s
medical/surgical unit, it was ethnography’s focus on the ‘how’ and ‘why’ rather ‘how
much’ and ‘how many’ that challenged me not only to confront the method –
ethnography and the theoretical framework used to understand nurses’ organising
practices – but also to deal with the hospital’s understanding of what this research may
offer in terms of ‘outcomes’.

The outcome of this study was not about providing an answer or solution for nursing
and its workforce problems. It was about seeing how the assumptions contained within representations of nursing as a workforce for government and governing actually govern nurses’ work in a location such as a private hospital.

Foucault’s (1972) archaeological work enabled me to explicate the discourses that lay within representations of nursing by considering the assumptions that shaped arguments about nurses and the profession: the ‘thinking’, ‘rationalities’, or the ‘(govern)mentalities’ that nurses working in private healthcare – as that ‘other’ healthcare sector – drew upon. I did this by showing how the issues for nurses in this sector fitted into wider debates of nursing and Australia’s healthcare system. Discourse analysis allowed me to understand how nursing was problematised – and how I was problematised in relation to that – to ask questions about understandings of the nature of nurses’ work as it plays out in the private healthcare sector. To quote Green (2006, p. 1), “writers about work are also their own subjects”.

One other limitation of the study was that it was conducted during a period of significant organisational change. The organisation’s re-workings were dynamic and I believe this influenced my understanding of the fieldwork context. Analyses of nurses’ working practices were embedded within broad organisational level changes, which may well have had an untoward influence on the understanding I came to have of nurses’ organising practices; obtaining only “partial truths” (Clifford, 1986). That said, the organising of organisations plays a major role in shaping how people do their jobs and how they “are always involved in a dynamic tension with their social and political environments” (Beynon et al., 2002, p. 26).
I have made it clear in this thesis that participants engaged in considerable discussion about changes that had taken place in their workplace over the years. Redundancies were key features of work organisation in this hospital as the organisation adapted to changing market conditions. How employment change is managed in private healthcare is an area that warrants further exploration because any notion of nursing as a workforce in ‘shortage’, and assumptions that nurses will always be required/employable, may not be enough to protect nurses working in this sector from dismissal. Organisational business practices such as managing change through redundancies have not been raised as a practice in nursing workforce management so far, although they are discussed and critiqued in broader management literature. These organisational practices could be brought to an exploration of nursing workforce management in the future.

**Implications of this study and recommendations**

This thesis contributes to studying what nurses actually do to get their work done. It has shown how nurses organise, manage, and make decisions in a medical/surgical unit of a private hospital through a focus on nurses’ ‘practice’, illustrating the sophistication in the thinking that has a bearing on nurses’ organisational activities. The thesis presents an alternative point of view about the nursing workforce and its problems to that which is commonly reported, most particularly as a discourse of nursing as a workforce in shortage.

This study has shown how flexible work practices contribute to work intensification for nurses, not only in terms of their workload but compounded by demanding patients, figured as ‘customers’, and the private healthcare sector’s expectations. The study has implications for the recruitment and retention of nurses in light of the nursing workforce
being represented increasingly as a workforce in shortage and ageing. Further research into nurses’ generational needs is suggested. Currently, only limited research considers how to best meet the needs of an ageing and mature nursing workforce. This is needed alongside research that considers transition strategies to meet the needs of graduates and staff new to organisations as this experienced, expert workforce retires.

This study picks up on the extent/depth of the nursing expertise found at this hospital. A study of nursing ‘expertise’ may also be a consideration for further research, particularly into how this skill is used in private healthcare as a commodity of care. The organisation of work in private hospitals is such that the majority of hospitals are not organised through wards constituted around medical/surgical speciality services as in large public teaching hospitals. Nurses in these small private units and hospitals are required to nurse across many different medical and surgical treatment regimens to meet the needs of the medical specialists who are the private hospitals’ customers (as much as the patients they bring with them). There may or may not be a medical officer on site in private hospitals.

In terms of nursing knowledge and skill, a greater level of clinical expertise is associated with the flexibility in work practices in the private healthcare sector; it is an unrecognised requirement of this sector, residing in the nurses who work therein.

All of these unique private healthcare sector requirements need further study to explore how nurses can be fostered in such a key part of the healthcare delivery system that is ‘mixed’ in its delivery and funding processes.
Conclusion

This thesis has explored nurses’ organising practices in private healthcare, identifying three features in relation to managing work: discourse of ‘(in)visibility’, particularly with costing the nursing service; discourse of ‘flexibility’ in work practices; and practices of ‘handover’ that hand over knowledge and an ethics of care. Nursing’s ‘hours’ are the “calculable space” (Miller, 1992) that links the hospital’s financial performance to nurses. Nursing hours are a technology of government giving nurses “spheres of discretion” (Miller, 1992, p. 77) as to how they manage their work.

Governments are constantly adjusting the organisation and financing of healthcare, as noted throughout the thesis. These adjustments enrol nurses into programmes of government that require further naming or classification of the work they do, reducing it to numerical data that is presented in government statistical databases and research reports. It enrols the profession in identifying itself in models of workload measurement and in classification systems for nursing practice; what it is that nurses do. In so doing, nurses are complicit in their own marginalisation as the value of the work they do is reduced to (in)visible status; to a number – as the ‘nursing hour’. Hospital administrators and nurses themselves rework the contours of nurses’ working time so that nurses ensure the hospital’s work is done, and done well, through the ordinary ‘technologies’ of job descriptions and handover sheets.

Foucault (1978, p. 26) writes:

In each sentence you pronounce – and very precisely in the one that you are busy writing at this moment, you who have been so intent, for so many pages, on answering a question in which you felt yourself personally concerned and who are going to sign this text with your name
– in every sentence there reigns the nameless law, the blank indifference:
“What does it matter who is speaking: someone has said: what does it matter who is speaking.”

It may not matter who is speaking, but in identifying who speaks it affords nurses a way of critiquing some of the profession’s taken-for-granted assumptions and practices.

In this study, I have endeavoured to reveal the subtleties embedded in nurses’ discourses and in the process identify how nurses are positioned and also how they position themselves, to recognise and possibly challenge what is seen, heard, or spoken. I have argued that nurses’ positioning reflects neo-liberal ideals where nurses are personally responsible for the financial viability of the firm and the wider healthcare system.

In all this, what is being said is that nurses individually and as a group – as a collective – draw upon their care ethos to meet their moral obligation to the patients, hospital, profession, and healthcare system. Nurses, as the subject of government, develop programmes that translate ‘care’ into strategies for the business of the hospital and in the private healthcare market in which it operates. In nursing ‘hours’, what requires acknowledgement and recording is how nursing knowledge and expertise make an ethos of caring ‘hours’ possible.
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APPENDIX 1 INFORMATION SHEETS FOR PARTICIPANTS

Information Sheet for Nurses

(Registered Nurses, Clinical Nurses, Nurse Managers/After Hours Co-Ordinators)

You are invited to participate in research as part of a Ph.D. thesis:

‘Nursing Hours’ or ‘Nursing’ Hours – a discourse analysis

Researcher:    Luisa Toffoli
               Doctoral Student,
               Faculty of Health Sciences
               School of Nursing and Midwifery
               Flinders University

Supervisor:    Associate Professor Trudy Rudge

What this study is about?

This study is about workloads in nursing. It is about the organisation of nurses’ work. It is also about how any private hospital addresses the question of ‘How many nurses do we need?’ Nurse staffing and workload is coming under increased scrutiny as hospitals examine how they manage patient care and how that care can then be accounted for. Nursing workload measurement systems, also referred to as patient classification systems are used by hospitals as one way of ‘working out’ nurse staffing, or the ‘nursing hours’ required for care. Some of these may be familiar to you, for example, Excelcare®, Trend Care®.

This study looks at the way that systems of workload measurement are used in your case to look at your work. It also looks at how these systems then go on to influence how nurses’ work. The ongoing refinement of systems for naming nurses’ work suggests that these systems are not measuring enough and need to measure more. What that ‘more’ is and how that is achieved and what these systems go on to hide or make visible about nurses’ work are part of some of the questions for this study.

How would I be involved?

If you agree to participate it will involve you being observed and/or interviewed about your professional practice. Interviews will involve you discussing your ideas, opinions, understandings and practices about how you organise your work. If you agree to participate in this study, it may also involve the researcher observing how you organise and provide care to patients.
It is anticipated that for the interviews will meet in a quiet, private area in a mutually convenient location. It will also occur at a mutually convenient time.

Participation is voluntary and you are free to withdraw at any time without prejudice. In the event that at any time participation causes you any personal distress you may withdraw and you will be offered the opportunity to debrief with the researcher, the counselling service for employees within your organisation or a person of your choice.

**How will confidentiality and anonymity be assured?**

Interviews will be conducted in private to ensure confidentiality. Your name or any identifying material will be removed from the interview transcripts by a qualified transcriber (a person provided from a pool of transcribers within the School of Nursing and Midwifery who has also signed a confidentiality agreement). You will not be identified in any way in the interview transcripts, in the thesis or any publications. This research is not being undertaken on behalf of your organisation and the names of participants will not be identified either in writing or verbally to persons within your organisation. Tapes of interviews and records of observations will be kept in a locked storage area in a secure office within Flinders University, School of Nursing and Midwifery and access will be limited to the researcher, her supervisor and transcriber. The information collected as part of this study in the form of records and transcripts will remain in a secure area of Flinders University, School of Nursing and Midwifery for five years after which they will be destroyed.

**How can I find out more information?**

By contacting the researcher, Luisa Toffoli, if you would like further information about the study or have any concerns on 8332 7594 or email Luisa.Toffoli@flinders.edu.au. Alternatively, you are welcome to speak with my supervisor A/Prof. Trudy Rudge on 8201 5353. If you have any concerns regarding ethical issues please contact Ms Sandy Huxtable Research Ethics Support Officer, on 8201 5962 or fax 8201 2035, email sandy.huxtable@flinders.edu.au.
Information Sheet for Administration

(Executive, Medical Records, Finance, Information Systems)

You are invited to participate in research as part of a Ph.D. thesis:

‘Nursing Hours’ or ‘Nursing’ Hours – a discourse analysis

Researcher: Luisa Toffoli
Doctoral Student
School of Nursing and Midwifery
Faculty of Health Sciences
Flinders University

Supervisor: Associate Professor Trudy Rudge

What is this study about?

This study is about workloads in nursing. It is about the organisation of nurses’ work. It is also about how any private hospital addresses the question of ‘How many nurses do we need?’ Nurse staffing and workload is coming under increased scrutiny as hospitals examine how they manage patient care and how that care can be accounted for. Nursing workload measurement systems, also referred to as patient classification systems are used by hospitals as one way of ‘working out’ nurse staffing, or the ‘nursing hours’ required for care. Some of these may be familiar to you, for example, Excelcare®, Trend Care®.

This study looks at the way that these systems are used in your case to organise the work of the organisation. It looks at how these systems then go on to influence how nurses’ work. The ongoing refinement of systems for naming nurses’ work suggests that they are not measuring enough and need to measure more. What that ‘more’ is and how that is achieved and what these systems go on to hide or to make visible about nurses’ work are part of some of the questions for this study.

How would I be involved?

To participate you will be asked to agree to an interview for a period of about 30 –45 minutes on a single occasion with the potential for a further 15–20 minute interview at the end of data collection. Each interview will be arranged at a time that is suitable for you and will occur at your workplace, during work-time. It is anticipated that for the interview we will meet in a private area, within the hospital grounds or alternatively in a place of your choosing.
Participation is voluntary and you are free to withdraw at any time without prejudice. In the event that participation causes you any personal distress you may withdraw and you will be offered the opportunity to debrief with the researcher, the counselling service for employees within your organization or a person of your choice.

**How will confidentiality and anonymity be assured?**

Interviews will be conducted in private to ensure confidentiality. Your name or any identifying material will be removed from the interview transcript by a qualified transcriber (a person provided from a pool of transcribers within the School of Nursing and Midwifery who has also signed a confidentiality agreement). You will not be identified in any way in the interview transcripts, in the thesis or any publications. The research is not being undertaken on behalf of your organisation and names of participants will not be identified either in writing or verbally to persons within your organisation. Tapes of interviews will be kept in a locked storage area in a secure office within Flinders University School of Nursing and Midwifery and access will be limited to the researcher, her supervisor and transcriber. The information collected as part of this study in the form of records and transcripts will remain in a secure area of Flinders University, School of Nursing and Midwifery, for a period of five years after which they will be destroyed.

**How can I find out more information?**

By contacting the researcher, Luisa Toffoli, if you would like further information about the study or have any concerns on 8332 7594 or email Luisa.Toffoli@flinders.edu.au. Alternatively you are welcome to speak with my supervisor A/Prof. Trudy Rudge on 8201 5353. If you have any concerns regarding ethical issues please contact Ms Sandy Huxtable Research Ethics Support Officer on 8201 5962 by fax on 8201 2035 or email sandy.huxtable@flinders.edu.au.
APPENDIX 2 LETTER OF INTRODUCTION

FLINDERS UNIVERSITY
ADELAIDE • AUSTRALIA

Dr Trudy Rudge
Associate Professor and Associate Dean: Higher Degree Program
School of Nursing and Midwifery
Faculty of Health Sciences

GPO Box 2100
Adelaide 5001 Australia
Telephone: (+61 8) 8201 5353
8201 3409
Fax: (+61 8) 8276 1602
Email: Trudy.Rudge@flinders.edu.au

LETTER OF INTRODUCTION

Dear

This letter is to introduce Luisa Toffoli who is a Research Higher Degree student in the Faculty of Health Sciences, School of Nursing & Midwifery at Flinders University. She will produce her student card, which carries a photograph, as proof of identity.

She is undertaking research leading to the production of a thesis or other publications on the subject of the organisation of nurses’ work. Her thesis titled ‘Nursing Hours’ or ‘Nursing’ Hours – a discourse analysis is about the organisation and management of nurses’ work within private health.

Nurse staffing and workloads is coming under increased scrutiny as private hospitals examine how they manage patient care and how that care can be accounted for. Nursing workload measurement systems, also referred to as patient classification systems are used as one way of ‘working out’ nurse staffing or the ‘nursing hours’ required for such care. The study looks at the way that systems of workload measurement are used and how these systems then go on to influence how nurses’ work.

She would be most grateful if you would volunteer to spare the time to assist in this project, by granting an interview and agreeing to observation of your professional practice, which touches upon certain aspects of this topic. No more than an hour of observation, on 2–3 occasions would be required. Interviews will initially be short, 10–15 minutes following observations with a more formal interview of 45–60 minutes at the end of data collection.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.
Since she intend(s) to make a tape recording of the interview, she will seek your consent, on the attached form, to record the interview, to use the recording or a transcription in preparing the thesis, report or other publications, on condition that your name or identity is not revealed, and to make the recording available to other researchers on the same conditions. It may be necessary to make the recording available to secretarial assistants for transcription, in which case you may be assured that such persons will be advised of the requirement that your name or identity not be revealed and that the confidentiality of the material is respected and maintained.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on 8201 5353, fax 8201 3410 or e-mail Trudy.Rudge@flinders.edu.au. This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of this Committee can be contacted on 8201 5962 fax 8201 2035, e-mail sandy.huxtable@flinders.edu.au. This project has also been approved by the [Hospital Human Research Ethics Committee]. The Chair of this committee, xxxx may be contacted on xxxx or e-mail xxxx.

Thank you for your attention and assistance.

Yours sincerely,

Trudy Rudge RN RMHN PhD
Associate Professor and Associate Dean: Higher Degrees
School of Nursing and Midwifery
APPENDIX 3 CONSENT FOR OBSERVATION

CONSENT FORM FOR OBSERVATION OF PROFESSIONAL ACTIVITY

I hereby give my consent to Luisa Toffoli a research student in the Faculty of Health Sciences at School of Nursing and Midwifery and whose signature appears below, to record my work activities as part of a study of my professional activities and role.

I give permission for the use of these data, and other information which I have agreed may be obtained or requested, in the writing up of the study, subject to the following conditions:

My participation in this study is voluntary, and I understand that I may withdraw from the study at any time.

SIGNATURES

Participant………………………………………………………………………………………………Date…………………………

Researcher……………………………………………………………Date………………
APPENDIX 4 CONSENT FOR INTERVIEW

CONSENT FORM FOR PARTICIPATION IN RESEARCH
(By interview)

I ……………………………………………………………………………………………………………………………

being over the age of 18 years hereby consent to participate as requested in the Letter of Introduction and/or Information Sheet for the research project on 'Nursing Hours' or 'nursing' hours – a discourse analysis.

I have read the information provided.
1. Details of procedures and any risks have been explained to my satisfaction.

2. I agree to my information and participation being recorded on tape.

3. I am aware that I should retain a copy of the Information Sheet and Consent Form for future reference.

4. I understand that:
   - I may not directly benefit from taking part in this research.
   - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
   - While the information gained in this study will be published as explained, I will not be identified, and individual information will remain confidential.
   - I may ask that the recording/observation be stopped at any time, and that I may withdraw at any time from the session or the research without disadvantage.

5. I have had the opportunity to discuss taking part in this research with a family member or friend.

Participant's signature……………………………………Date……………………..
I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

Researcher's name.................................................................

Researcher's signature........................................Date....................

6. I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.

Participant's signature........................................Date....................

7. I, the participant whose signature appears below, have read the researcher’s report and agree to the publication of my information as reported.

Participant's signature........................................Date....................
APPENDIX 5 OPEN-ENDED QUESTIONS

QUESTIONS

1. How did you come to work at this hospital?

2. What are some of the changes that you have noticed in your time here?

3. How have these changes affected how the work is done?

4. Can you describe what a ‘good day’ at work is for you?

5. Can you describe what a ‘bad day’ at work is for you?

6. What are the differences between a ‘good’ and a ‘bad’ day at work?

7. How would describe the processes that organize nurses’ work here?

8. (Probe) What strategies do you use to organize your care of patients?

9. (Probe) When and where do you use them? Are they always successful?
Appendix 6 - University correspondence and approvals

APPENDIX 6 UNIVERSITY CORRESPONDENCE AND APPROVALS

Dear Ms Toffoli,

Project 3078 'Nursing Hours' or 'Nursing' Hours - a discourse analysis

At its meeting on... the Social and Behavioural Research Ethics Committee considered the application you submitted in respect of the above project.

The Committee is satisfied that in most respects this project meets the requirements of the MHRRC National Statement on Ethical Conduct in Research Involving Humans (National Statement). However, some further clarification is needed.

The Committee resolved that conditional approval be given to this project, subject to:

i. Confirmation that incident people will have the opportunity to refuse permission for the observation of the nurse during the time that (s)he is with them (refer item D5).
ii. Editing the Letter of Introduction to make reference to approval of the study by the Hospitals.
iii. Acknowledgement that at this time approval is given only for the observation phase. To facilitate approval of the interview stage, please forward an interview schedule in due course.

Please provide a copy of an approval letter from the Hospital, when this is received.

Please submit further information relating to, or confirmation of, the above matters to me in writing as soon as possible to enable final approval of the project to be confirmed. My office is located in Room 155, Registry Building.

Yours sincerely,

Lesley Wyndham
Secretary
SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE

cc: A/Prof Trudy Rudge, Nursing & Midwifery
Dr Lynne Bannas, Nursing & Midwifery

Lorraine: Sturt Road, Bedford Park, South Australia.
Project 3078 ‘Nursing Hours’ or ‘Nursing’ Hours – a discourse analysis

Further to my letter dated  am pleased to inform you that approval of the above project has been confirmed following receipt of the additional information you submitted on.

Approval is valid for the period of time requested and is given on the basis of information provided in the application, its attachments and the information subsequently provided. In accordance with the undertaking you provided in the application, please inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion and report anything which might warrant review of ethical approval of the protocol. Such matters include:

- serious or unexpected adverse effects on participants;
- proposed changes in the protocol; and
- unforeseen events that might affect continued ethical acceptability of the project.

May I draw to your attention that, in order to comply with monitoring requirements of the National Statement on Ethical Conduct in Research Involving Humans an annual and/or final report must be submitted in due course. If a report is not received beforehand, a reminder notice will be issued in twelve months' time. A copy of the report pro-forma is available from the SBREC website http://www.flinders.edu.au/research/office/ethics/index.html.

Yours sincerely

Sandy Huxtable
Secretary
SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE

c.c. Mr Simon Macdonald, Office of Research
     A/Prof Trudy Rudge, Nursing & Midwifery
     Dr Lynne Barnes, Nursing & Midwifery

NB: If you are a scholarship holder and you receive funding for your research through the National Health & Medical Research Council please forward a copy of this letter to the Head, Higher Degree Administration and Scholarships Office, for forwarding to the NHMRC.

(3078fnnapp)

Location: Stuart Road, Bedford Park, South Australia.
Dear Ms Toffoli

Project 3078  ‘Nursing Hours’ or ‘Nursing’ Hours – a discourse analysis

I refer to your application for a modification of the above project which had been approved previously.

I am pleased to inform you that the Chairperson has approved your request to amend the interview schedule, the Letter(s) of Introduction and the end date of data collection.

Yours sincerely,

Sandy Huxtable
Secretary
SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE

cc: Ms Lynne Barnes, Uni of SA (City East Campus), North Tce, Adelaide, SA 5000

(esnletter/30787 modapp)

Location: Sturt Road, Bedford Park, South Australia.
APPENDIX 7 FINAL APPROVAL FROM HOSPITAL

Dear Luisa

Following your application to conduct a discourse analysis, "Nursing Hours" or "Nursing Hours at the Hospital, it is with pleasure that I write to inform you that approval has been granted to undertake your project within this organisation.

Once you have received final written confirmation from your ethics committee, I would be pleased to meet with you to discuss the implementation of the project in the coming weeks.

Should you require any further information regarding the Hospital, please do not hesitate to contact me. I look forward to discussing the project with you at a later stage.

Yours sincerely

Appendix 7 - Final approval from hospital
 LETTER TO HOSPITAL CONFIRMING FINAL ETHICS APPROVAL

(Address)

(Date)

(Name)
(Position title)
(Hospital)
(Address)

Dear xxxx

Re: Research Project ‘Nursing Hours’ or ‘Nursing’ Hours – a discourse analysis

Enclosed is a copy of the letter from the Flinders University Social and Behavioural Research Ethics Committee confirming final approval of the project.

Yours sincerely

Luisa Toffoli
Transcription Confidentiality Non-disclosure Agreement

Sharyn Taylor Secretarial Services will maintain strict confidentiality of the information contained within the audio-recorded interviews transcribed for a research study conducted by Luisa Toffoli.

Sharyn Taylor Secretarial Services agrees to take reasonable steps to maintain the confidentiality of interviews audio-recorded by Luisa Toffoli and in pursuit thereof will communicate to all of its contractors and/or employees, both present and in the future, in writing, the confidentiality and non-disclosure that must be maintained with respect to all interviews audio-recorded by Luisa Toffoli.

Confidential information includes all information contained in any audio-recorded interviews provided to Sharyn Taylor Secretarial Services for transcription including, but not limited to, the identity of research study interview participants, the identity of their organisation, the nature of their work, the subject-matter or content of the transcription and any other incidental information relating to any third party so contained therein.

Sharyn Taylor Secretarial Services agrees:

1. Not to duplicate or transmit or permit the duplication or transmission of any confidential information except as may be necessary for the purpose of supplying word-processed transcriptions to Luisa Toffoli;

2. To take all reasonable security precautions to keep the information confidential and to exercise a sufficient degree of control over all confidential information provided to Sharyn Taylor Secretarial Services to assume full responsibility to protect the confidential nature of the data and to institute any necessary procedures to protect its confidential nature, and to ensure employees and/or contractors of Sharyn Taylor Secretarial Services do not:
   (i) discuss the confidential data with any other person not also bound by the terms of this Agreement; or
   (ii) remove the confidential information from secure data housing where the data is maintained on the premises of Sharyn Taylor Secretarial Services other than to return or make available transcription of the confidential data to Luisa Toffoli; or
   (iii) produce any additional copy, image and/or recording of the confidential information other than as required by Luisa Toffoli;
and
(iv) following completion of transcription, will return all confidential
hard copy data supplied by Luisa Toffoli.

3. All transcribed work will be held on file by Sharyn Taylor
Secretarial Services, until unless advised to be deleted by Luisa
Toffoli.

4. Sharyn Taylor Secretarial Services will notify Luisa Toffoli
immediately upon discovery of any unauthorised use or disclosure
of the confidential data or any other breach of this Agreement by
Sharyn Taylor Secretarial Services or its employees or contractors
and will cooperate with Luisa Toffoli in any reasonable way to help
Luisa Toffoli regain possession of the confidential information and
prevent any further breach.

5. All Confidential Information will remain the property of Luisa
Toffoli including any transcription of the confidential information
prepared by Sharyn Taylor Secretarial Services.

Accepted and agreed for and on behalf of Sharyn Taylor Secretarial
Services:

Signed Sharyn Taylor
(Secretarial Services)

Date
Dear Luisa

Project 3078

"Nursing Hours" or "Nursing" Hours – A Discourse Analysis

Confirming our telephone conversation on , I hereby advise that I have received a letter from the Chief Executive of Hospital requesting that the Social and Behavioural Research Ethics Committee consider a request for new terms and conditions for the above project.

Their requirements are:

- Removal of any reference to a "stand alone" private hospital in any documentation or publication;
- All nursing staff interviewed or observed undertaking nursing practice as part of this study be required to sign a confidentiality agreement ensuring that they do not discuss the study, their participation in it, or their comments with anyone other than the researcher;
- The Hospital be provided with the opportunity to read the first and final drafts of the thesis. Should there be any commentary that, in the view of the Hospital has the potential either directly or indirectly to be of concern, namely is:
  • commercially sensitive;
  • damaging to the image and/or reputation of nursing at the Hospital or
  • damaging to the image and/or reputation of the Hospital as an entity
    that the Hospital has the right to alter the document to the mutual satisfaction of the Researcher and the Hospital;
- Any document that is generated from the research for publication or presentation will require the approval of the Chief Executive of the Hospital prior to its release, publication or presentation;
- The Researcher undertakes a presentation to the senior nursing staff of the Hospital at an appropriate time in the duration of the study.

Please reply to me addressing each point individually.

The Hospital has withdrawn authorisation to conduct interviews or observation of nursing staff until the matter has been resolved to their satisfaction.

If you have any queries please feel free to contact me.

Yours sincerely

Sandy Huxtable
Secretary
Social and Behavioural Research Ethics Committee

cc: A/Prof Trudy Rudge, Nursing & Midwifery

Location: Sturt Road, Bedford Park, South Australia.
LETTER OF REPLY TO HOSPITAL CEO

Replica Letter

xxxx

Ms Sandy Huxtable
Secretary
Social and Behavioural Research Ethics Committee
Flinders University
GPO Box 2100
ADELAIDE SA 5001

Dear Sandy

Project 3078 ‘Nursing Hours’ or ‘Nursing’ Hours – a discourse analysis

Thank you for your letter dated xxxx indicating the new terms and conditions for the above project from the Chief Executive of xxxxx.

Please be advised that a reply to your letter is being formulated by Dr Alan Wilson, Chair, Faculty of Health Sciences Research Higher Degrees Committee, with assistance from Associate Professor Trudy Rudge and will be forwarded to your office in regard to this matter.

Yours sincerely

Luisa Toffoli
RESEARCH HIGHER DEGREE COMMITTEE REPLY TO HOSPITAL

Replica Letter

(Date)

(Name)
(Title)
(Address)

Dear xxxx,

I refer to your letter dated xxxx addressed to Ms Sandy Huxtable, Office of Research, Flinders University, regarding xxxx Hospital’s concerns about Ms Luisa Toffoli’s research.

I can reassure you, that under no circumstances will the xxxx Hospital be identified or identifiable in any documentation or publication arising from the research. Nor will there be reference to ‘stand alone’ private hospital, commercially sensitive information or material that would damage the image or reputation of xxxx Hospital and its nursing practices. The data obtained from the participants will be woven into the thesis along with data from publicly available sources (eg government policies, acts and reports, royal commissions, conference and other reports, publications and other literature). Thus, data gained from the hospital would form a small but crucial part of this study into nursing workload measurement systems.

In addition, under no circumstances will the researcher include identifiable information about the participants in any documentation or publication arising from the research. The carriage of this study is bound by the Human Rights Convention and the Privacy Act which form basis for the National Health and Medical Research (NH&MRC) Guidelines for Ethical Conduct of Research. Each participant will be given a pseudonym. The key to this pseudonym will be destroyed upon completion of the thesis and before the data is stored for five years in a locked area in the School of Nursing and Midwifery at Flinders University, as required under the Joint NH&MRC/AVV Statement and Guidelines on Research Practice. After five years, all de-identified data from volunteers will be disposed of by a specialist confidential disposal service.

Senior staff at the xxxx Hospital will have the opportunity to provide feedback on the thesis when Ms Toffoli presents her work to them. In addition, the Chief Executive of the xxxx Hospital will have the opportunity to comment on any material that includes data from the hospital, before publication. I’m sure Ms Toffoli would appreciate the feedback. I should point out however, that to restrict her from including important de-
identified data in the thesis, could have a serious impact on the integrity and hence the viability of the thesis. Furthermore, any restrictions on her ability to publish her findings could have a major adverse effect on her career.

I hope that this response alleviates the xxxx Hospital’s concerns so that Ms Toffoli may continue writing her thesis. No more interviews or observations are required. It is noted that the xxxx Hospital requires all participants to sign a confidentiality agreement. If so, this is a matter for xxxx Hospital to arrange with Ms Toffoli. These would have to be administered and held by Ms Toffoli who is the only person who knows the identity of the participants, and who is ethically bound to maintain their anonymity.

The Higher Degrees Committee of the Faculty of Health Sciences is most grateful to the xxxx Hospital for allowing itself and its staff to take part in Ms Toffoli’s study, the first of its kind in Australia.

If you would like further clarification or discussion on the matter, Associate Professor Trudy Rudge, Associate Dean (Higher Degrees Programs), School of Nursing and Midwifery and I would be happy to meet with you at the xxxx Hospital.

Yours sincerely

Dr. Alan Wilson
Chairperson
Higher Degrees Committee
Faculty of Health Sciences
Replica Letter

(Date)

Ms Sandy Huxtable  
Research Ethics Support Officer  
Office of Research  
Flinders University  
GPO Box 2100  
ADELAIDE SA 5001

Dear Ms Huxtable,

Re: Ms Luisa Toffoli’s Research

You will recall I wrote a letter to you last year dated xxxx advising of our concerns in relation to research being conducted by Ms Toffoli at the xxxx Hospital.

You may be aware that last week I received a letter from Dr. Alan Wilson, Chairperson of the Higher Degrees Committee of the Faculty of Health Sciences. In that letter, Dr Wilson acknowledged the specific concerns raised by the Hospital in my xxxx letter. I am pleased to advise that as a result of the assurances provided in his letter, the Hospital is now sufficiently satisfied for the Hospital’s involvement in Ms Toffoli’s research to continue.

For your reference, all the points raised in my letter to you xxxx, were satisfied in Dr Wilson’s letter and as such, I expect the support of your office in meeting these understandings.

Yours sincerely,

Chief Executive