THE PARADOX OF SOCIALLY ORGANIZED NURSING CARE WORK

by

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A thesis submitted in conformity with the requirements for the degree of Master of Arts
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Abstract

As contemporary health care organizations struggle to control costs, yet deliver quality patient-centred care, the concept of care becomes socially transformed through the use of quality improvement models (i.e., Lean methodology) and quality assurance documentation. This research investigates how nurses’ care work is socially organized in a system that defines care through quality management practices. I use Dorothy E. Smith’s Institutional Ethnography as a feminist mode of inquiry and as a guiding framework for my interviews with nurse participants as I explore the complex social relations within the health care system from the vantage point of nurses undertaking care work. I argue that the social reorganization of care work has affected the emotional lives of nurses as they try to balance actual patient-centred care with their reporting obligations under quality management.
Acknowledgements

This is a learning journey. It is the starting point for a direction I would never have imagined for myself it were not for my supervisor, Dr. Nancy Jackson. I am deeply grateful to her for seeing potential in me that I did not realize until I embarked on this journey. I cherish her mentorship and intellectual guidance.

I thank Dr. Roxana Ng, a Member of my Thesis Committee, for her attention to detail, intellect, and supportive encouragement. I have great respect for her work.

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I give special thanks to the nurses who participated in my research. I am grateful for the rich stories they told and the time they took from their busy schedules to meet with me. These men and women are the moral anchors of the health care system. They are truly committed to compassion and caring.
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Chapter 1
Introduction

Why am I doing this thesis? Who am I telling this story to? I can only answer these questions by reflecting on the start of my nursing career. As a new nurse, I had the privilege of knowing and working with a diverse, warm, and inclusive group in the second year of my nursing career. To me, they characterized the warm, therapeutic, and caring essence of the *esprit de corps* of nursing. This is the true art of caring.

I remember my first shift as a new nurse. Stepping on the ward, with my freshly ironed Sears uniform carefully folded in my bag and my RN certification in hand, I felt a mixture of excitement and sheer terror. After listening to report and getting my patient assignment, the charge nurse asked me to collect some supplies from 5C. As I summoned my courage and desperately hoped I would find the right supplies (I did not want to disappoint the charge nurse), I ventured down the hall to 5C, an acute step-down unit. A senior nurse called out a warm salutation as I approached nurse’s station. Rather than give me a disparaging look as most senior nurses did with their new nurses, she smiled, and said, with a twinkle of mischief in her eye and said, “I’m Jean, how can I help you?” Feeling more at ease, I stammered my request as Jean gently guided me by my thin arm to the supply room. As she piled the requested items into my arms, she asked whether I knew the new graduate nurses recently hired on her floor. I nodded as she recalled the names of her new charges. Completing the task, Jean smiled, placed a reassuring hand on my shoulder, bade me a goodnight, and instructed me to visit anytime.
I did return, but not for a visit. I was hired on Jean’s floor 6 months later. As I was introduced to my new teammates throughout my orientation training, I noticed that each nurse came from a different background and joined the nursing profession for a different reason. But that is where the differences ended. Although each nurse was unique, they accepted their colleague’s diverse views. There was an atmosphere of acceptance and respect that I later realized did not exist in most workplaces. It was not the fact that I was inexperienced in the work world. It was not that simple. We understood individual strengths and weaknesses. We worked on helping each other rather than reporting one another for minor infractions. We chatted on night shift. We gained insight into each other’s life challenges. We worked with this in mind when developing patient assignments. We circled the wagons when physicians were out of line.

Individual relationships within the team were not perfect. We had our differences. We candidly verbalized our displeasure. But, at the end of the day or night, we resolved to work as a team or, at least, agree to disagree. Even in the midst of life and death or unthinkable tasks such as cleaning a soiled elderly dementia patient, we built a cohesive group; one event at a time and one shift at a time. I had my mentors Jean, and Mary (a warm and compassionate British nurse with a flaming carrot top). With them in my inner circle, I could aspire to be like them. I was sorely short of that goal! What was that special glue they created?

Our off duty antics were shared. Young or seasoned, we galvanized a spirit that replenished our emotionally frayed work selves with camaraderie and a few cocktails (outside of work hours!). Seasoned nurses, like Jean, reveling in the junior nurses’ antics and their precarious love lives. How can I forget the young man visiting me in the middle of the
night bringing refreshments for all of my teammates with Jean appraising him as only a mother could do, much to my chagrin? Stories of love and courtship told by seasoned nurses gave us a hint of what each was like in their younger years. As I listened to their stories and worked under their mentorship, I wondered about the tales I had heard in nursing school. The popular expression, *nurses eat their young*, seemed like a *Grimm’s fairy tale*. I could not relate to the author’s tale. Surely the author must have had an unfortunate but rare experience (I hoped!).

As I gained more bedside experience, I felt I still had much to learn. I watched as Jean effortlessly connected with patients through a warm smile and a caring touch as she gently cajoled them through difficult procedures with calm reassurance. I felt like a failure. How I wanted to be like Jean. She was so skilled at creating a warm and safe environment. I often heard colleagues comment at the beginning of a busy shift, ‘we’ll be OK, Jean is working tonight’. She knew when to inject humour. She also knew when silence was needed. How do you learn to become a nurse like Jean? I desperately wanted to know.

As I climbed the ranks from beginner to novice nurse, I felt it was time to leave the nest. It was time to spread my wings and work at a larger hospital, a hospital offering more advanced procedures in comparison to the community hospital in which I began my career. These larger, university affiliated hospitals were adopting best practices and technology that were all the rage in the 1990s. Moreover, health care organizations not adopting the latest technology were perceived as being as antiquated as the hula-hoop by the politicians of the time. I didn’t want to belong to a community hospital any longer. I wanted to advance my career. So, I bade everyone a tearful farewell. “You’ll be back. You’ll see. Other hospitals are not the same as this one”, Dr. Peters asserted. In my mind, I thought, ‘what would he
know? He could not possibly understand the standpoint of a nurse.’ Unfortunately, as difficult as this is to say, I can see that he was right.

My reconnection with nursing through my thesis research told me otherwise. As I interviewed men and women delivering care at the front-line, I had a discomfiting feeling. Before I left bedside nursing, I was acutely aware of how technological advances and business practices were taking my time away from the bedside. But, as I met each of my participants, I became concerned. Despite health care reformation, each participant told stories of how they managed to compress so much care into their 12-hour work days/nights. But, what I saw, apart from their remarkable ability to balance competing, and often, contradictory demands, were professionals who needed as much emotional care as their patients. I heard stories of nurse colleagues who appeared uncaring, which is a complete departure from what I had known. I had a sense that these nurses were not uncaring as individuals, but they were stretched to capacity by the forces of change and had lost their space for some elements of care. I realized I had experienced a rare luxury in my formative years. The space for care, especially emotional care, is diminishing in the wake of reformation. Nurses supporting nurses through emotional care and extending it to their patients no longer exists. Such space has been deemed waste in the lexicon of leaning and corporatizing the health care system. As I explored each participant’s world through this research I had admiration for their strength and agency in providing some holistic care in their busy everyday lives.

As I sit and write my thesis, I cannot help wondering how these nurses are coping with the ever-changing social and political landscape of health care. I no longer belong to the esprit de corps of nursing. I am situated in the periphery. I still hold my RN registration. I
work at a government office using the valuable nursing skills I learned in my formative years. But, I belong to this story too. I sit in a place where I am observer and participant. I am neither inside nor outside of the story. I weave my insight and experience into this tale along with the members of the esprit de corps. I stand among them as I explore the forces that carve and reshape their everyday world. I will never forget to look back and see their faces as I move from their local shared experience in their hospital wards to examine the forces that reshape their work and cull the caring essence from bedside nursing. It is from their standpoint that I examine the current state of health care and nursing care.

To me, this story is written for the men and women who care for all of us in times of vulnerability, fear, despair, and joy. They’re the last vestiges of caring in a fast-paced, compartmentalized society. It is my goal to examine how these nurses are coping with the changes in the health care system and how care, including the emotional care of each other, has been reshaped by the changes in health care institutions throughout the province of Ontario. It is also my intention to explore how care is reshaped at the bedside by forces beyond the walls of respective health care organization.
Chapter 2
Defining Socially Organized Care

Introduction

My research explores how the concept of care is socially organized in the business of health care and nurses’ care work. Although care has been primarily studied as a ubiquitous yet nebulous concept, it takes on many forms when studied within the social and political system in which it is practiced as a set of values, beliefs, and actions. It is here in this complex terrain that I will explore the different standpoints or viewpoints on care as expressed by my research participants within the context of their everyday/night nursing care and within their respective organizations. I will explore how care is transformed in a social and political climate where the demand for efficient, safe, and high quality care has transformed the delivery of care through contemporary business philosophy and methodologies such as Lean. However, it is important to emphasize my research data does not include observations of the phenomenon of care, as it is directly carried out at the bedside by my participants in this research. Instead, I gain access to their everyday/night nursing care through our conversations about that work, and I follow these conversational threads that connect their care work to a complex social network which I will argue is implicated in mediating their care work. It is through this social mapping, developed by D. E. Smith (1987, 2005, 2006), I will explore how care or patient-centred care is problematized from the managerial business perspective and the nurses’ holistic perspective as each group attempts to fulfill the delivery of high quality patient. It is at this conjuncture where the problematic is revealed as the focus of the institutional ethnography (IE) investigation. In
essence, I will illuminate how nurses are caught in the middle of this often-stressful impasse as they physically and emotionally labour to fulfill their obligations as employees and carers.

Methodology and Procedures

Institutional Ethnography:
A Way of Seeing How Care Is Socially Organized

To begin, I will introduce some basic principles of D. E. Smith’s (1987, 2005, 2006) IE as a feminist sociology or mode of inquiry. First, the use of the term *institution* does not refer to a building or organization, as commonly known, but to a series of complex social activities orchestrated around a particular social or societal function such as education, medicine, or health care. Second, the mode of sociological inquiry arises from people’s knowledge of everyday activities and their coordination. Unlike conventional methods, which start with the application of theory, IE begins by exploring complex social functions from the vantage point of ordinary people undertaking daily activities. With this in mind, the entry point for my research is through interviews with nurses working at the bedside. This guiding epistemology, or philosophy of where knowledge is located, was accomplished through interviewing nurse participants and exploring how things work in their everyday nursing care work. This type of knowledge of care is not found but, rather, constructed by the various social influences located in their everyday world. Thus I am using IE to explicate the social organization of nurse’s care work so that I may answer my two research questions:

1. How is nurses’ care work socially organized by the contemporary quality management practices commonly used in health care organizations?
2. How has the social reorganization of care work affected the emotional lives of these nurses?

This methodology is important to my research because I am not interested in exploring the concept of care from any number of philosophical or theoretical perspectives, but rather how care work is shaped by these organizational influences. By illuminating the ways in which nurses’ care work is socially mediated, I can begin to shed light on organizational practices that may not be apparent or visible as a potential source of mediation of care work. I also emphasize that, while I am using IE as a methodology and way of knowing, it is not within the scope of a thesis to fully explicate the complex network of social relations, which influence and coordinate many institutional functions in contemporary health care organizations. Rather, I will be using IE as a methodology to open a small portal on the social organization of nurses’ care work within the contemporary hospital environment.

As part of using IE methodology for my research, it was necessary to determine the sampling method I would use to select participants. Although the health care literature provided ample discourse on the conceptualization of care and the contextual elements influencing care, there was still much not known at the outset of this research. In such circumstances, IE researchers follow a metaphorical ball of string as they explore the social relations implicated in their studies. Hence, I followed the same trajectory, tracing the strands of care throughout the local health care sector, using purposive and snowball sampling. The snowball sampling method aligns with IE as, from the outset, it is not certain who will be suitable as a research participant. According to Noy (2008), snowball sampling follows the same dynamic as social knowledge as it unfolds in an emergent manner that takes advantage of social networks and exposes power relations. It is the participant’s knowledge of who may have the requisite knowledge that may
add to the richness of the research that informs your choice of the next contact. The purposive sampling method involves pre-determining the selection criteria for recruitment. On consideration, it was important to recruit registered nurses with 5 or more years of bedside experience in Toronto tertiary care hospitals as I needed a perspective on nurse’s experience on the impact of organizational redesign of care work. Therefore, I needed nurses with some knowledge of how things worked before and after reorganization. During initial recruitment, I sent copies of participant forms to co-workers and colleagues, which explained the purpose and background of my research. Through these contacts, I obtained names of potential participants and contacted them by my University of Toronto e-mail, inviting them to contact me if they wished to participate. As I interviewed participants, I was provided with names of additional possible participants who may add richness to my data.

The Participants

The primary mode of inquiry in this research is through interviewing participants. According to Campbell and Gregor (2008) interviews are one way in which we can gain an understanding of the participants’ world of work and the social relations of the setting.

Embedded in informant’s talk about their work, generously defined, is their tacit knowledge of how to do it, how to concert their own pieces of work with the work of others and how to work with texts that coordinate action. All these activities contribute to what we mean by social relations. (p. 79)

Therefore, this observation provides the guiding framework for my research interviews.

Throughout my research, I interviewed 5 nurses (RNs) and a nurse manager. The one-one interviews were approximately one hour in length with an open dialogue. The interview was recorded via Mac software. I met with my participants on a mutually convenient date, time, and
setting. I interviewed one participant a second time in a half-hour phone interview to obtain further information on a patient care management system used by her hospital. This conversation was particularly helpful in my general understanding of how text-based technology mediates nursing care work at the bedside.

The confidentiality of my participants was ensured through anonymization of names and places and the use of pseudonyms. The participants were informed that they may withdraw at anytime throughout the process or decline any question they did not wish to answer. A copy of the interview transcripts was sent with encryption and passwords to each participant for review and comment.

Data Management

The interview was transcribed from MP3 format to a Word document. These transcripts were protected by encryption and passwords. Only my supervisor and I had access to these records. Other forms of public domain data were obtained from public institutions such as hospital and government websites. The raw data will be destroyed 5 years from the date of this research. Along with the transcripts of interviews, I kept a journal to write my reflections on the interview process, which is stored under lock and key.

Relevance

In discussions of the utility of social research, much emphasis is given to the issue of generalizability, or the extent to which research findings can be applied statistically to settings beyond the research study environment. This is a commonly accepted measure of the value of quantitative research. However, in qualitative research, the concept of relevance is used to address the same concern, that is, how much the research findings can be said to illustrate similar
experiences across settings. This approach, sometimes called, soft generalization fits well with D. E. Smith’s (1987, 2005, 2006) feminist mode of inquiry. In IE, researchers use the notion of reverse generalizability or the assumption that individuals are shaped by commonalities in their environments. Thus the relevance of a small study is suggestive of the larger picture. Accordingly, Hamilton and Campbell (2011) posited,

Working from the actualities, not the theory, of the social organization of institutional knowledge provides for its particular form of generalizability. Findings from one site can be generalized to other sites where it can be shown that the same social organization is in place. (p. 283)

Following these principles, I argue that the participants in my research, who are employed at different hospital sites in the Toronto area, have similar experiences because they are situated within similar institutional arrangements. This makes the findings in this research relevant within the social organization of health care work in and around Toronto and possibly beyond, wherever similar conditions prevail.

Chapter Outline

Chapter 2 will explore the standpoint of the participants in my research and the patient-centred holistic care they espouse as nurses. From these participants’ standpoint, the patient-centred care they attempt to provide is at odds with the patient-centred care as defined by their respective organizations. We begin to see a rift between both the institution and the nurses as these nurses struggle to provide both conceptualizations of care. It is here we begin to see the transformation of care as the strands or the core elements of physical and emotional care are reshaped by the reformation of the health care system.
The third chapter explores the redesign of contemporary health care organizations as they adapt quality improvement philosophies and methodologies, such as Lean, to their current organizational structures to re-conceptualize care through the lens of quality management. Here we see that care and the value of care are cast in a complex social web of relations within the system where power throughout this social hierarchy is at odds with the standpoint of the nurses expressed in Chapter 2. As these quality improvement methodologies are applied to work processes by senior management and external consultants, care is reconstituted or reformulated into a concept much different from the standpoint of nurses at the bedside. Although we see that the organization must continually adapt under the pressures from the Ministry in order to remain financially viable, we also see how patient-centred care, from the standpoint of those involved in direct patient care, is becoming transformed in the contemporary health care environment. It is from here we see the disjuncture between the actualities of patient-centred care, as experienced at the bedside and the organization’s conceptualization of care through the lens of Lean and/or quality improvement.

In Chapter 4, I explore the emotional work of caring or the emotional labour of nurses caring for patients in the redesigned organizational setting outlined in Chapter 3. Here I explore how nurses are emotionally labouring to care for patients in the contemporary system as they struggle to balance bedside care with the documentation work required by their organizations for the purposes of quality improvement (QI). We begin to see how nurses may be emotionally affected by the multiple demands on their time at the front-line of patient care. Moreover, as the organization struggles to align quality measures with Ministry objectives, there is increasingly more emphasis on the documentation of patient-centred care from the standpoint of the organization and the Ministry. As nurses try to balance care work with the organization’s
expectations, care or the perceived lack of care becomes an individual nursing problem. It is here I examine emotional labour, not as an everyday practical activity, but as a socially constructed object as I explore the world of my participants as they struggle to provide this dual conception of care. If this remains problematized at the local level or bedside, nurses may experience emotional exhaustion or burnout as they attempt to achieve both conceptualizations of care.

In Chapter 5, I explore how organizational texts associated with quality improvement/management (e.g., information technologies, paper documents, e-mail) unravel into the daily lives of the participants, further mediating the care they deliver at the bedside. In chapter four, as we begin to understand the effects of increased emotional work of nurses as they struggle to provide care under divergent conceptualizations of patient-centred care, we are introduced to the incursions in their everyday/night care of patients in the form of documentation technologies of quality management. In this chapter, I will explore, through my participants, the texts they use and how these texts coordinate care at the bedside. Here we see how nurses and the type of care that is being delivered are being reshaped by QI texts as they coordinate the work done by nurses. We also see, from the standpoint of senior executives of health care organizations, how they pressured to be accountable to the Ministry and to the public for the delivery of safe and quality health care. Furthermore, we see how nurses are made accountable, at the local level, through their documentation of certain elements of care that are conceptualized as value and quality care under the arm of quality management. It is here we begin to see the magnitude of the problem from the standpoint of nurses as care is transformed in socialized health care and as care activities are rewoven to a quality management framework.

In Chapter 6, the conclusion of my research, I will explore the social utility of IE by discussing the problem of how patient-centred care, as described by the participants, has been
restructured by quality management. I will use IE as a tool for workplace learning or as a way of seeing some of the issues illuminated in this research that may not have been seen as a systemic problem, for example, blaming the individual for the delivery of care that is not in keeping with the standpoint of what care is taken to be or from the standpoint of nurses.
Chapter 3
What Is Care?
Unraveling the Core Elements of Care

As I explore the construct of care, I am overwhelmed by the richness of what actually happens at the bedside from those with everyday and night knowledge of providing care. As each participant added to the mosaic of collective stories from where they stand at their respective places at the bedside, I became aware of some of the disruptions in their daily/nightly care work causing them to question their delivery of care. It is in these moments that the concept of care becomes visible as a social relation; care is not an abstracted concept but actively constructed by various actors such as RNs, physicians, administrators, hospital boards, and the government. Through my conversations with my RN participants about the challenges of providing care at the bedside, I gained an entry point into their worlds as social actors within the complex social relations of the health care system. It is their local knowledge of how the care work gets done, how it is coordinated, and under what rules that is of particular interest and aids in our understanding of the complex social relations that extend beyond the walls of their respective organizations. This entry point allows us to see how care is socially organized. From here I have developed the standpoint for my research. D. E. Smith (1987) posited, “A standpoint in the everyday world is the fundamental grounding of modes of knowing” (p. 108). Hochschild’s (1983) conception of emotional labour aligns with D. E. Smith’s social ontology. According to Hochschild, emotional labour is a social construct living within the complexities of the contemporary organization and socio-economic world. It is from this view that I will also illuminate the participant’s increased emotional demands while providing care within the contemporary health care system built on efficiency and accountability. Throughout this chapter,
I will develop the standpoint for my research by exploring the literature on emotional labour and the work of caring and through interviewing my research participants whilst gaining some insight into their care work.

Although my past nursing experience provided a frame in which to view care at the beginning of this research, I turned my inquiry to scholarly literature to answer: ‘What does care look like within the context of the work environment?’ Campbell and Gregor (2008) posited,

In Institutional Ethnography, the researcher reads the literature both for conventional reasons - to discover the scope of research knowledge in this area - and for a particular reasons related to her own positioning…For the beginning institutional ethnographer, the work of conceptual framing of the research project identifies both what is known and what needs to be discovered about the topic to explicate its social organization. (p. 51)

It is the culmination of experience and knowledge gained from the literature that prepares me for my journey as I explore how nurses deliver care in the hospital environment from a particular point in time. In particular:

1. How are they providing care within the reformed health care system?

2. What is their experience in relation to how care is being done and what constitutes care in their respective organizations? What is left out of daily or nightly care?

3. What is replacing certain elements of care? What is being left out?

4. How do the nurses feel about this? How did I feel about it from an historical account?

I first searched the nursing science literature on my topic of inquiry. The nursing literature provided alternate humanistic theories on caring within the context of nursing science and the health care system. Conceptual models of nursing define nursing care work or the art and
science of nursing practice based on the conceptualization of the patient, the nurse, health/illness, and the environment. As I began to conduct interviews with my participants, some core elements of nursing theory were mentioned during our conversations. Although these nursing theories were instrumental in defining elements of humanistic caring in everyday or night nursing care, this academic discourse did not carry in the everyday conversations of the participants in my project.

Nursing scholars and nursing leaders struggle to define care and care work within the context of contemporary health care and the bio-medical model. McCrae (2012) noted that nursing scholars and leaders have attempted to define the concept of care and carer however, it becomes problematic when it is translated into in the practice setting. McCrae’s discussion paper outlines nursing conceptual models from their inception in the 1950s and discusses some of their limitations such as ambiguity and abstraction when attempting to translate them into everyday/night nursing practice. However, McCrae cautioned that in the current environment of evidence-based medicine and managerial practices, a lack of nursing theory or nursing conceptual models in the practice setting may endanger nursing practice by leaving it vulnerable to the influences of corporate defined care, quality standards and the episteme of medical science. Although these nursing conceptual models of care provide a framework for defining nursing care, they offer a limited lens for viewing the rich and complex social world of relations in contemporary health care. Moreover, these models do not provide an accessible way of seeing how the broader social relations of health care are connected to bedside nursing care.
What the Concept of “Care” Looks Like:
Linking the Literature and My Data

The nursing literature provides a historical and evolutionary perspective on *caring* as a concept from which elements of care resonate, not as theory, but as values and/or beliefs communicated by and enacted by my participants in their everyday/night nursing care. Brilowski and Wendler (2005) identified the concept of care as ambiguous in their review of the literature on caring science. These researchers contend that the concept of caring did not enter the Cumulative Index of Nursing and Allied Health (CINAHL) as a search term until 1988 and the concept continues to evolve as a relatively new concept. They conducted a scholarly analysis of the concept from 68 articles from the literature in order to clarify the elements, antecedents, and the effects of caring. Of particular interest to my research, the attributes of caring within the nursing profession such as relationship, action, attitude, acceptance, and variability are resonated in my participants’ interviews.

Brilowski and Wendler (2005) identified the element of relationship in caring as the foundation of nursing care. These researchers contend that “Trust and intimacy were essential in a professional caring relationship” (p. 643). They also identified the role of the nurse in a professional caring relationship as responsible from a current knowledgeable and ethical code of standards of care. These researchers also identified attitude and acceptance as antecedents of relational as well as physical care. Attitude was distinguished as the positive and caring disposition of professional nursing care, whereas acceptance was identified as seeing the patient as an individual and respecting their individuality by preserving dignity and respect. These elements resonated with my participants in my research through our interviews, as illustrated in
the following excerpt from Sara, an RN working in the orthopedic ward of a university teaching hospital in Toronto:

(Communication with Sara, RN, March 21, 2011)

Sara: So I think that how patients end up remembering [nursing care] is often more how you made them feel. I've had a few patients where they've been very upset or anxious, and you know, you've talked to them, ‘what are you upset and anxious about?’ A patient I have today, who was worried sick about going and getting her x-ray of her hip, because she was worried about transferring from the bed onto the x-ray table. And, we talked about [how] unlikely that you would fall between the bed and the table. That we're going to use a transfer board .[We] went through all kind of the rational type things. But then I also said, ‘and you know what? The x-ray's a good thing because you'll know that your hip's healing and in place so that you can keep going with your physiotherapy and keep moving.’ And she did verbalize later to her husband that, she could never had had the x-ray if I hadn't sat and talked to her. So, so today's actually a good day.

In this interview excerpt, Sara describes an encounter with her patient who had recently undergone a hip replacement surgery. The patient was thankful that Sara spent time building rapport and discussing her fear of falling while being transferred from her bed to the stretcher for her X-ray. Sara recognized and accepted the patient’s perception of insecurity and fear through well-honed intuition and tacit knowledge. Sara built intimacy and trust by taking the time to listen to her patient’s fears and used her knowledge to explain the procedure from a safety perspective. Sara also demonstrated, through her actions and discourse, her clinical knowledge of the benefits of the X-ray. Moreover, Sara built trust and developed a climate of intimacy and safety much attuned to the her own high standards of practice and ethics whereby, she understood the emotional needs (establishing trust and the perception of safety) and physical
needs of her patient (in order to progress in physiotherapy, the X-ray must be done to ensure this patient’s hip was healing). Sara espouses building connections with her patients in her everyday nursing care as she identifies in this scenario as “so today’s actually a good day” in the context of this interview or exploration of the emotional care and care in nursing. Similarly, James (1992) defined a carer as, “someone who gives sustained, close, direct mental and physical attention to the person being cared for” (p.489), and that that care and carer are entwined within the complex fabric of social relations in a gender divided society. Accordingly, James exemplified a positive and caring disposition in her approach to caring for and helping her patient overcome fears related to treatment. To Sara, care is both physical or clinical and emotional or relational. These aspects of care are inseparable in the everyday/night care of patients under Sara’s charge on an orthopedic ward in a Toronto hospital. In fact, Diamond (1995) and Stacey’s (2011) research on health care aides highlighted the common values of those working directly at the bedside. These researchers found that relational care was integral to bedside care and the participants in each of the researcher’s respective studies strived to provide, either through their choice of an autonomous work environment in home care or through finding time in their busy institutionalized schedules, emotional and psychosocial care for their charges.

The concept of action or the physical attribute of caring in professional nursing, as identified by Brilowski and Wendler (2005), involved caring actions such as nursing care, touch, presence, and competence. According to their literature search, nursing care was defined as, “the actions and interactions between nurse and patient (Fealy, 1995, as cited in Brilowski & Wendler, 2005, p. 664), with physical care as a primary focus (Garbett, 1996; Gullo, 1998; Shamansky & Graham, 1997, as cited in Brilowski & Wendler, 2005, p. 664). Caring touch was identified as the intentions of the nurse as he/she provides routine care as well as the little things
such as a back rub and is based on the perceptions of the patient receiving that care. Another sub-element of action in professional nursing care was presence or the use of self, physically and emotively, as a tool to become totally present during nurse-patient interactions. The fourth action in professional nursing care was competence or the competence in the clinical component of caring, which espouses the art and science of nursing care.

The following excerpt from my interview with Janet, an RN working in a pediatric intensive care unit (ICU) in a Toronto teaching hospital, exemplifies the caring actions of professional nursing:

(Communication with Janet, RN, May 4, 2011)

Janet: “I had a little guy, 8 years old. He was so cute. I had to take his chest tubes out. So I said to him, I said, ‘now, this might be a little uncomfortable. Do you know what that means?’ He goes, ‘What does that mean?’ It means it might be painful. ‘Oh. I don't like that.’ I said, ‘I know. But you're 8.’ And I said, ‘what's brilliant about people being 8? Do you know what's brilliant about people being 8?’ He goes, ‘I don't know.’ I said, ‘you can be distracted.’ I said, ‘that's a big word. It means, think about something else and you'll let me do something for you.’ And he went, ‘Okay, so what do you want me to do?’ I had a scrub shirt with bunny rabbits on it. I said, ‘I need you to count how many bunnies are on my shirt, because I don't know how many is there.’ So he starts counting. So while he's counting, I'm pulling out his chest tube. So I pull out the chest tube when I all of a sudden hear this voice, ‘Can you turn around, I finished counting the front?’ I said, ‘well, that's good, because I just finished taking out your chest tube.’ And he went, ‘Really? I didn't feel a thing.’ So I immediately turned around so he could count my bunnies on the back. And it seemed I had 37. But he knows, this was from an 8 year old, 37 bunnies on my shirt. And he told his mother, ‘The nurse has 37 bunnies on her shirt.’ The mom is looking at me like, 'Why does he need to
know how many bunnies are on your shirt?’ He had totally forgotten about the chest tube. Like I thought that was so brilliant.

In this interview excerpt, Janet describes a moment in her nursing care of a child admitted in the ICU who was afraid of a potentially painful, yet necessary, procedure. Janet not only exemplifies caring professional nursing practice through acceptance of her small charge as an individual but exudes the attitudinal and relational elements of caring. She creates a safe space by engaging the small child in a game, familiar at his stage of development, which creates a familiar space within the boundaries of ICU care. Janet practices caring touch as she prepares her small patient for the technical procedure she has performed adeptly on many occasions during the everyday/night care on her shift. It is the little things, like playing a game of counting bunnies, which defines the qualities of professional nursing care. And, as in Janet’s statement, “I thought that was so brilliant”, she embraces this element of nursing care as part of her core beliefs. Moreover, it is her tacit knowledge of emotional care of her tiny charges that translates into her bodily caring of her patients. Her caring touch is the presence of her emotional and physical being as she guides her small charge through a frightening and uncomfortable medical procedure. For Janet, it is the merging of physical and emotional care that these elements of care identified by Brilowski and Wendler (2005) are practiced as embodied care. There is no separation of these elements of care. Similar to Janet’s experience, P. Smith and Gray’s (2001) research on student nurses found that emotional labour or the emotional work of caring was part of the daily routine of nursing. A participant of P. Smith and Gray’s (2001) study provided an account of her everyday work at the bedside as,

Part and parcel of the normal routine of nursing, which included the psychological and social aspects of care. The psychological aspects of care involved “friendship”, being more intimate and building up trust and showing the patient “a
little bit of love”. The social aspects touched on “making patients feel at home.” (p. 232)

This is not so easily understood by the lay public, or outside, or within the nursing profession, as the mother of the pediatric patient could not understand the connection between counting bunnies and the clinical task of removing a chest tube. Here is where professional nursing care is misunderstood. It is the alignment and embodiment of emotional and physical aspects of care, which is not easily understood outside of the nurse-patient relationship. This leads to the following questions:

1. How is care interpreted outside of the nurse-patient relationship?
2. How is it redefined within the context of social relations and its many interpretations of care within an organization?
3. Who defines what care is? Who has limited autonomy in defining what constitutes care?
4. How does this reconceptualization of care look? How does this organizationally defined concept of care affect the nurses providing the care?

What Care-Word Looks Like at the Bedside:
The Invisible Work of Care

How does bedside nursing care look within the context of an organization and the competing demands that often place the nurse in the middle? How is care defined as paid labour? As I turn from the elements and values espoused in the conceptual notion of care to the organizational adaptation of care, I will explore how it is translated in the social realm. Hochschild (1983) coined the term emotional labour or paid emotional work and the social
control of emotions within the organization. Emotional care work becomes emotional labour in organizations where employees’ emotions are shaped by organizational feeling rules when providing a direct paid service to the public. Hochschild’s research on flight attendants revealed that the study participant’s genuine feelings were often either suppressed or evoked depending on the nature of their social exchange with the public. Recognizing nurses’ emotional labour as unique from other direct service workers, P. Smith (1992, 2012) conducted research on student nurses’ emotional labour. P. Smith’s research highlighted the extent of emotional labour required by students when encountering the physically and emotionally challenging work of nursing care. Nurses must display a certain demeanor when confronted with the noxious smells from cleaning soiled patients or witnessing the death of a patient in order to preserve the dignity of those in their service. The attainment and maintenance of professional demeanor requires emotional work to suppress feelings of disgust or feelings of sorrow the nurse may privately feel. Kelly, Ross, Gray, and Smith’s (2000) research on bone marrow transplant (BMT) nurses highlighted the importance of recognizing the emotional labour required in caring for palliative patients within the context of death and dying in the medical literature. These researchers maintained that, although there is more research interest in the humane and emotional care of patients, more research needs to focus on the unique area of BMT as the relational work and emotional labour the nurses do at the bedside is emotionally taxing as they are frequently confronted with death and dying in the clinical area of leukemia. Corresponding with Kelley et al.’s (2000) research, Bailey, Murphy, and Porock (2011) recognized a need for emergency nurses to develop emotional labour skills when dealing with the stress of unexpected death in the emergency room. These researchers maintained that nurses might experience emotional burnout if they do not have
the emotional management skills to effectively deal with the ongoing, highly emotive work of unexpected death and dying

Highly emotive work such as nursing can lead to burnout. According to Maslach (as cited in Bartram, Casimir, Djurkovic, Leggat, & Stanton, 2012), “Burnout is a psychological syndrome that involves losing concern for the people with whom one is working and is commonly associated with workers in caring professions” (Maslach, as cited in Bartram et al., 2012, p. 1569). The Bartram et al. (2012) study of Australian nurses found a statistically significant association between high emotional labour and nurses’ intention to leave their employer. These researchers found that organizational social support systems such as high performance work systems may mediate burnout and affect retention of nurses in the workplace.

The participants in my research express similar emotional challenges when providing nursing care in emotionally charged situations similar to the situation in the following excerpt from my interview with Janet, an RN working in a pediatric intensive care unit (ICU) in a Toronto teaching hospital:

(Communication with Janet, RN, May 4, 2011)

Janet: “Some will have a temper tantrum that goes with the territory. But, all in all, um, most families are, ‘Whatever you need to do.’ It can be just the proverbial straw on the camel's back. Maybe it's just been a bad week for them and this is just one more thing. It can be, as I said, when a family are having a difficult time with grace and they're not able to accept that there may be some limitations as to what can be done, I think the challenge we have now, which is a real difference in the last ten years, children can be intensely sick and chronic requiring great supports but there's really no sign that they're getting better. I call it purgatory. It's at my facility. It's our ICU. When families are stuck in a cycle, for many, many
days, many, many weeks and we can't say to them, 'We know when your child is going to get better, or not better, or we'll move forward.' It gets tiring. And I can't imagine what it's like. I get to go home. I get to have some days off. And they don't. So, we actually have this acronym, which is a really great teaching mechanism for our young colleagues as well as those of us who have been doing this for a while: ‘QTIP, Quit Taking It Personally.’ And it's actually really good, because when a family is really beating at you, you're thinking to yourself 'Okay, there's something big going on here.' And I have to just step out, just for a second, just to remind myself, don't take this personally. It's just because I'm wearing the ID badge and I happen to be assigned here, and they're pissed with the world. All I can do is acknowledge they are frustrated, acknowledge that this is going on and try to show them that I'm doing tasks to their child to help their child. I'm also attempting to reconcile for them what's going on. And those are the days when you really want to find something for that family to do or to give them some kind of capacity that they can see there's something that they can have some control of. Because there are times when their child is so out of control, I will actually say to parents, ‘You have a choice, I can attend to your needs, or your child's.’ Because if I do not focus on your child, I can not guarantee they survive this shift.”

Janet’s interview provides a perspective on nursing care when it is not ‘a good day’ or when a higher degree of emotional labour is required to care for her young patients and their families. In this excerpt from our interview, Janet recounts a shift where the young patient’s family has vented their feelings of anger and frustration on the nursing staff. She describes the context of the situation where bio-medical technology has prolonged the life span of certain patient populations she commonly cares for, which still face an uncertain, if not poor prognosis. These families face a long-term, often protracted, series of good days and bad days with limited control over the outcome. As well, despite advancements of bio-medical technology, the outcome of chronic illness remains incurable. Given the bio-medical advancements in the last 20
years, patients’ and families’ expectations, as consumers of health care, have increased. However, the limitations of these technological advancements are often realized over the protracted course of chronic illness. And, as Janet exclaims, sometimes, another turn in her young charge’s condition is the “proverbial straw that broke the camel’s back”. For Janet and her colleagues, it lies within their scope of care, to emotionally manage their patients’ and families’ reactions to illness and the limitations of medical care from which they had built their faith and expectations. Janet’s representation of context through her care of patients and families resonates strongly with Kelly et al.’s (2000) and Bailey et al.’s (2011) research findings in the highly emotional settings of the BMT ward and the emergency room. Moreover, Janet’s experience parallel’s Kelly et al.’s (2000) findings on the prolongation of leukemia patients lives. These researchers cautioned that, in a clinical area defined by the bio-medical cure model, nurses might suffer emotional consequences such as burnout if the literature remains silent on the issue of emotional labour of nurses and the need for discussion on death in dying with their BMT patients. And, as Janet defines the clinical setting as “purgatory”, there is a sense that the emotional climate is complex and highly demanding of the nurses caring at the bedside. In essence, from Hochschild’s (1983) and D. E. Smith’s (1987, 2005, 2006) lens, Janet’s experience at the bedside has been socially reshaped by the increased organizational demands of emotional labour required for caring for their patients and families who often place their hopes on the bio-medical model espoused by the health care system, particularly in university teaching hospitals.

Notwithstanding, Janet acknowledges the feeling rules required by her employer and the College of Nurses of Ontario (CNO) as she points out that the family’s emotional outlet happens to be because she is wearing “the ID badge”. It is the family’s expectations that Janet will remain compassionate and caring despite how she personally feels. These expectations are reinforced
socially through media or text, which communicates the attributes and demeanor expected from caring professionals. Complementing Janet’s bedside experience, Carlton, an RN nursing instructor at a university nursing program, who has experience working in the area of mental health, states:

(Communication with Carlton, RN, February 16, 2011)

Carlton: “You need to know yourself and affect your emotions in order to deal with people. Nursing practice is an uncomfortable lens to wear…you need to learn how to use it. We all function in a range. In a nurse-patient relationship it is a very structured space…it is bound by legal, and ethical considerations…you need to know why you are hugging a patient and how the patient will perceive this…you need to be mindful…it is more work than our everyday relationships…..you leave your emotional everyday at home…who you are is in the background. It is an unbalanced relationship…you do not pay me enough to listen to you swearing at me…but, you have to be in the moment…we tend to want to run from these situations.

One salient point from my interview with Carlton is that “nursing practice is an uncomfortable lens to wear”, so you must “know yourself and affect your emotions in order to deal with people”. Janet acknowledges this by empathizing with the family’s frustrations, as she understands the challenges of care in her work environment. Janet states that she can leave after a 12-hour shift or have a few days off, but these families have no respite from the turmoil of ups and downs of chronic illness. P. Smith (1992) described this emotional technique in nursing as deep acting, which “requires us to change our feelings from the inside using a variety of methods such as imaging, verbal, and physical prompting so that the feelings we want to feel show on our face” (p. 7). Janet draws on her experience and knowledge in her recognition that the emotional
and behavioral actions from the young patient’s family is telling her that they are not pushing her away but they are showing that they need her more. And, as Carlton points out, the nurse-patient relationship is more difficult work than personal relationships as it is unbalanced by legal and ethical considerations in the form of institutional feeling rules and expectations of conduct. The nurse must work harder, emotionally, in these situations despite what they actually feel, as Carlton points out “you do not pay me enough to listen to you swearing at me”. Janet also points out through the use of her acronym, “QTIP, or quit taking it personally” is a teaching tool for learning the deep acting skills for those experienced or novice to the profession. This is reflective of P. Smith’s (1992, 2012) and P. Smith and Gray’s (2001) research on student nurses where these researchers emphasized the importance of nurse mentors to guide students through reflective nursing practice in order to explore and develop tacit knowledge through their personal experience to learn emotional labour skills. This is also reflective of Mann’s (2005) research on the development of a health care model of emotional labour that values emotional management skills as a valuable workplace skill. Carlton’s point about the difficulty of wearing the nursing lens is also reflective of P. Smith’s research (1992, 2012) as the relational skills we learn in our personal lives are very different from the emotional labour skills in providing care under the legal and ethical rules that socially shape nursing care at the bedside. In fact, the nurses have increasingly limited control over emotional labour as the bio-medical and administrative definitions of care place greater expectations at the bedside with fewer resources to provide this care.
What Does the Organizational Delivery of Care Look Like?

“It Is All a Numbers Game”

(Communication with Sara, RN, March 21, 2011)

The previous section illuminated the emotional work of care and how nurses aim to act within the organizational confines and social expectations of what care is. I will now look at how care is defined in the organization. How do these conceptions of care differ from the standpoint of nurses at the bedside? How is this increasing the emotion work of caring seen in the last section? I now turn my attention to other contextual influences of care, where social, political, and economic forces reshape the physical and emotional elements of care in the everyday/night delivery of care. It is from exploring the organizational standpoint and the standpoint of nurses working at the bedside that I will be able to explore the disjuncture between each and arrive at the standpoint for my research. According to Campbell and Gregor (2008), D. E. Smith defined disjuncture as two different versions of reality, one from an organizational perspective, and one from the everyday/night experience of those working at the front lines or of those who interface with the public (Campbell and Gregor, 2008). It is here where the literature on the concept of care assists us in understanding how the core elements of nursing care espoused as the standpoint of the nurse participants in my research has been redefined from an organizational perspective. It is at the crossroads between these standpoints that I will locate my own standpoint by following the loose strands to explore the how nurses are providing care in the contemporary health care environment within their respective organizations in Toronto.

I will first turn to the literature on nursing care within the organization in order to see what care looks like from an organizational standpoint. James’s (1992) research has been widely
cited in the literature and provides an instrumental view of how care is re-interpreted within the organization. James’s (1992) reference to care work as it applied to her research on hospice care is helpful in delineating family care, which we are most familiar with, from nursing care work conceptualized as the family care model in the hospice. James compared and contrasted the components of care work within the home and the hospice environment and identified the skills involved in both types of care work. In the context of nursing care work, she identified the emotional, physical, organizational, managerial, planning, and evaluation skills needed to plan care. With all the components of care defined and compared between family care and nursing care work within the family care model, James constructed a formula of care which is “care = organization + physical labour + emotional labour”. What is interesting about this formula is care is now abstracted, mathematically, through division, into separate elements of care for the administrative delivery of care. James’s experience in the hospice environment gives reference to the separation or apportionment of components of care through a division of labour suggesting a medical and administrative conceptualization of care. James’s research is important as it highlighted the disembodiment of care as it is defined and applied to nursing care within the organization. Moreover, care, under the direction of the organization, becomes a series of tasks and schedules that are under the priorities of management and not the patient. It is from this definition of care, that we can see the separation of the strands of the core elements of care, from an IE perspective, and how these strands of care are reshaped disproportionately through health care reform, which contrasts with the embodied core elements of nursing care as highlighted in the previous section on nurses own conceptions of caring.

Considering this perspective, we can begin to see the social relations and how they interact and mediate the elements or threads of care that James’s (1992) research brought into
focus. D. E. Smith (2006) defined social as what arises out of people’s everyday activities to achieve social order. Their decisions and actions are coordinated, which they may be unaware of, by persons or groups outside of the local or immediate setting. According to Campbell and Gregor (2008), D. E. Smith called these social connections or the coordination of activity as social relations (Campbell & Gregor, 2008). Nurses at the frontline of care may not be conscious of how their choices are shaped by these social relations in their care work. As James (1992) illuminated in her research, there is a division of labour when care enters the social organization of hospice care. Although James’s research was restricted to the local or organizational view of hospice care, she gave us a picture of how the organization of care is divided from the standpoint of the providers of care within the hospice. From here we can appreciate the gendered, hierarchical nature of care in an organizational setting as compared to the embodied care work done within the family. Also from here we can explore the interrelations from a feminist approach espoused by D. E. Smith (1987, 2005, 2006) where embodied professional nursing care becomes disembodied. In James’s abstract equation of care we see the strands, or the physical and emotional core elements of care, reshape under the organizational and administrative reformation of health care.

Diamond ’s (1995) research on nursing home care similarly illuminated the deconstruction or unraveling of the strands of care within the social and political environment of the United States health care system. As the organization and the government, in the form of regulation and policy, redefined care, some forms of physical and emotional care became an errant thread within the context of rationalizing nursing care. As the residents strived to find ways to fulfill their emotional and physical needs, they were confronted with organizationally defined or accepted forms of care. No longer could an institutionalized daughter visit and
console her elderly mother in her room within the same nursing home. For this mother and
daughter, the bureaucratic rules of care required each to be sequestered in their own respective
confines of the nursing home facility as their whereabouts must by accounted for by the nursing
aides through their documentation. Moreover, nursing aides, overburdened with the delivery of
all the necessary administrative and medical priorities of care, were unable to provide the
physical and emotional care needs of the more isolated residents of the home. The care defined
by the system was completed based on a prescriptive set of physical tasks and left minimal time
for building the nature of relations most commonly associated with James’s (1992) definition of
non-institutionalized or family construct of care. Moreover, from the standpoint of the nursing
aides the tasks, as defined by the organization, were in conflict with their everyday/night
experience of delivering care to those with unfulfilled physical, social, and emotional needs.
Diamond illuminated, for his research participants, the bureaucratized redirection of nursing care
away from the physical and emotional needs of the residents towards the managerial work of
documenting the medical and regulatory work of the organization. Hence, the institutional
processes inhibited emotional or relational caring. These institutional processes also increased
the emotional work of nurses as they attempted to suppress their feelings of frustration with the
delivery of inadequate physical and emotional care. They created a disjuncture between the
standards of care the health care aides espoused and the actual work they were required to be
performing.

Complementing Diamond’s (1995) research, Stacey (2011) and Lopez (2006) contrasted the type of care directed by the management of bureaucratic organizations with the everyday world where those giving and receiving the care practiced care. Stacey’s work with home care aides revealed why, despite the lower pay in home care in relation to long-term care facilities,
those participants chose to remain in the home care environment. The participants, who chose to stay in home care, cited autonomy in providing the standards of care that mattered to the clients they were assigned to and described the rewards of their work in relational terms. Lopez’s comparison of three nursing homes highlighted the variance of feeling rules within each of the organizations through organizational emotion management. Each home in the study had organizational or managerial processes that either embraced emotional or relational caring or inhibited this element of care as in Diamond’s (1995) experience. Lopez (2006) conceptualized organizational management that facilitates relational caring as organized emotional care:

The defining characteristic of organized emotional care is that managerial attempts to legislate how workers are supposed to feel are replaced by organizational rules, procedures, and recordkeeping, aimed at the creation of organizational spaces within which caring relationships can develop. (p. 137)

Similar to Diamond’s (1995) experience, Stephen, an emergency nurse at a university teaching hospital, describes his frustration with how direct patient care is circumvented by the frequency of filling out documentation and other accountability measures:

(Communication with Stephen, RN, October 27, 2011)

Stephen: “We look after humans. So you can't tell when the next patient is going to have the urge to urinate, cannot hold it in, has incontinence. You can't tell when the lab is going to [call] it's a complex process…those are interruptions that we're not able to control…those are just part of the job. …they're part of the patient care process. The different set of interruptions or pulling away, that tends to compete with the patient's interests, tend to be not those, but those that are beyond what I would call humanistic care, or maybe what you would call emotional care. I would call humanistic or local caring work. Local caring work for me is the happenings of everyday life. I walk into the emergency department; I meet my colleagues; I meet whoever's on the floor; I get to know my patients; I do their
clinical work; their counselling work. I get to know them; get to know their family members; their social history; their psych histories… all that stuff. The everyday, that happens…the interactions… that are local caring work. What pulls me away from that, and that I would call, would compete with that is anything beyond that; anything that is superimposed: administrative process that want to organize my work and my experience and that of my patients and their loved ones in a way that tends, that is dissonant with their interests. So there's a regime called the patient flow regime. There is a regime called, I would call the documentation, the recording and reporting regime that would pull me away from my patient.

'Now Mr. So and so, I have to stop talking to you, even though you're talking about a very important thing. I got to go and document. I have to go and chart. I have to go and report your vital signs, because now is the 4-hour mark and therefore the regime asks me that I must do this, otherwise, I will be in trouble.'

There's a sense of control, that's there.”

Stephen describes the core of his nursing care work as humanistic where the relationships between colleagues, patients, and patient families. Care work is getting to know patients and families through communication and understanding their care needs. Stephen describes a disruption in his caring practice by organizational processes and reporting that shift his attention away from his care, almost deterring relational care work. He describes a patient flow regime or a governing authority that influences his autonomy as a professional. He describes the disjointed care that fragments and limits care at the bedside. His care work is reshaped or mediated by the ruling relations that organizes his care and coordinates his actions in the workplace. What are the ruling relations? They are the governing policies and procedures of the institution (defined as the complex interconnected social organization of health care) that shape the actions and priorities of those ruled by this system, namely those lower on the social hierarchy of power. According to Diamond (as cited in D. E. Smith, 2006), the ruling relations are located, “Often right there in the
rules and their local practices” (p. 60). It is here where Stephen’s local caring work is ruled by "I got to go document .... I have to go and chart”. I have to and report your vital signs, because now is the 4-hour mark”. Stephen and the organization he works for are caught in the web of social relations of the institution of health care. Both Stephen and his organization have been caught in ruling practices where social relations that extend beyond the local four walls of the hospital, have reshaped care delivery. These ruling relations enforce the accountability practices of documentation and record keeping that limits the choices of the local providers of care. The organization, which is struggling to remain a viable entity, becomes hooked into the larger health care system; thus, too, Stephen’s local care work becomes hooked to the same system. However, according to Stephen, and from the standpoint of where he literally stands in the hallway of the emergency department, this caring work that has been mediated by the routine documentation practices of his organization causes frustration, as these practices are not compatible with his local humanistic care. These accountability practices do not make sense from the standpoint of humanistic or relational care, as these practices focus his attention from the direct relational care he espouses as caring work.

Parallel to Diamond’s (1995), James’s (1992), and Lopez’s (2006) research findings, Sara, an RN working on the orthopedic ward of a Toronto teaching hospital, illuminates the disjuncture between how she feels she ought to do nursing care and how the work was being done at her hospital:
(Communication with Sara, RN, March 21, 2011)

Sara: “It is all kind of a numbers game.”

My response: Now how, how do you feel about this numbers game in the way of doing nursing care? I used to find that sometimes I would feel distressed. I remember at my hospital, there was such a demand for the ICU beds, and oftentimes, we would extubate a patient, send them up the floors, say 'Yes, you're off and ready.’ And they leave the ICU and would have an arrest [cardiac arrest] and come back.

Sara: I certainly worry. Some people that I send home at 4 days. Are they going to manage? Some people I know are going to do just fine. But some people I'm not terribly comfortable with it. And you start to feel like you're more working an assembly line, rather than really a caring profession. It is just bring the patient through, do the surgery, and get them out. You know, just a real assembly line type thing, to the point where when I, some of it might be age, but when I started nursing, I could remember every patient's name that I had taken care of for the last 10 years and what room they were in and what surgery they had, and everything else. Now I'm lucky if I remember whom I took care of last week.”

It is here where we see the separate strands or elements of care and how they are reshaped disproportionately in bedside nursing care. Sara recounts to the days of her nursing training where she “could remember every patient’s name that [she] had taken care of for the last 10 years and what room they were in and what surgery they had”. In Sara’s past experience, where most organizations had processes similar to Lopez’s example of organized emotional care, she was able to focus on the care that was meaningful to her patients and their recovery. It is a time where nurses were more autonomous and accountable to their patient’s needs rather than being accountable for priorities and care imposed by managerialism. Sara could spend the time assessing her surgical patient’s social support system while providing a back rub necessary for
post-surgical patients who have not regained sufficient mobility. What Sara is describing is the disembodiment of care where, as Diamond (2005), James (1992), and Lopez (2006) pointed out, the relational and emotional care of patients are considered an expense that the organization can no longer afford under current health care reform. Sara contrasts the attributes of a caring profession, as I outlined earlier in this chapter, to assembly line work or the processes that value efficiency over relational care or physical care that fall outside the parameters of the biomedical or rational care model (e.g., back rubs). This is the line of separation or when the strands of care start to unravel, and resemble James’s abstract equation, care = organization + physical labour + emotional labour. It is also here where we see from Sara’s everyday/night nursing experience, what she considers as being a caring professional. Sara’s standpoint, from where she is located at the bedside tells her that spending more time with patients and providing health teaching or assessing her elderly patient’s social supports is at odds with the care she is expected to provide by her employer. This is counterintuitive to Sara’s experience, as her caring work requires more emotional labour as she tries to suppress her anxiety about her limited contact with her patients. In fact, the delivery of care in contemporary health care organizations has become more centred on the physical or biomedical and administrative model. As health care organizations attempt to serve the demands of government and public expectations, access to key medical and surgical services are prioritized for these groups. It is from the standpoint of the health care organization that the more measurable aspects of care have increasingly come to define care, as senior executives must be accountable to the social relations extending beyond the real estate or property line. And it is here where the two worlds collide: Sara and the caring professionals who participated in this research and the organizations that were unable to spare the expense of their employees’ time. Their stories resonate strongly with the stories told by participants in Diamond,
James, and Lopez’s research. And, if this a numbers game, as Sara remarks, then who wins in this game? How did the rules and structures of the game come into existence?

Deconstructing Care:
The Disjuncture

Diamond (as cited in D. E. Smith, 2006) emphasized, behind almost every research problematic, there is an author who has background experience in the area they are conducting an IE. This is also true for me. Similar to Diamond’s (1995) and James’s (1992) experience, I have experienced conflict between my perception of care as humanistic or holistic and the organization’s conceptual definition of care. I have been torn between finding the time to provide the nursing care I was taught and delivering the standardized care expected by my employer.

During the period I worked as a bedside nurse, the Ontario government, under economic austerity measures, began dismantling many social programs. According to P. Armstrong and H. Armstrong, (2001), this era, the 1990s, was defined by the assumption that “when less is better” or by the efficiency model of care. This was not unique to Ontario, but part of a global shift toward managerialism in which efficiency was central to the new accountable public service. I, along with front-line staff, patients, and their families, endured the closing and amalgamation of hospital and services throughout this period. I no longer had the resources of time or emotional team support to care for those who relied on my nursing care as more of my time was rationalized by workload management systems. Working more with less, I observed the decline of the esprit de corps I had known as a student nurse, as colleagues struggled to provide the basics of care for their patients. As the emergency department filled to capacity, illuminated with the flashing red of ambulance lights at its threshold, the beds our patients occupied became a highly coveted commodity. I saw my patients removed from life support prematurely, respiratory
muscles barely able to sustain lung capacity, and transferred to the hospital wards only to return by evening intubated and in need of ventilation support. I saw my patients’ eyes as they were wheeled away on a stretcher to the wards; they showed vulnerability, fear, and powerlessness. Their fear actualized as their conditions declined on a busy ward, far from a watchful eye. Their weak respiratory muscles, prematurely removed from mechanical support, were no longer able to sustain the breath of life. Some returned to the ICU. Others did not.

Through the process of constructing my research questions and reflective journaling, it became apparent that this story of how care is being delivered at the bedside in the contemporary health care organization is viewed not only from the standpoint of the nurses in my study but also by me. It is part of developing the standpoint. It is how I weave empathy for my participants and the esprit de corps I had the honour of working with into my research. As daughters, sisters, mothers, friends, and colleagues, it is here I delve into the experience of everyday life as a woman caring professionally as well as in my personal life. It has taken a culmination of personal, professional, and academic experience to get to this point. It brings awareness of how our everyday subjective lives as women and men in caring professions are hidden in the larger story of life. However, our lives are not distinct from the system we are a part of in which our embodied experiences are interwoven. Our conscious minds may connect with our loved ones at home while caring for a child with a terminal illness in an ICU. There is no separation of our multifaceted lives. These embodied lives converge in the moment transcending all temporal separation. There are no boundaries. As McGibbon, Peter, and Gallop’s (2012) IE on nurses’ stress highlighted,

Nurses’ connections as women, mothers, sisters, daughters, and aunts are not accounted for, and thus are not accountable as stressful. In some ways this has come about because these connections, and the emotional work associated with
them, are socially undervalued as women’s work; yet they are necessary for sustaining life and community around the globe. (p. 1373)

So, how do we cope within our work environment where experience is disembodied within the rational medical and administrative models of care, which are bereft of subjectivity? The work involved in the actual lives of carers demands that we suppress the existence of emotion within the temporal realm of health care. Moreover, care for each other and our patients has slowly detached from the system designed to treat illness. A system we depend on in our most emotionally wrought time of need, whether as a patient or as a nurse who has a sick child at home and needs the collegial and financial support of her work environment. How are nurses providing care within the accountability demands of a system at odds with their conception of care? How do nurses feel about caring for patients who could very well be their own family member in a system where care has been reshaped by an efficiency model of care? The relational/emotional element of care has become an expensive, limited, and yet coveted resource.

It is clear, from the literature on care and caring work, that care has been widely researched from a conceptual and organizational perspective. Research on how care and caring work is influenced within the organization highlights some of the local social relations implicated in shaping how caring work is done at the bedside. This literature is helpful by giving us insight into the complexity of local relations but it gives us only part of the story. The forces that shape our decisions in caring work extend beyond the organization and deserve more research attention as it is here we can expose the cracks and concentrate on social activism. These forces are often covert in the everyday/night activities of care and care work. The local actors may not be conscious of how these covert, albeit powerful forces shape nursing care and become a source of frustration. Rather than focusing my project on what care is and what
contextual elements influence care, as the majority of literature on care illuminates, I will focus on how care and care work is being reshaped. Diamond’s (1995) research on long-term care facilities in the United States shed important light on such opportunities to expose the cracks in the system and creates areas of opportunity for social activism. I will explore, on a small scale, how care is being done at the bedside in Toronto hospitals using IE methodology to show the linkages of social relations from a local level. This research is intended to be a small glimpse into the health care system and how care is being done at the bedside using methodology pioneered by D. E. Smith (1987, 2005, 2006).

**Three Themes of Care**

As I gained an entry point into the nurse participants’ everyday/night caring work throughout my interviews, I developed three common strands or themes from which I have crafted the following chapters of my thesis. In the first strand, as Sara and Stephen pointed out, through our discussions, there is a streamlining of care or leaning of care where the nurses’ time is considered an expense the organization cannot afford to waste. It is a “numbers game” where I will explore how care is streamlined; thus revealing what is counted and what is not counted in care work. Second, I will explore how the local carers have limited time to care for themselves and each other, as time has become an expensive commodity not to be wasted on free time. As Sara pointed out, she spent time worrying about the patients who were discharged too soon. The increased work demands and the increased emotional labour expended by this very rupture on local caring can have a negative impact on the health of carers in an environment where developing relationships or the esprit de corps of nursing within the work environment is considered a waste of valuable organizational time. The third strand is how local accountability practices circumvent time away from the bedside through documentation technologies. As
Stephen succinctly pointed out, he must, under policy and procedure, leave the bedside to
document vital signs at a particular time or he will “get into trouble”. This “getting in trouble” is
based on his accountability to the organizational standards and regulations as an employee. It is
here I begin to connect, on a small scale, the social relations controlling what he is accountable
for, thereby revealing how his local caring work is ruled from extra-local forces shaping his
professional autonomy in his everyday/night nursing activities.
Chapter 4
The Leaning of Care:
The New Wave of Managerialism

We are in very tenuous economic times, and decisions that are made not within health care but within the areas that influence the determinants of health need careful consideration… I am very concerned about people looking for a quick fix versus long-term solutions to some of our biggest challenges. I don’t want hospitals to become factories. That’s a concern because that takes the heart out of health care. (Rhonda Seidman-Carlson, President of the Registered Nurses Association of Ontario, as cited in Di Costanzo, 2012, p. 25)

Background on Quality Improvement in the Delivery of Patient Care

QI models, originating from the Japanese manufacturing sector, are a relatively new business approach to organizational development in Canadian health care institutions. “Quality improvement (QI) is a process by which individuals work together to improve systems and processes with the intention to improve outcomes” (Seidl & Newhouse, 2012, p. 299). In response to growing public concern over the access and quality of health care services, quality improvement models were adapted into the health care system in the 1990s (Axelsson, 2000). The first models adapted to health care organizations were Total Quality Management (TQM) and Continuous Quality Improvement (CQI), which were based on the science of organizational management. Hence, management focus shifted from simply the delivery of care to providing accountable, quality care from the patient perspective. And, as management consultants travelled globally, they brought new science-based quality models to the health care system such as Six Sigma (originated at Motorola), Plan-Do-Check-act (PDCA), root cause analysis (RCA), Kaisen-Lean (originated at Toyota), and failure mode effects analysis (FMEA) (Fine, Golden, Hannam, & Morra, 2009; Seidl & Newhouse, 2012). Although these quality models differ slightly, the
essential premise of quality improvement in health care is the continuous redesign or improvement of patient processes at the front-line where everyday patient care is delivered. Therefore, the intent of these models, from a quality perspective, is to improve the patient experience whilst reduce waste and costs in providing health care services.

Lean:
The Era of New Quality Improvement

As senior executives of health care organizations struggled with “doing more with less”, they looked to private business for answers. Over the past decade, these organizations have undergone massive changes, realigning their corporate strategies with the Ministry of Health and Long-Term Care (MOHLTC) metrics and funding criteria. As the public and media pressured the Ontario government to remove barriers to access, the First Ministers (Provincial/Territorial Premiers) established national wait times for key surgical procedures and medical services. These wait time initiatives reshaped what medical procedures and medical services health care organizations were to prioritize in a timely manner. In tandem with these services, hospital emergency departments, sites highly visible to the public were criticized for inefficiency and were added to the national wait time strategy. Ultimately, hospitals were hooked into the medical and administrative models of care as provincial funding and national benchmarking reshaped what types of care would be prioritized under temporal parameters. With these provincial mandates in place, health care organizations restructured care processes to eliminate waste, reduce costs, and add value to the patient experience thus, re-shifting efforts on key provincial timelines and access to provincially defined priorities. Moreover, in response to The Canadian Adverse Events Study, the Ministry established benchmark patient safety indices (e.g., infection control and fall prevention), which added more elements of quality improvement measurement
and accountability at the institutional level (Baker et al., 2004). As such, extra-local interests, or what some have deemed, the new managerialism of Lean, started to rule health care delivery within organizations. At first glance, from the organizational perspective, or from the health executives’ standpoint, the principles of Lean philosophy or other adaptations appear to be the panacea for the reality of rising health care costs and the need for reducing waste. However, it is here, and in the following chapters, I will examine how quality improvement principles and tools such as Lean may be paradoxically ineffective in producing the results they were designed to achieve, particularly quality of care as espoused by the nurses and patients at the bedside, as they enter the socially constructed power relations of care and care work within Toronto hospitals.

The Lean philosophy or the Lean concept was originally conceptualized by Taichi Ohno for the Japanese automotive industry, particularly Toyota, however it spread globally to other manufacturing sectors, and, eventually, to the service industry (Fine et al., 2009). More recently, Canadian hospitals have embraced the Lean philosophy or an adaptation of the Lean concept in an effort to simplify patient care processes and take out added steps thereby improving organizational efficiency in health care delivery. In fact, the Saskatchewan government has funded Lean methodology incentives for its entire public service. Accordingly, health care organizations adopting Lean thinking, espouse some of the principles of Lean thinking: the value desired by the end customer, the value stream or end to end journey of the patient, continuous patient flow through a service process, and continuous quality improvement. Based on Poksinska’s (2010), literature review on the application of Lean philosophy and methodology in health care, the most commonly referenced Lean principles and methods were standardized work, waste reduction, and continuous flow. Young et al. (2004, as cited in Poksinska, 2010) found that organizations using Lean methodology focused their efforts on wait times, repeat
visits, errors, and inappropriate procedures. Spear (2005, as cited in Poksinska, 2010) emphasized that organizations also used Lean to empower employees by providing them with the tools to improve work processes. The successful outcomes for organizations adopting Lean, for example the Virginia Mason Medical Center in Seattle Washington, were reported by these organizations as reduced costs, increased quality, increased output, increased patient satisfaction, and increased employee job satisfaction. This success story, among others, becomes palatable to senior executives looking for improvement in organizational efficiency, from a systems perspective that does not involve extensive reorganization or any substantial financial investment (Poksinska, 2010).

The first principle of Lean methodology, a quality improvement method, is to provide value, from the customer’s perspective, by eliminating waste and streamlining complex processes thereby improving productivity and efficiency. The concept of value is a relatively new formulation in health care as Lean has been defined by the manufacturing sector as, “[the] Work that adds value from the perspective of the client or customer; it is the kind of activity or service for which end users are willing to pay” (Fine et al., 2009, p. 33). This formulation of value becomes problematic when introduced to the health care system or the complex web of social relations. As Poksinska (2010) pointed out that the concept of customer becomes complex when introduced to the health care system as the customer forms a network of stakeholders such as patients, families, communities, and tax payers that are not part of the market economy. Further, the notion of value becomes complex as care delivery involves the complex network of stakeholders and their divergent views on what constitutes value in care. Nevertheless, the intention of Lean philosophy or a way of thinking in the context of the health care system, is to
design or organize patient care processes around the patients thus, increasing value and reducing the time between when a service is ordered and when it is delivered (O’Neill et al., 2011).

Separating the Threads: Care Becomes Unraveled

Here I will focus on the Lean concept of *waste*, or what is considered not value. The eight health care wastes or mudas are defined as activities of overproduction, waiting, transportation, extra processing, inventory, movement, non-utilized people, and defective products” O’Neill et al., 2011, p. 547). Overproduction, from a health care perspective could be the scheduling of unnecessary tests such as performing electrocardiograms on patients undergoing procedures that only require a local anesthetic. The waste of time waiting for an appointment or admission into a hospital bed is one example of waste. Transportation of patients has been a source of frustration for the patients and their health care providers, as procedures are scheduled in a department geographically far from the patient’s room. The duplication of effort, or over processing, has long been a source of frustration for health care workers. An example of over processing would be communicating the same information in separate disciplinary rounds rather than in a multi-disciplinary team. The issue of missing inventory has been a sore spot for any nurse responding to an emergency situation. Here too, the unnecessary steps in searching for missing equipment or as defined by Lean as the waste of movement. The issue of not using nursing staff to their full potential has been an issue for nurses delegated to non-nursing tasks who would rather spend their time on direct patient care. Last, defective products are a contentious issue as hospital borne infections and medication errors have been a focus of media attention (Baker et al., 2004) and a cause of social and financial harm.
Leaning the Organization:
Aligning With the Reconceptualization of Care

Certainly on first glance, the principle of value in Lean thinking, or, reducing waste, appears pragmatic in its application to daily/nightly nursing activities. I remember waiting for porters to assist in transporting a critically ill ICU patient to diagnostic imaging, only to discover, once the test was completed, the porter was not available to help return the patient to the ICU. Certainly, my peers would have appreciated focusing their skills and efforts on direct patient care rather than focusing their time on non-nursing tasks such as answering the phone or searching for equipment and supplies. Moreover, nurses can appreciate quality patient care as many expressed in Chapter 2. These colleagues would agree that increased and often duplicated documentation attributed to technology and risk management, takes them away from the direct care of their patients. And, as I interviewed participants, particularly Sharon, the Patient Care Manager of a busy surgical unit at a Toronto teaching hospital, it became apparent that there were good intentions when organizations adopted Lean thinking:

(Communication with Sharon, Patient Care Manager, March 14, 2012)

My response: you're busy restructuring it [the operating room (OR)]. What um, what led to that? What was the reason behind it?

Sharon: Chaos…I just finished restructuring the red blood cell disorders program. So, it was a similar process, for similar reasons. So what happens in health care is that, um, we're really good clinicians. We're really great at caring for patients. We're not so good at process. And ah… and making it work. So there is um, I know the OR redesign was based on a similar model. It's called Lean. It's called Lean Methodology. It's part of ah, it's ah, an industrial, um, ah, an initiative that looks at process improvement and gets rid of all the waste in the system. ...thus, the Lean name…and, in fact, the entire province of Saskatchewan has been
funded to Lean their entire health care system. There's a model in the States, or there's a hospital in the States that has done a lot of work in this process too. It's called the Virginia Mason Model. And um so, we're looking at that. But, um, it's a fairly, ah intense process because you have to really think about why we do things and 'Why do we do that?' and, and really like where does it, where does it fit in our goals? But before you start looking at why do we do that; it's 'What do we do and why do we do it?' What gets us up in the morning and brings us to work?' And, we were the first program in this hospital to have a patient involved. So you really become quite vulnerable when you bring ... the point of care into your discussions. Because you know what, you really show what goes on behind the scenes. And you have the patient's input, because they're really the one that you're doing the work for. So, in this particular process, they say what they value; what is it, what's important to them. And they recognize they're speaking for their, their constituents. And then everything we do, and everything we look at, is based on 'How do we met those needs?' So, the wait times, so ambulatory wait times, um, for example one of the things that we found in the um, hematology program was we really never knew where the patient was. They were upstairs; they were downstairs. You know? It was, they were going around finding their health care provider. Now, through the process, everybody comes to them. So if the physician has to see them, a nurse practitioner, a social worker, we all come to the patient. So it helps us do that.”

Sharon describes the flow or efficiency of the OR department and the Red Blood Cell Disorders Program as chaos before restructuring. Here she applies the conceptual lens of Lean. *Learning to see* is an instrumental principle of Lean methodology, “which is a structured process where those involved intensely observe (track) nurses in the actual workplace to construct a deep and shared understanding of the current state” (O’Neill et al., 2011, pp. 547-548). And, as Sharon walked me through this process, I could appreciate the need for organizational restructuring of patient care processes as there appeared to be a need to account for the
whereabouts of patients. Certainly, as my research participants have attested, “what gets them up in the morning” is caring for their patients or the need to connect with their patients. Certainly this Lean mantra must appeal to the nurse’s sensibility around patient-centred care. I can also see how stressful cancelled or delayed surgeries would be for those patients diagnosed with a critical illness and their families, especially when these delays are associated with waste such as unavailable staff, supplies, or equipment. It is also stressful from the standpoint of those who are “really great at caring for patients”. Here is where we see the beginnings of a fracture in everyday/night care work. As our conversation continues, the wait time discourse begins to enter our discussion. The Ministry wait time guidelines enter as a dominant rationale for the application of Lean as a managerial tool. The patient volunteer participating in the restructuring of the hematology program, representing his constituents, becomes emblematic of public interest, as represented in the Ministry’s wait time guidelines. The Lean concept of quality management becomes the ruling arm for those guidelines. And it is here where the health care organization is socially hooked into those guidelines through its delivery of everyday/night care. It is also here where the local hematology clinic enters the broader scope of social relations as care is reconstituted under the managing arm of Lean practices and value and waste are redefined by those who rule these relations in the form of the wait times guidelines. And it is the local care providers who come under pressure from such guidelines even though they may not be aware of how quality management plays a role in ruling their practices at the bedside.

This quick sketch illustrates clearly where texts enter the picture as ruling practices. D. E. Smith (1987, 2005, 2006) posited that texts coordinate people’s work from across multiple sites. A text is created by a group of people, read by another and acted upon by individuals or groups doing the front line work. These texts rule what is done and what is not done in the local setting
as well as how it is to be done. In essence, texts in the form of process maps, policies and procedures, clinical documentation, checklists, e-mail, and research literature become alive as a social artifact that coordinates the lives and activities of people across multiple sites of the health care system. Therefore, the wait time guidelines became actualized as the senior executives of health care organizations read them and develop corporate strategies that direct what surgical and medical services will be prioritized and how they will be delivered at the front-line of care. It is here where care is socially constructed in the coordination of activities stemming from organizational strategic direction and through written policy and procedures. Again, as these executives struggle to keep their organizations viable, strategies are mapped out using other texts, for example, schedules or checklists, which are subordinate to the ruling text or the Ministry wait time guidelines. As hospital executives read texts on Lean principles or quality management, they then embed these principles in their corporate strategies on how they will adhere to and measure their success in achieving quality as defined by the wait times guidelines and quality indicators. There is a confluence of textual documentation, wait time guidelines, and Lean principles, as they merge in the everyday conversations of health care managers and health care providers. Moreover, as Sharon engages in the textual discourse of wait times in the context of Lean methodology, we see how these texts are socially mediated in the local activities of the hematology clinic. And, as Sharon learns to see waste, as defined within the ruling documents and the ruling arm of quality management, we begin to question:

1. What elements of care are being left out?’

2. Who defines the value of care?’

3. How does the organization see the time nurses spend on some elements of care as problematic?’
Here I need to emphasize once again that the Ontario health care system is a very complex social structure that cannot be examined in its entirety in a thesis. My aim here is more modest as I explore, on a small scale, how quality management processes, informed by the Ministry wait time guidelines, reshapes nurses care work at the bedside. Examining this issue allows me to begin to question, “Who determines value on behalf of the patient?” and “Who determines waste, the antithesis to value?” It is here where we begin to see the links between provincial objectives and the local health care organization. The value added care is predetermined by the prioritized surgical procedures and medical services highlighted by the province. Here we also begin to see that the services end users are willing to pay has been predetermined by the province, which holds the coffers of tax dollar money for social services. Moreover, we begin to see that the universal care that has been determined by ruling relations has had a hand in reshaping patient care processes and tasks into standardized medical care that rules what care and care work is to be done at the bedside. At the same time, this standardization of care processes is at odds with the care values and care work expressed by nurses, as explicated in the previous chapter; it is here we begin to see the contrast in both standpoints. We will see how this is problematic for the organization and for those working at the direct point of care. We will also see how the application of Lean concepts to organizational processes becomes messy as they are translated into the everyday/night care work of nurses caring for their patients. In this chapter, I will illustrate, based on my interviews with my participants, a view contrary to the literature on Lean, that value is not always being achieved from the standpoint of those delivering care at the bedside.
Remove Waste, Create Value: What’s Left Out of Care?

As Lean thinking and the concept of waste enters the social relations of the health care sector, we begin to see how care or patient-centred, humanistic care becomes reshaped, deviating from the essence of its traditional meaning in the nursing profession. As, Poksinska (2010) illustrated, the meaning of value, from a Lean perspective, in the construction of care and care work in an organization becomes problematic when introduced to the complex web of social relations involved the definition and delivery of care. It is here we add the patient, the family, the community, hospital executives, taxpayers, and the provincial and federal government to the formulation of care through the lens of Lean methodology. This is where learning to see from a Lean perspective gets messy. The concept of care is a social construct that can be viewed through multiple lenses or from local and extra-local vantage points. The concept of care viewed through the lens of value is as dynamic as the perceptions of care espoused by the stakeholders socially and politically involved in its conception. Nevertheless, Campbell’s (2003) account of D. E. Smith’s sociology for people illustrated the importance of not disregarding a concept as its construction is an important way of seeing the social relations at play. According to Campbell, D. E. Smith

had learned not to be satisfied with treating the conceptual as a given - rather to view concepts and categories as expressions of social relations and hence as opening up a universe for exploration that is ‘present’ in them not explicated. (Smith 1990a, p. 37, as cited in Campbell, 2003, p. 8-9).

In the case of health care, we can see how care is constructed based on the socio-political environment it becomes operational in. As health care organizations adapt Lean thinking into their processes, care becomes constructed by the ruling relations, under the guise of Ministry guidelines, and corporate quality measures created by local and extra-local groups struggling to
remain economically and politically viable. Moreover, the definition of care espoused by those ruled by these relations becomes seen as waste or an expense by those in charge thus, learning to see from the perspective of Lean methodology. Seeing the concept of care from the various formulations, as D. E. Smith espoused, becomes a valuable way of understanding how care is reshaped in the context of restructured health care.

If you want to learn about regional anesthetic, you come here.

(Communication with Sara, RN, March 21, 2011)

As I entered Sara’s everyday/night world through our conversation, I explored how care has been transformed, as though through ether, from an embodied experience to an objectified form of care, as defined by the ruling social relations. Sara’s organization has adapted Lean methodology into their way of delivering care. After an amalgamation in the 1990s, this organization became part of a larger corporation. Sara’s orthopedic floor is busy as the hospital has shifted from providing a variety of surgical procedures to providing the surgical procedures outlined by the Ministry wait times and funding criteria. Sara’s organization also adopted the principle of flow or the patient pathway/journey through a series of processes within the organization to facilitate improved efficiency and productivity. These principles were applied to areas typically seen as bottlenecks in the system such as the emergency department and the surgical suites. This shift in organizational care or shift in vision of what is considered care chafes those attempting to provide what they see as the holistic care defined in Chapter 2:

(Communication with Sara, RN, March 21, 2011)

My response: “I know that this hospital amalgamated with hospital Z. Have there been any changes to the unit where you’ve had, maybe workload impact or
management changes that have made it more difficult to provide that type of care [emotional care]?"

Sara: “Yeah, certainly and whether or not it's amalgamation or it's just Ministry funding that we are doing more joint replacements. So whether or not it would have happened anyway, is hard to say. I mean, certainly the perception is that, it's since amalgamation… but it may have happened anyways… our workload has certainly increased… went from having, perhaps 4 or 5 surgeries a day, to 8 to 10 on a routine basis… patients are all having spinals, rather than general anesthetic, which require a little more care… they are older and have more co-morbidities… and it's all about numbers now. It's a 4 to 1 ratio on days; 5 to 1, evenings; 6 to 8 patients on nights. So… the patient is never looked at anymore. All that's looked at is the number. So, it doesn't matter if you have 4 patients that require a lot of emotional support, you have 4 patients that require a lot of emotional support and you can't give them as much as they need.”

My response: “So when you're saying spinal, [do you mean] they've changed maybe the way they're doing surgeries?… they're giving spinals instead of general anesthetic.”

Sara: “Yes… years ago, we had problems keeping anesthetists here. They wanted to work at, probably, more exciting facilities. And they decided that one way to encourage anesthetists to work here would be if we became a centre of excellence in regional anesthesia. So this site has been established as the place in Toronto for regional blocks and spinal anesthetic. If you want to learn how to do it [the spinal procedure] as an anesthetic resident, or even a nurse anesthetist, any of those. If you want to know about regional anesthetic, you come here.”

Sara: “So it was a bit of a dollar and cents thing. But it was also, actually, dollar and cents because then we would be guaranteed having anesthetists and we wouldn't have to cancel surgery. Spinal anesthetic is, I believe, more expensive. But, um, so it really just was to ensure we always had anesthetists.”
My response: “Oh, I see… and there's more, tasks involved in caring for a patients with spinal anesthetic, compared to the general anesthetic?”

Sara: “Yeah, you have to ensure that the spinal is wearing off appropriately, so you have to do dermatome testing, both spinal and motor… if they’re very high up on the abdomen, up close to the chest, then they require even more frequent monitoring and [it] could be as frequent as every ½ hour to hour set of vitals as well as dermatome testing. So, they don’t go to a step down unit; it's recovery room directly to us.”

My response: “Going back to the initiative from the government… we need to get more orthopedic surgeries and get the wait time down. Have you seen that [initiative’s] impact on nursing care?”

Sara: “We're doing more joint replacement, than [before restructuring]… we've lost a couple of surgeons that have ended up going up to hospital Z because they're no longer able to do their sports medicine, their small cases. A couple of other surgeons have changed from doing smaller cases, e.g., bunions, foot surgery, to just doing hip and knee replacements. So that I think almost every surgery is a hip or a knee replacement. So again, it's maybe, on average, it would be a slow day if we only had 4 ORs. It's usually somewhere between 6 and 10. And they could be bilateral knee replacements on top of that”

Throughout our interview, Sara refers to the delivery of care as numbers of surgical cases as per the Ministry quota for hip surgeries. Initially I had assumed that the amalgamation may have been implicated in how her care practices were shaped at the bedside. But she makes clear that this “may have happened anyways.” The information that Sara provided about her everyday/night activities, the care or the medical care of post-operative hip surgeries requiring a new anesthetic procedure, was linked to the Ministry wait times. In relation to this, Sara describes an increase in surgical cases and the workload associated with the high volume of
cases. The care that Sara provides is defined in medical tasks of checking dermatomes, which involves testing sensory and motor nerves from the abdomen or chest level on a more frequent basis because of the location of the anesthetic and documenting vital signs along with these frequent checks. She points out,

So…the patient is never looked at anymore. All that's looked at is the number. So, it doesn't matter if you have 4 patients that require a lot of emotional support, you have 4 patients that require a lot of emotional support and you can't give them as much as they need.

It is here where you begin to see the deconstruction of care. From Sara’s standpoint, the holistic caring she has been trained to provide for her patients is now seen as an expense from the organizational perspective. The strands or elements of physical and emotional care become unraveled as all health care practitioners are expected to provide the socially constructed care that is necessary for the organization to remain viable. Sara’s time for the more relational elements of care is considered an expense that the organization cannot afford as the funding formula accounts for the type of care prioritized by the Ministry. Care, or the social construct of care, embedded within the complex web of social relations becomes defined as delivering a certain number of hip surgeries and the care work associated with hip surgeries is defined as doing spinals and checking dermatomes and vital signs. Moreover, the care Sara espouses as patient centred and embedded in social relationships becomes waste or not contributing to value according to the customer, which becomes unclear, from where she stands, as the social relations of health care extend well beyond the walls of her organization.

It is here that we ask the question of how Lean thinking and similar quality improvement methodology has reshaped holistic patient care. At first it did not become readily apparent to me,
as I followed the unraveling of the strands of care throughout this research process. However, as I followed the IE methodology, it now becomes apparent that patient flow is an integral part of Lean. As the organization needed to increase its capacity to do more hip procedures, Lean methodology was applied to answer any problems with patient flow. According to Sara, there appeared to be a problem retaining the number of anesthetists necessary to fill the surgical quota of patients needed to keep the operating room running at maximum efficiency. Sara indicated that one of the ways to accomplish this organizational goal was to become the regional centre for learning spinal anesthesia. This strategy solved an organizational problem or as Sara posited:

    Years ago, we had problems keeping anesthetists here. They wanted to work at, probably, more exciting facilities.”

This is in keeping with the Lean concept of removing waste and adding value by recruiting under-utilized health care professionals in the effort to increase flow or throughput in the operating room. According to the organization, bringing on board under-utilized anesthetists or other health care professionals to prevent the cancellation of surgeries increased the volume of patients having hip surgery. To the organization, the delivery of care is accomplishing the goals of Ministry wait times. However, here is how care is shaped by quality improvement initiatives such as Lean where those at the bedside are ruled by the dominant conceptualization of care, which is a medical and administrative definition residing outside of the local point of care. But, from the standpoint of those at the bedside, providing the care work, this does not appear to be the value they espouse as patient-centred or humanistic care. Notwithstanding, the organization, became *the centre of excellence*, but for those caring at the bedside, the care they provided fell short of their expectations, or certainly any level of excellence.
Who Defines Care?
Learning to See From a Dominant Vantage Point

A key principle of process improvement or Lean thinking is learning to see or a structured process involving observation of the actual work activities of bedside nurses (O’Neill et al., 2011). The application of this conceptual tool involves observing and tracking nurses’ work for 24-hours to understand the actual activities at the bedside. A quality improvement team then analyzes these work processes and conceptualizes improved work processes to test in the patient care area. These processes are then tested using the model line concept coined by Toyota (Spear, 2005). According to Spear, the model line concept or problem solving approach is,

Creating, essentially a model of the production line, a small incubator within the larger organization in which people can develop and practice the ability to design and improve work through experiments…and managers can rehearse their roles in facilitating this ongoing problem-solving and improvement process. (Spear, 2005, p. 8)

Spear emphasizes that this approach identifies the ambiguities or the work around of hospital staff and helps reduce errors by identifying and coordinating the activities of those at the front line of care, thus giving clear direction in care work (Spear, 2005). Such ambiguities or work around are considered as waste because of extra steps and the possibility of medical error. The literature identified a variable composition of the teams typically recruited for quality improvement projects and training however, most model line teams comprised of an external consultant or sensei, management, frontline nurse leaders, and clinical educators (O’Neill et al., 2011; Poksinska, 2010; Wilson, 2009). The implementation of quality initiatives arising out of these teams were also variable. Some hospitals adapted Lean or some of the principles of Lean to existing quality programs or concentrate on patient care areas defined at the ministry level as issues for accessibility such as the emergency department or the surgical area. Nevertheless,
successful implementation of Lean processes and improvement in the patient journey was contingent on the training and involvement of nurses at the frontline of patient care as they are in direct contact with patients and families. However, according to the literature, achieving success in Lean was contingent on frontline involvement in reshaping patient care processes so that improvement in the patient experience and staff empowerment can be achieved within the organization.

It is here I turn to the messiness of applying the abstract concept of Lean to the everyday care work of nurses within a socially constructed environment. The concept of value is contingent upon the lens we learn to see it from. Young and McClean (2008) maintained that the issue of value in the health care system is very complex as there are a vast number of stakeholders and there is no single customer or single view on value. These researchers contend that the concept of value will lean either towards those who view value as efficient throughput or those who value holistic care depending on their individual or collective standpoint. They contend that most health service redesign methods, especially those that remove what is considered waste have some unexpected outcomes. Therefore, it is imperative to define value in more than a singular dimension. These researchers proposed the concept of value be defined in three dimensions: clinical or as the best patient outcome; operational or the cost of delivering care; and experiential or the patient and nurses’ experience of care. Waring and Bishop’s (2010) ethnographic account of the implementation of Lean methodology in redesigning a UK hospital illuminated the messiness of applying Lean conceptual thinking to the everyday/night work of nurses within the social dynamics of power. These researchers maintained that as Lean was interpreted into practice, the care work of nurses became standardized and monitored through the managerial arm of Lean and National guidelines, thus re-focusing some of their attention away
from direct patient care. Furthermore, some hospital staff perceived value as an organizational or managerial definition of improved efficiency and cost reduction rather than patient-centred holistic care. Waring and Bishop’s (2010) ethnography also illuminated the tensions and conflicts experienced between champions or frontline staff leaders of the Lean working group and those involved in direct patient care. This exercise of power, often referred to as ruling by I.E researchers creates more disempowerment in those whose actions are being ruled at the direct line of care.

We don't make coffees, we make people.

(Communication with Stephen, RN, October 27, 2011)

It is here, I enter Stephen’s everyday/night world. Stephen is an RN who works in the emergency department of a large university teaching hospital in Toronto. Stephen’s hospital adopted Lean thinking during the re-structuring of the emergency department. In Ontario, access to emergency services is a target-driven priority that is monitored by the Ministry. As I interviewed this participant, I was transported into a world where care and care work was socially reconstructed by quality improvement processes such as Lean:

(Communication with Stephen, RN, October 27, 2011)

Stephen: “Well, waste, first of all, waste was identified within practitioner's practices.”

My response: Okay. And practitioners, you mean, what do you mean by practitioners?

Stephen: “Mainly nurses and service staff. Let me put something very politically, very politically troubling on the table. When the hospital, the entire hospital,
sought this consulting group to come and help the hospital eliminate waste, no physician partook in the process. Physicians were excluded, as a group. So, no physician's practice was looked at as wasteful and therefore changed or modified, and so on and so on. ...the nurses, yes, and service and clerical staff, yes. And that's who essentially was the target of this elimination of waste ideology. So I'll give you an example of how waste was identified and therefore attempted to be eliminated, although not successfully, because again, we don't make coffees, we make people.

The porters were made to identify a difficulty in their work. So that when they come, for example, to the emergency department, to pick up a patient, to transport them to their CT scan the patient is not ready to go. So the porter has to wait for the patient to be prepared to be transported to CAT scan, often more than 5 minutes, sometimes in excess of 15 or 20 minutes. And that was identified as a waste of the porter's time. So how did we work on helping to eliminate that, or reduce it or make things [more efficient]. Well, the idea came up that the patients, maybe should be pre-packaged, if you will, for the porter to arrive and take the patient away. Well, that didn't work, because when we have patients with cardiac issues, they need to be on the monitor until the last possible [moment] in case a cardiac episode happens. Okay, so that didn't work. So patients cannot be pre-packaged. There still has to be work done by the nurse, as the porter arrives. Right? So, okay, what about patients who can be pre-packaged, patients who don't really need to be hooked up to anything? Okay, oftentimes a lot of our patients are elderly patients, who have incontinence, often of bowel and bladder. So when they have to pee, it's an emergency. They have to pee. They have to pee, because they cannot contain 600 cc like your bladder and mine can. So, the thing came up where, okay, well, porters came up with the difficulty that, 'patients are often on bedpans when I come and take and that takes such a long time.' Well, that too, is a last minute thing right? I mean, as far as I'm concerned, my patient is packaged. You know? The nurse says, 'the patient's packaged. The porter comes, she suddenly has to go.' Well, she has to go. So, here again, we've identified an area where part of the human caring process, that you can't control,, I'm not making
espresso. We can't plan for this. She has to pee. So here, this is seen as wasteful as well. So that didn't work out. So, I don't know what the solution is. And I don't think we ever came up with the solution, but I think what is the point of an analysis here, is what is being identified as wasteful and how that consultation, though costing the hospital $900,000, in excess of that, actually as far as we're concerned, was very unsuccessful. If you ask the ministry, now that's a different story…the ministry is smiling very widely. But if you ask the ground workers, it's a different story they have.”

Initially, I explored Stephen’s understanding of waste through his local practice of caring for patients not knowing of the extra-local influences, discourse or the construct of Lean value and waste. Nevertheless, as I followed the strands or the basic elements of care, I was led to the extra-local practices of wait times and the socially constructed categories of Lean such as waste and value. As Stephen’s organization struggled to balance care with the Ministry wait times, using the concepts of Lean became palatable by way of their application in the improvement of patient flow in a high volume trauma facility. Through senior management’s lens, value is seen and defined as the improvement of patient flow, the reduction of cost associated with waste, and fulfilling the outcomes defined by the Ministry. However, the problem, as Stephen elucidated, from an organizational standpoint, value or waste is contingent on the temporal throughput of patients in the emergency department. Waste, defined by these terms is attending to the contingent needs of the patient in the emergency department. But for Stephen and his patient, tending to the physical needs of care is a priority that cannot follow a schedule that coordinates with other steps or processes in the system. This is where the application of a concept such as Lean becomes messy in the everyday/night lives of nurses and patients. The notion of work around and reducing ambiguities knows no place in the social world, as elderly patients scheduled for transport to another department for tests cannot predict when they may require a
bedpan. And nurses providing patient care are in a conflict between these contingencies and the expectations of the organization to improve patient flow by “pre-packaging” their patients for transport. In fact, in the everyday/night care work of nurses, the patient’s journey is not defined temporally or through a linear pathway as conceptualized in Lean thinking. It is here where we see the tension between what management considers waste or value in the delivery of patient care and what both the nurse and the patient consider to be value from an experiential perspective. As we begin to see these tensions at the contours of care, we begin to question, how effective Lean thinking is when applied in the socially constructed everyday/night world of care and care work. It is here we also see from the lens of the patient and nurse, the added value in patient-centred care is responding to a full bladder just in time and preserving patient dignity contrasted with the organizational value of efficiency espoused by health care executives. In this case, the nurse’s choice is obvious as he/she confronts the tension or conflict of being caught in the middle between delivering patient-centred holistic care and maximizing organizational efficiency.

It is apparent from Stephen’s interview which lens was used to analyze and redesign patient care processes. As Stephen emphatically maintains, “we make people, not coffee”, we see how the discourse of private business or the lexicon of business enters the local practices of socialized health care. Stephen’s story illuminates the influence of business principles as external consultants enter the emergency department and participate in the organizational dialogue on value and waste in patient care. Further, nursing care work has been preconceived as an organizational problem where wasteful activity must be mapped out of the system while other social actors such as physicians and their curative work have been excluded from the discourse
Discourse is maintained by practices that determine who can participate in it as fully competent members. It develops as a process of organization and reorganization of relations among participants through the medium of their work. To be recognized as a proper participant, the member must produce work that conforms to appropriate styles and terminologies, makes the appropriate deference’s, and locatable by these and other devices in the traditions, factions, and schools whose themes it elaborates, whose interpretive procedures it intends, and by whose criteria it is to be evaluated. (Smith, 1987, p. 61)

Stephen’s nursing care work is located in the complex web of medical and administrative discourse whereby care and care work is reinterpreted into the frame of process improvement technology and the biomedical model. It is here where Stephen’s concept of care and care work is outside the frame of the medical and administrative lens used to evaluate the efficiency of care delivery. Here he illuminates a problem where processes that do not make sense at the bedside have mediated his everyday/night practice. Stephen’s care of his patients has been reconfigured to that of prepackaging his patients for transportation to medical procedures however he is confronted by the reality of his care work and his patient’s needs. He expresses his frustration, “Let me put something very politically, very politically troubling on the table”, as his work has been reconstructed through the abstract model line approach of quality improvement. Stephen points to the extra-local forces implicated in the redesign in nursing care work, the Ministry is “smiling very widely”, as the organization aligns with the wait times and quality indicators set in place to ensure the accessibility of medical resources and the accountability for quality and safety in the Province of Ontario. It is here that we see the patient-centred, humanistic ideals of care, espoused by my participants, are considered waste and of no added value as dominant discourse and technologies are pervasively centred on the discourse of efficiency and
productivity in medical curative work. It is also here, located within this ruling discourse, where care is redefined and reinterpreted into another version of patient-centred care. It begs the question, “what is meant by patient-centred care?” The answer is a provisional one. It depends where you stand or what lens you are wearing. For Stephen and his colleagues, their lens becomes a frustrating and disempowering instrument to wear in the political and hierarchical world of health care.
Chapter 5
The Emotional Care and Support of Nurses

We’re running life support here.
(Communication with Marian, July 23, 2011)

In the previous chapter, I focused my inquiry on how quality improvement methodologies such as Lean have been used by health care management to shape health care delivery. Accordingly, local hospitals adopting these methodologies to existing quality management programs have re-engineered patient care processes through the lens of value and waste, reorganizing nurses’ local care work and patient-centred practices. In this chapter, I will explore the socio-political relationship between nurses’ local caring work, the emotional labour of these nurses caring for their patients and families during acute and terminal illness, and the extra-local quality improvement management practices adapted by their respective organizations. I will also explore the implications of these extra-local influences on nurses’ emotional work of caring, or emotional labour, and how these sociopolitical influences reshaping bedside care may lead to increased stress and possible burn out. I will follow the separation of the strands or elements of emotional and physical care and reveal how patient-centred holistic care is contrived into the physical, intellectual, and technical care espoused by the medical curative model, thus relegating the emotional element of everyday/night patient care and the everyday/night care of nurses to subjective silence. It is also here where I illuminate the role of the ruling relations in constructing the local social environment of the contemporary health care organization, which places much of the burden of structural and process changes on nurses’ care work, thus possibly affecting their emotional health. I will explore the questions:
1. How did extra-local influences enter the nurses’ discussion on emotional labour and care?

2. How have institutional processes and procedures used to make the organization accountable to quality assurance emotionally affected the experiences of nurses providing the work of caring?’

The Emotional Work of Caring: The Intersection between the Concept of Care and the Emotional Labour

Although the literature on emotional labour or emotional work mainly focuses on the individual, management styles, and the organizational structure, Hochschild’s (1983) concept of emotional labour provided a seminal approach for exploring emotion within local nursing care and care work. Moreover, Hochschild’s mid-range theory was instrumental in providing linkages between the prevailing concepts of care espoused by my research participants and their socially located emotional work of caring. The intent of this chapter is not to explore or review the literature on the construct of care or the emotional work of caring, but rather to contextually use these social constructs to socially map nurses’ care work to the extra-local socio-political forces that reorganize care work and influence nurses’ emotional health. Accordingly, in this section, I will review the literature on emotional labour to construct a conceptual foundation germane to understanding and mapping the social relations embedded in nurses’ local care work and the emotional work of caring.

Hochschild (1983) coined the idea of emotions as socially constructed within the complex web of the organization thereby entering the contextual world of emotions and emotional work. Accordingly, Hochschild’s research shifted the focus from the study of emotion
as a psychological or biological phenomenon to the study of emotion as a social construct within the context of the organization. Hence, for Hochschild, unlike scientific management, emotion existed in the organization. Hochschild built on Goffman’s (1959) earlier insights on impression management and performance of self to create the concept of emotional management or emotional labour. Hochschild (1983) defined emotional management as the induction, transformation, or suppression of feelings to create an environment that is keeping with the social conventions of the situation or environment (p. 7). Hochschild implied that emotional management is the act or effort of trying to feel what is expected in a social situation by aligning what you actually feel with what you should feel. It is paying respects according to social conventions. It is deeply rooted in the social world. From a feminist perspective, D. E. Smith (1987, 2005, 2006) acknowledged that Hochschild has contributed to the study of social construction of emotions in the organization. Nevertheless, D. E. Smith posited that sociologists study the organization in its traditional administrative or managerial form through organizational theory, and the sociology of work, largely ignoring other standpoints that exist beyond this limited frame. Accordingly, D. E. Smith argued that the very organizational processes that render women’s standpoint invisible have also reshaped their daily experiences and re-structured their lives.

Hochschild (1983) suggested that if we do not feel the way we should (according to feeling rules or social and cultural norms), we engage in the process of emotional management or emotional work through either surface acting or deep acting to consciously or semi-consciously manage our feelings and influence other’s emotions within a social interaction. In surface acting we change our outer expression to elicit the same feeling within others and ourselves that we are visually conveying. It is the superficial display of an emotion. Alternatively, in deep acting we
get in touch with our inner feelings and emotions to change them from the inside and alter our outer expression to create the mood that we want others and ourselves to perceive and feel. It is an inner and outer reflection of genuine emotion. Therefore, Hochschild highlighted an important conclusion from the concept of emotional management/labour and feeling rules/social norms; emotional management/labour is a social process that is fundamentally based in emotion.

An important contribution of Hochschild’s (1983) research on emotional labour/management was the examination of what happens when we manage our emotions to accomplish work tasks or trade them as economic currency in the service industry. Hochschild suggested that the feelings and emotions that we privately manage become subject to inequitable power relationships when we fabricate our emotions for profit. She asserted that when emotional labour is “put into the marketplace, it acts like a commodity” (Hochschild, 1983, p. 14). It is at this point where Hochschild delineated emotional management, the private, discretionary emotional work done for social purposes from emotional labour, the emotional work done under organizational rules for public service and profit. Her research on flight attendants revealed that emotions and feelings were no longer under the flight attendant’s discretion when engaged in emotional labour for customer service, as defined by the organization. The tasks of the flight attendant role were standardized and customer service expectations were redefined by the organization, leaving less time for customer interaction. Hochschild concluded that, as a result of increased organizational demand in the form of emotional labour, some flight attendants engaged more in surface acting or emotional dissonance as a result of self-estrangement or distress. Therefore, Hochschild suggested that the gap between genuine personal feelings and the unauthentic display of emotion or emotional dissonance contributes to burnout.
Recognizing that emotion work continually crosses boundaries and may not necessarily be subject to economic gain, Hochschild (1983) introduced the concept of gift exchange. According to Hochschild, we pay respects to others by giving, evoking, transforming or suppressing our feelings through our social interactions. We have ideas about what feelings are owed to one another and mentally keep tally of this give and take. Hochschild referred to this social process of give and take as a gift exchange, which is governed by feeling rules or social norms. Bolton (2000, 2005) defined gift exchange, more specifically, as philanthropic emotional management where it is possible to offer something extra, informally, such as emotional support to a colleague on a particularly difficult day at work. Bolton suggested that philanthropic emotional management is less about the private emotional management of feelings based on social formalities or implicit feeling, as in Hochschild’s gift exchange and more about organizational social interaction, which helps glue collegial relationships within the work environment. Bolton (2000, 2005) refined emotional management into four distinctive typology; prescriptive or professional feeling rules and norms; pecuniary or commercial/organizational feeling rules and norms; and prescriptive and philanthropic; social feeling rules and norms.

Building on Hochschild’s (1983) concept of emotional labour and recognizing the uniqueness of the nursing profession in relation to emotional caring work, P. Smith’s (1992, 2012) research on student nurses conceptualized emotional labour in the nursing profession noting that emotional labour or the emotional work of caring is central to nursing practice. P. Smith defined emotional labour as a component of emotional care where nurses subordinate their feelings, irrespective of how they personally feel, in order to make patients feel cared for and feel safe. Huynh, Alderson, and Thompson (2008) and Gray (2009) agreed that emotional labour is a relatively underdeveloped concept within nursing literature however, emotional labour is the
underpinning of patient care. Moreover, nurses are not only governed by feeling rules in the form of professional and institutional standards but also provide discretionary emotional care requiring, as Bolton (2000, 2005) defined, philanthropic emotional management. P. Smith and, later, Bolton (2000, 2005), and Gray (2009) maintained that emotional labour should be further defined by building on Hochschild’s concept of the gift exchange given the complex nature of emotional care work in nursing and that the gift exchange can take place not only in the private realm but in the workplace. Student nurses participating in P. Smith’s research study often suppressed or evoked their feelings in the form of an emotional gift to patients to fulfill professional ideals of patient-centred, holistic care. Smith’s (1992, 2012) research on hospital nurses illuminated the uniqueness of nursing care and the need for a contemporary definition of emotional labour in professional nursing. Bolton (2000, 2005) explored emotion work as a gift in the nursing profession by researching individual motivation. Bolton concluded that more research is needed in the area of emotional labour in the nursing profession (Bolton, 2000; Bolton & Boyd, 2003). Her research findings suggested that nurses’ use of emotional management strategies extend beyond the professional and organizational feeling rules required for maintaining a professional demeanor.

Emotion Work in the Context of the Organization and Managerialism

As we look beyond the local site of emotional care of patients and the emotional work of those nurses providing patient care, we begin to see the contextual elements or the layers of social relations implicated in how care is conceptualized and how care is actually delivered at the bedside. We can also see how these differences may place burden on those conflicted or caught in the middle at the front-line of nursing care. In fact, the literature highlights the problem of
organizational structure and redesign in the context of nurses attempting to delivery patient-centred care, thus exposing some of the elements of care that becomes less visible. Moreover, the literature highlights how care is politicized throughout the hierarchy of care delivery and how certain elements of care, most notably emotional care, have been marginalized, thus placing an additional emotional burden on those struggling to balance holistic patient-centred care with the medical-administrative model of care. It is here where I will turn to the literature and explore the contextual influences implicated in the delivery of nursing care and their relationship with nurses’ emotional labour. In the literature, this is often discussed as the risk of burnout.

Hochschild’s (1983) study illustrated the re-structuring of flight attendant’s emotional worlds by exploring the consequences or psychological costs of exchanging emotional labour as a commodity for economic support. Hochschild posited that the flight attendant’s way of knowing and acting in the world was sculpted by the organization. Hochschild questioned, “how deeply an organization can go into an individual’s emotional life apparently honoring the worker’s right to privacy...emotion is a way of knowing the world” (Hochschild, 1983, p. 33). She found that the flight attendants in her study developed strategies to cope with the loss of control over their own emotional management/labour. Some flight attendants were able to distinguish between their private selves and their commercial selves. These flight attendants engaged in surface acting to create a sense of detachment from their personal selves, to preserve their own sense of self: “we make up an idea of our ‘real self’, an inner jewel that remains our unique possession no matter whose billboard is on our back or whose smile is on our face” (Hochschild, 1983, p. 34). Complementing Hochschild’s research on flight attendants, Hulsheger and Schewe (2011) studied the costs and benefits of emotional labour in their meta-analysis of
three decades of research on emotional labour and cautioned that surface acting or emotional dissonance may impact employee well being.

Building on Hochschild’s (1983) concept, P. Smith (1992, 2012) found that the student nurses in her study developed similar management strategies to cope with increased emotional labour due to high emotional, physical and technical workload demands on the hospital ward. P. Smith found that some student nurses working within a hierarchical management structure reported suppressing their emotional distress or becoming emotionally distant. These student nurses reported that they felt like a failure when they were not able to devote the emotional care required from patients due to a heavy physical and technical workload. This suggests that the student nurses’ identities were fused with professional ideals of patient-centred care within the nursing culture. In fact, P. Smith suggested that there may be two conflicting entities, which influence the emotional labour of nurses: nursing ideology and the organizational culture.

P. Smith’s (1992, 2012) research emphasized the implications of negative emotional labour by examining the wellbeing of nursing professionals and their care of patients in the health care system. Some of the student nurses working on hospital wards who espoused a hierarchical management model reported that they subverted their own emotions to satisfy the wishes of their superiors. In fact, P. Smith suggested that the longer the student nurses suppressed their emotions to satisfy those in authority, the more they valued the detached aspects of physical and technical care valued in a hierarchical system. As the student nurses naturalized these norms in deference to authority, they incorporated the dominant cultural discourse of patient labeling and stereotyping. The nursing students began to perceive patients who required more complex emotional care as a pain or difficult to care for. P. Smith suggested that these conditions contributed to the burnout of nurses and, therefore, some patients did not receive the
care they needed. Similarly, Seery and Corrigall’s (2009) cross-sectional survey of nurse’s aides and childcare workers found that surface acting was related to negative work outcomes such as emotional burnout, lower job satisfaction and affective commitment, and higher motivation to leave the organization.

In contrast, Hayward and Tuckey’s (2011) research explored the dynamic and complex emotional boundaries of nurses in a hospital environment, which supports positive emotional management using the concept of the gift exchange and expands on Bolton’s (2000, 2005) concept of managing emotion in the workplace. These researchers found that the nurses participating in their study used emotional regulation as a healthy strategy for adapting to varying degrees of professional and social interaction. The nurses in the study who were skilled at the manipulation of emotional boundaries created a positive working environment through the proactive regulation of emotion for various purposes such as task accomplishment, building camaraderie, and building therapeutic relationships with patients and families (Hayward & Tuckey, 2011).

Hochschild’s (1983) research suggested that emotional labour is a skill that can promote social good. Hochschild (1983) suggested that emotional labour is a skill that is akin to deep acting or method acting and may be a pre-condition necessary for engaging in positive emotional labour. P. Smith’s (1992, 2012) research on student nurses built on Hochschild’s earlier research, by concluding that emotional literacy is a necessary skill conducive to quality patient care, which should be included in organizational training and nursing education. P. Smith asserted that student nurses can be trained on how to care by learning how to manage complex emotions through practicing interpersonal skills within an emotionally challenging environment where they may need to deal with work that is demanding, exhausting, laborious, and stressful.
Complementing these studies, Staden (1998) concluded that emotional labour is a component of care that requires the skill of being alert to the needs of others. Staden (1998) posited that emotional labour or the emotional care of patients is not scripted, rather, emotional labour is adjusting your affect from deep inside so that you are “giving evidence of what they [the patients] are going through” (p. 153). Similarly, Bailey et al.’s (2011) study concluded that emergency nurses who worked on developing their therapeutic selves in the nurse-patient relationship experienced less emotional exhaustion from increased emotional labour during death and dying, thus, emotional care competencies or occupational skills are significant antecedents of emotional labour.

The organizational structure and management style of the work environment is a significant pre-determining factor in emotional labour. P. Smith (1992, 2012) found that student nurses reported less anxiety and stress in hospital wards that embraced a holistic model of care in comparison with a hierarchical model of care. Moreover, Lopez’s (2006) qualitative research on the comparison of three long-term care facilities found that emotional labour and care were located on a continuum of organizational management. According to Lopez, the emotional labour imposed by management through professionalism was less conducive to emotional care in comparison to organizations that supported emotional care through organized emotional care. Nursing work engineered around the concept of organized emotional care humanized patient care by weaving emotional care and support into task related processes. P. Smith and Lopez emphasized the importance of humanizing patient care processes within the health care organization to optimize emotional care.

P. Smith (1992, 2012) found that nursing leaders who embraced a caring management style recognized the importance of emotional care as a component of nursing, which cultivated
an environment endorsing the emotional care of staff, patients, and nursing students. More recently, Huynh et al.’s (2008) concept analysis on emotional labour supported these findings by concluding that positive emotional management/labour is fostered by a supportive work environment and should be included in nursing continuing education. Ironically, James’s (1992) work on care work and hospice care found that contrary to the hospice’s endorsement of the family model of care, the actual nursing work was done under a hierarchical care model. Some nurses reported increased stress and anxiety when they were not able to give emotional care to patients under a standardized medical regime endorsed by management. McGibbon et al. (2010) used institutional ethnography to map how nurse’s stress was socially constructed. These researchers found that nurses’ stress, in relation to the human connection they experienced as women, mothers, sisters, and professional nurses, was central to the increased emotional labour they also experienced. They had no opportunity to share this textually or verbally as they lacked the language needed for discussion within an organizational environment that valued scientific and technical knowledge in everyday/every night work processes.

Schaubroeck and Jones (2000) concluded that emotional labour is related to perception, which may influence physical stress-related symptoms. These researchers found that workers who identified with corporate ideology suffered less ill effects than their counterparts who experienced less identification with their organizational culture. They suggested that the perception of emotional labour was influenced by how well the individual emotionally adapts to the corporate or work environment. Resonating with Schaubroeck and Jones’s research, P. Smith (1992, 2012) concluded that student nurses working in an emotionally supportive team environment experienced less anxiety and stress than their counterparts working in a hierarchical management structure. Correspondingly, P. Smith found that nurses who worked in a
hierarchical environment reported more stress and anxiety when they perceived a conflict between their work environment and their professional ideals. Thus, this research suggests that nurses may experience or perceive more intense emotional labour in comparison to other occupational groups in the service industry because of their divided and conflicted loyalty between the employer and the nursing profession.

It is clear from the literature, that the social reorganization of care has placed increased burden on nurses at the front-line of care. As the literature suggests, the emotional burden of those struggling to balance patient-centred care with the organization’s medical-administrative conceptualization may impact not only the health of patients and their families, but the health of nurses providing care at the bedside. As health care organizations adopt models of care using quality improvement methodologies to align patient care processes with their respective ‘patient care’ philosophies, nurses are linked locally into this extra-local or extra-organizational mode of organizing care. Nevertheless, with the exception of McGibbon et al.’s (2010) IE on nurses’ stress, the literature primarily focuses on the local influences of care at the bedside. And yet as I entered the world of my participants, it became increasingly clear to me that there were influences in place, which extended beyond the walls of the organization that impacted their day/night nursing care and their emotional responses to the care they actually provided on their respective wards, units, and departments. This has encouraged me to explore beyond the temporal and corporeal world of knowing and follow the strands of care to map a connection to influences beyond the bedside where care has been individualized at a local level. As my earlier participant problematizes the efficient care of her colleague, we begin to see beyond the local level, and connect to social influences well beyond the floor where individual nurses stand and do their work. Although my research can cover only a small connection to the complex structure
of health care, it is nevertheless my intent to reveal a small part of the larger system is wound around the local one.

Mapping the Burden:
The Emotional Work of Bedside Care

That person checked out.

(Communication with Janet, RN, May 4, 2011)

Through my interview with Janet, an RN in the pediatric ICU, I entered the everyday/night world of her organization. In this rich description of her emotional work, she describes how has been left with the burden of providing emotional care to her colleague’s patients and families. Janet has considerable experience in comparison to her novice colleague. According to Janet, she feels that it is her responsibility to coach novice nurses the cues of observation and to help her colleagues develop the emotional labour skills necessary in the provision of emotional care of pediatric patients and their families. Janet has developed these skills through her tenure in the ICU, an environment that that is rife with emotion, such as grief, guilt, and anger, as families navigate the difficult phases of the chronic, yet terminal illness of their children. It is here, where Janet, despite her own personal feelings, dons her nursing cap and expends considerable emotional labour in helping families through their personal journeys. Janet has, according to Hochschild (1983), and Bolton (2000, 2005), provided a gift in the form of philanthropic care, which is essential to her nursing care as well as helping bind the nursing team together. Throughout my interview, it is clear that she has extended herself beyond the nursing care of her assigned patient and family as she extends the gift of emotional care to mother of a child, which has been assigned to her colleague for the duration of the shift. Janet expresses
frustration, which she works to maintain as she extends emotional care to this mother of a child scheduled for discharge from the hospital:

(Communication with Janet, RN, May 4, 2011)

Janet: “So I'm not in that position anymore, of actually needing to have lots of advice to me, but I am certainly in an obligation to teach my colleagues about how to do this. And...to be conscious of the cues to know when a family needs them. And, that's where I sometimes find, they'll do the tasks for the child and then they wander away and check out their iPhone, or their Facebook account.”

My response: “That's interesting. Do you have a specific story?”

Janet: “I could have, like ten, but I'll give you one. About a mom just sitting there, by her child's bedside. And the nurse had done her stuff and she's efficient and she's kind and all this good stuff. And she's done the child up. And she walks away and plops herself down and opens up her Facebook account. And I'm doing my thing, because I haven't quite got the art of getting all my stuff done in 20 minutes and back to a computer. I'm watching, cause, I scope the room, because that's the nature of my experience, and I saw this mom just looking really sad, you know, really sad. And so, I went over to my colleague and I said, I think the mom needs a little TLC. Have you given her a task or job to do? ‘I just don't want her to bother the child’ [colleague responding to Janet]. It's her child, find something for her to do. Your mother is in distress. So, she pretty much ignores me. And I'm like, oh man. It’s kind of an interesting permeable boundary, because you know, I'm not going to tell someone 'You're not doing your job.' So the decision was kind of made for me when she decided to go for first break. Now I'm covering for this patient. Okay. The field is open. So I go wandering over there and do my: Hello, how are you? I'm Janet. I'm the nurse covering. And how are you doing? And of course, the tears come. I get the box of Kleenex. I find out that daddy had gone back to work that day and she's all by herself and she'd just been discharged from the hospital and this is all so overwhelmed. I said, why don't we put the side
of the bed down? I want you to touch your baby. ‘Well, the other nurse said I can't’ [patient’s mother responding to Janet]. And I said, she's not here. Let's just have some fun, while she's gone. So I had mummy put her hand on her little baby. And I said, what do you feel? She said ‘I'm feeling breathing.’ I said, what's he doing? She said, ‘He's sleeping.’ So I'm going through all these things and I said, what do you notice about your baby? And she said, ‘Well, I can't really see.’ And I said, well, just look at what his face looks like? And in that little moment, that took all of about five minutes of my life, I established for that mom, her role. I hate to say it, I gave her permission to actually do something with her child. And I gave her an inkling of what she can contribute to her child's life, who has this very long-term condition. And, when my colleague came back, I essentially opened the gates to talk to my colleague about this. At first, she didn't have a clue what I was talking about. And I thought that was really quite illuminating, because I said to her, did they not talk to you about bedside matter? Did they not talk to you about the connection of the unit? It's not just the child; it's the mother and the family and the aunties and; the neighbours. And she says ‘Well, that's not my job.’ Ah, I beg to differ. How would you like it if your mom was stuck in a bed somewhere and the nurse just came over, clinically did what needed to be done and just left her? She said, ‘Well, I hope they would be caring.’ I said, well, you know what? You weren't. I finally had to be really blunt with this person, and so, it was interesting with your phrase, emotional labour, because that person checked out. She did not actually do that extra step.”

As Janet recounts her story of providing patient-centred care, she draws from an embodied experience as she guides the small child’s mother through the practice of bodily care whilst providing the necessary emotional care for the mother who is coping with the diagnosis of her child and the frightening prospect of bringing her child home. In fact, Janet illuminates the social world of caring from the standpoint of women as she emphasizes to her colleague assigned to this mother and child,
Did they not talk to you about bedside matter? Did they not talk to you about the connection of the unit? It's not just the child; it's the mother and the family and the aunties and; the neighbours.

In essence, Janet is labouring emotionally against the administrative and medical model of efficiency. Janet’s holistic values are at odds with the care practices espoused by her organization, which leads to frustration that must be emotionally managed at the bedside. Moreover, it is here we begin to see the how nurses are affected emotionally by the assumptions and processes of quality management under the guise of organizational efficiency. As Janet inquires “how would you like it if your mom was stuck in a bed somewhere and the nurse just came over, clinically did what needed to be done and just left her?” she illuminates the social standpoint of women, which has been undermined by a hierarchical system designed by the ruling power of administrative and medical science. At this point, Janet has revealed the disjuncture between how patient-centred holistic care is done in her everyday/night work as a nurse in the pediatric ICU and how the efficiencies of quality patient-centred care, as defined by the organization, were in conflict with her ideals of care. As Janet’s colleague, had “done the child up”, she completed the tasks of physical and technical care required by the organization’s mandate to provide care as an objective form of care adhering to the quality indicators measured the institution. Moreover, Janet’s colleague established the boundary of superficial emotional labour in order to accomplish the tasks required of her as an employee of the organization, thus aligning with the definition of care adopted by her employer.

But here is where I began to see the cracks in the process of delivering health care. The dominant discourse locates the problem of care, or more specifically, emotional care and the emotional labour of caring, as an individual activity and responsibility. But as I conducted
interviews with other participants, it became apparent that the problem or the perception of lack of emotional care was not a generational or individual problem located at the front-line of care, but rather an entry point from which to explore how emotional care and the emotional labour of providing care is socially constructed within the organization. It is clear from Janet’s account that she experiences extra burden from the emotional labour of caring on her shoulders as she strives to extend care beyond her patient assignment. Here I want to emphasize that the burden of emotional labour, which appears in discourse as an individual matter, actually in practice involves a host of extra-local socio-political forces that mediate the everyday/night delivery of emotional care of patients. The generational differences cited by my research participants locates the problem of inattention at the bedside as an individual problem when, in fact, it is a systemic problem. We see that the concept of patient-centred care as defined by the organization becomes problematic in the delivery of care by the nurse at the bedside. As nurses take up this organizational concept of care, this socially arrangement is no longer visible to those providing the care at the bedside. It is here, where I draw concern for those shouldering the burden of emotional care above and beyond their patient assignments. As inattention to the emotional care of patients is perpetuated as an individual problem, the issue of burnout becomes an inevitable reality for nurses.
In the previous chapter, we explored how nurses are emotionally burdened by their dual accountability to the patient and the organization. We began to see how documentation of organizational indicators of quality care began to reshape or coordinate the actions and threads of care provided by nurses at the bedside, further increasing the emotional burden of these nurses. In this chapter, I will explore how texts in the form of quality management documentation, pull nurses away from the bedside, thus reshaping nursing care activities. I will use D. E. Smith’s (1987, 2005, 2006) conception of text, in the form of paper, patient care management systems, etc., to explore how these texts are read by nurses and enacted in a series of activities that coordinate and transform their care work at the bedside and bind them to the concept of care espoused by the organization. In this way, the ubiquitous text, enacted within the context of delivering value in quality patient-centred care becomes another strand of quality management that connects actions both within and beyond the walls of the organization and is a central mechanism in the redesign of patient care. These texts reshape and translate care work practices from a local sense of care based in the embodied experience of nursing care work to the institution’s conceptualization of care, based in quality management systems.

Although health care organizations have traditionally standardized work processes to a certain degree, for example, medication administration, there is an increasing reliance on tools or technologies of standardization. However, as contemporary quality management shifts into the clinical area, work standardization using documentation or technology becomes crucial in
sustaining or maintaining the processes created through Lean/quality methodology. Moreover, quality improvement methodologies used in process redesign focus, in principle, on making the work standard, making the work more visual, and standardizing the environment (O’Neill et al., 2011; Seidl & Newhouse, 2012). As such, high volume nursing care activities are made more visual and standard through documentation systems (e.g., paper documentation, electronic patient care management systems), which record and measure data for the purpose of evaluating quality care performance. And, as health care executives are under pressure to measure and report quality indicators such as safety and efficiency to the Ministry, these contemporary quality management technologies are central to producing the evidence necessary for reporting due diligence. In fact, high volume patient care areas such as the OR suite, have been transformed by documentation technologies, much akin to airline pilot checklists in the aviation industry, which measure patient throughput, safety, and Ministry wait list timelines. At this juncture, it is apparent how it would be problematic for organizations, struggling to remain financially viable, if such standardized documentation technologies were not in place to capture institutional reporting obligations. At the same time, although such mandatory checks are desirable, we can begin to appreciate how they have transformed the core elements of patient-centred care as the organization captures a story or version of care that may not entirely coincide with the story as told from standpoint of the nurses at the bedside. As these documentation technologies reshape care through standardization of work processes, we also begin to see the complexity of the issue, often invisible from the nurses’ standpoint as they struggle to fulfill their obligations to their respective employers and patients; we also see the complex web of social relations within health care. Hence, we can see how the introduction of standardized documentation technologies may
add more layers of complexity, creating more tension and burden for the nurses, as they are pulled deeper into this complex social web.

Here we enter Sharon’s everyday world as Patient Care Manager of a busy Toronto hospital. As we enter her world, we begin to appreciate the balancing act she must perform to ensure the delivery of quality patient-centred care for which the organization is accountable. In fact, the Hematology Program’s performance, for which she is accountable, is visually captured, tracked, aggregated, and reported through the organization’s website linking electronically to more stakeholders than can be captured in this thesis project. It is here I will explore Sharon’s world at a local level and explore the social relations that are visible there:

(Communication with Sharon, Patient Care Manager, March 14, 2012)

Sharon: “When you're doing the reprocessing, restructuring, for everything to flow, you put anything in the process for safety…in the way of tracking safety and recording for accountability purposes? [Sharon is talking about the processes used during the restructuring of a department within the hospital] It's all about patient safety. So whether it's confidentiality or, just even the travel. But I mean…it blurs a bit with quality…[for example] the hemoglobinopathy program. About 150 of those patients need transfusions and so there's a whole process around that. And it's driven by standards and checklist and patient identification”

My response: “Can you give me examples?”

Sharon: “Well, you're a new patient, we have to take two separate group and screens, so two positive samples. So that's safety, and that's a standard. And every patient has to have two samples, to make sure that it's right and it's consistent. So then it goes to the blood bank. So then, let's say you need a transfusion, so we do a cross and screen. It goes to the blood transfusion [department]. They spin it; they wash it; they call the Canadian Blood Services; they put their order in. The
blood comes in; they look at it; they match it. And then before you actually pick it up, there's another patient identifier from the order. And then when you take the blood, it has to come back to the unit and then it's checked again. So there’s mandatory checks. The blood product doesn't move to the next stage unless it's gone through its check. The operation room, we have a checklist. It's not unlike the airlines where the nurse, the anesthetist, the surgeon, the circulation person, any resident that's in the room, all have to do a time out, stop, Is this done, this done, this done, this done? So, have they received their pre-op antibiotic? Are we doing the right operation? Got the right patient? Got, you know, the right body part?

My response: “So is that captured in any way for quality? Quality indicators that might be tracked by the Ministry?”

Sharon: “All of our work [is tracked]. We have a balance scorecard, which anyone can look at through the Internet. And that's driver for balance. So we look at that. So from a business perspective, balance scorecard drives business, drives operations. Where do we need to pay attention? What do we need to focus on? So did the surgeon show up on time? Cancellations…was the preoperative drug given; DVT [deep vein thrombosis] prophylaxis…and so, all of that goes into the provincial score. But definitely, time to operate, so if we say that OR is at 8, that surgeon better be there, ready to go, at 8 o'clock. We time that. And so we talk about that in our business meetings. But then having to extrapolate that, so let's say one of the drivers is around post-operative delirium. So we take pieces of that, for example, our sitter use, so that's definitely a financial driver, so that stays in the business arm of what we do. But, why do we need sitters? What are we doing clinically, at the bedside, that's requiring it? So, are we looking at pharmacological review? Are we identifying these patients before they come into the OR? Or can they come into clinic? And so, that becomes a clinical activity. So, how we structure our program is that [in] the business meeting [it] is our oversight. And then with, under the business meeting, um, we have [a] quality
unit council governance that reports into a community, like a corporate practice council.”

As Sharon exclaims emphatically, “Where do we need to pay attention? What do we need to focus on?”, we are drawn into her analytic lens. She embraces quality patient-centred care not only as a manager but also as a nurse. We can see how the value and quality lens is used to visualize patient care processes such as the administration of blood products and the performance of safe processes and procedures in the OR suite. We can certainly see the critical importance of safe patient care through the process of checking and rechecking as blood products are prepared and administered. But as I further explore Sharon’s world, I notice how the lexicon of business enters the discussion in the form of a balanced scorecard, which drives business and operations. This is an important juncture, where Sharon switches to the lens of quality management as she views care from a business perspective when discussing clinical activity. Through this window, the lens of the Ministry and the public view the accountability of Sharon’s organization. It is also here where we begin to see the fusion of documentation technology with the care activities of the organization as surgeons literally and figuratively are poised, ready to operate in accordance with their pre-prescribed OR schedules and the nurses assisting these surgeons are capturing the necessary temporal and bodily measurements considered mandatory by their organization and the Ministry. It appears, from the balanced score card, that these health care professionals are performing or working to the score of a pre-orchestrated sequence where there is minimal autonomy or control from where they stand in the OR suite. It is apparent that the attention and focus of management has been redirected to the business of balancing multiple demands as each manager struggles to deliver both the quality care orchestrated by the Ministry and the quality patient-centred care required by patients and families on their respective units. Moreover, we
begin to appreciate the double lens Sharon must wear on a daily basis in order to maintain this balancing act, thus increasing the tensions she must feel as a manager and nurse, as she is also accountable to her nursing staff and patients and families. But as the “business arm of what we do” becomes embedded within the documentation technologies that support it, another layer of incursion into their daily/nightly nursing care ensnares us. As Sharon illuminates the organizational issue of patients experiencing the side effect of post-operative delirium, we begin to see the cracks. Here, Sharon asks, “What are we doing clinically, at the bedside, that's requiring it (the use of sitters to watch delirious patients to ensure they do not fall and injure themselves)?” Notwithstanding her valid concern, we begin to see how the organization has problematized the falls of delirious patients as a clinical or bedside nursing problem rather than a systemic problem. It is here we see the influence or power of the hierarchy where quality patient-centred care is preconceived or conceptualized as a balanced scorecard. The issue as defined is not that the nurses are struggling to complete their obligations to their employer whilst also caring for the needs of their patients. It is not the fact that the standardized work practices and record keeping of nursing work is taking them from the bedside when the work of caring is not complete. It has been framed as a clinical problem that must be remedied by better management. And as Sharon provides us a glimpse of the complex web of local quality improvement committees and councils we see how the visual practice of record keeping/documentation technology is implicated in this local clinical problem of nursing care.

**How the “Text” Binds Nurses’ Care Work to the Health Care System**

As we can begin to appreciate from these stories of nursing, text in the material form of paper or electronic technology shapes our lives as we read, interpret, and perform the steps
necessary to accomplish certain tasks in many domains of life. D. E. Smith (2001) conceptualized text as an active medium in which we engage in a conversation with unseen others as we attach meaning and context. She often used the example of the coordinating effects of getting a driver's license to illustrate how such arrangements are a routine feature of contemporary life. Such texts coordinate our actions along a sequence of activity that extends beyond the walls of our organizations and our immediate social organization/professional networks. D. E. Smith (2001) asserted,

The text itself, as a material presence (paper, electronic, and so on) is produced, read, (watched, listened to) in particular local settings by particular people. People’s activities in local settings are in this way connected into social relations organized by the text. When a text is read, watched, or heard it brings consciousness into an active relationship with intentions originating beyond the local. (p. 164)

It is here where I will introduce how nurses’ local care work becomes coordinated with the intentions of others around questions of what constitutes quality patient-centred care and how care ought to be done. We will see that the seemingly innocuous text becomes the arm of quality management as local care work is drawn into the complex web of social relations of the health care system. As Mykhalovskiy (2001) observed, texts transform managerial and clinical work by mediating, realigning and harmonizing many kinds of work with the objectives of the organization [Mykhalovskiy, 2001]. In fact, text such as Ministry wait time lists redirect management’s attention to areas of nurses’ care work that is problematic for the organization. To show this, I will enter through Stephen’s world to explore how documentation practices reorganize his care work:
(Communication with Stephen, RN, October 27, 2011)

Stephen: “The patient flow regime is different from that of the recording and reporting structure. The patient flow is a very different, so, what I was referring to when I said, I have to go and document now? It's time to document your vital signs…that's recording and reporting…so, what is it? I belong to an emergency department that has policies about documentation. That's, obviously, it's pulled from the College of Nurses. And it pulls from various quote, 'evidence based practices and literature', and it's distilled into our practices of everyday life.

It tells us that every patient in the emergency department who is still an emergency patient, must always have…4-hour vital signs recorded on their charts. In fact…if not more than that. If they're a critical care patient, they have to have every 1-hour recorded vital signs. If they're a neurosurgical patient, they have to have neurological vitals recorded. And so, you know, the key word here is recorded…the emphasis of the structure is really that if somebody's audited you, they're not interested in the assessment…they’re not interested in the patient's experience. They're more interested in what has made it onto the chart. That's why it's a recording and reporting regime. But if somebody wants to see if you've actually done your job, if you've recorded vital signs every hour, as far as they're concerned, that satisfies the condition of having done your job well, regardless of that patient's experience. So that's the competing interest, in fact. So if the advance practice nurse tells me, “You must have vital signs recorded every hour in order for me to deem you have done your job well.” And so therefore, regardless of how I obtain these vital signs, whether it's through [rushing in and saying], Hi, I need to get your blood pressure; pick up your arm; I don't want to hear anything else. I need vitals, because now I've got to move onto my next patient, because I have to do them every hour, regardless of whether or not I think they should be done. The regime asks that they are done. Otherwise then, it would look like I hadn't been doing my nursing job well. I think it's more important that I sit down and get a social history from you; talk to you; get the social worker
involved; get the wife in here. Get on the phone with your family member, which I would maybe think is more important. I can't do those things.”

It is here we see the influence of social relations extending well beyond Stephen’s emergency department as he lists the regulatory and professional requirements he must be accountable to in his daily/nightly nursing care work. According to Stephen, he must be accountable to these social relations through his careful documentation of information considered important in capturing quality patient-centred care. It is here where we begin to see how Stephen’s care work is regulated by the temporal need to capture certain information. Moreover, we see how his actions are mediated through regulatory text such as professional standards of practice and organizational policy. It is a double-bind where his care work is not only mediated by text but he is also drawn away from patient care as he must fulfill his individual accountability to his employer and his professional college through careful documentation within text. It is here we also see how he is caught in the middle of a complex web of social relations, which extend well beyond what this thesis can explicate. But, we can appreciate how trying to balance multiple demands adds to the emotional tension and frustration Stephen experiences as he attempts to provide patient-centred care for his patients and their families. In fact, we get a sense of this frustration as Stephen emphasizes, if vital signs are recorded every hour that satisfies the condition of having done your job well, regardless of that patient's experience. We clearly have a sense that Stephen is not satisfied with this textual incursion as his holistic care work is circumvented by his reporting obligations. As Stephen’s direct patient contact is limited by these incursions, we see how care work is being actively reshaped by the system. No longer can Stephen autonomously provide philanthropic care (e.g., calling a patient’s family member, providing counselling) as he feels necessary, he must follow a
pre-prescribed schedule regardless of his professional discretion or judgment. Stephen must fulfill his individual accountability as the arm of management, and someone such as the Clinical Nurse Specialist, will audit Stephen’s documentation to ensure his practice is in keeping with the organization and quality assurance standards. Further, from the organizational standpoint, Stephen has done a good job if he fulfills the documentation requirements. But, clearly, from our glimpse into Stephen’s world, we have a sense that Stephen is not in agreement. And, we can also appreciate how trying to balance these complex documentation standards with holistic patient-centred care can lead to emotional burn-out as the emotional labour of managing frustration reaches a tipping point

Care Work:
The Textual Representation of a Standpoint

If it’s not charted, it didn’t happen.

(Diamond, 1995, p. 130)

By this point in the chapter, I have tried to illustrate how documentation technologies have pulled nurses’ priorities away from hands on care work at the bedside. But this is only part of the story. As text captures the administrative story of care, this account becomes a prominent voice within the social relations that form this complex system. As the power and politics of various groups of stakeholders take hold of the direction of the delivery of care, care work becomes defined according to their standpoint. Furthermore, senior executives will align their respective organizational strategic directions with the concept of care upheld by this standpoint by writing policy and procedures reflecting this view. This textual discourse winds its way throughout the wards and units of health care organizations, transforming the way care is
delivered at the bedside. In fact, Rankin and Campbell (2006) illuminated how nurses’ knowledge has been subverted within this textual discourse. As we learned from Stephen’s account, not only has documentation prioritized care away from the bedside, care has also been redefined textually at the organizational level and retold at the Ministry level. But, on closer examination:

1. What are we not saying?

2. What’s missing from this story?

3. Do we want to inherit this idea of care as it is replicated throughout the system, casting a wide net on the actions of all social actors in the system?

4. What are the effects on the emotional and physical health of nurses, families, and patients as care becomes reconstructed under the powerful business lexicon of quality management?

As we read between the lines, we see the richness of the participant’s care work through my research. Yet, these voices and their stories on patient-centred care work have become silenced by the dominant voice of medical and administrative care. It is here we will examine what didn’t happen or almost did happen as we enter Janet’s world:

(Communication with Janet, RN, May 4, 2011)

Janet: “Rounding is when the team of doctors come…that's, they talk about the plan, what's on for the day and what the plan will be for the rest of the day.

Depending on what's going on. And, when it's the child in question, the parents are welcome to be at their bedside and listen in on rounds, which can actually be rather interesting because the doctors can be yattering at each other about
different things. And it can get very heated. And every so often, there can be a bit of a glitch, because a new piece of information that the family are not privy to, is raised. And so you’re standing behind the doctors going, Oh Christ. You just told them you want to list the kid for transplant and you haven't told the family that. Oopsy. [A staff member asks Janet], “Is there something you wanted to say?” [Janet replies] I just wanted to flag for you [Dr.] that you might want to just book some times after rounds, to talk to Mr. and Mrs. so and so, because you just presented a new piece of information… so this dad was like, “Well, we don't want a transplant.” So then the staff physician's trapped, because now this dad wants to get into this conversation with the 10 other people that are there. And I'm trying to do a little traffic control, to say, I think [the] doctor, you know, wants to talk to you [dad] after rounds. I said, you know [Janet addressing the doctors], I think you guys really need to be straight with this family. They're not, dumb. They didn't just fall off a tree somewhere. They know what's going on.” And you know, it, it kind of blew back on that doctor. But you know, it was a learning thing for him. But he also thanked me, because he said, “I could just see your eyebrow.” And he said, “I knew I'm in big do-do. Oh god, yeah.”

We enter Janet’s world through her account of “rounding” where interdisciplinary teams comprised of physicians, surgeons, nurses, and allied health care professionals discuss the plan of care for patients and families in the pediatric ICU. It is clear from Janet’s account, as she and the child’s parents stood bodily apart from the main conversation on the surgical plan of care, that surgeons dominated the discussion. We begin to see the power and hierarchical elements of the social organization of the health sector as the care conversation centres on the medical or curative aspect of care delivery. We also see that care is emphasized by the surgeon’s care planning as a form of diagnosis and treatment. But what story or standpoint are we missing here? As we follow Janet’s account, we see the omission made by the surgeon, as his focal lens did not have a more peripheral view to recognize the holistic patient-centred care required by the
patient’s family. As Janet illuminates, the plan of care, seen from the surgeon’s lens, we begin to see how the dominant discourse of medicine can be, at times myopic, when viewing patient care. It is here that the dominance of medical text becomes alive in conversation and participates in the power and structure of the organization and coordinates the activities of its subordinates. Notwithstanding, it was not the intention of the surgeon to disclose this potentially harmful information, but rather it resulted from his/her preoccupation with the medical discourse of colleagues within the context of the organization. When Janet’s standpoint enters the conversation, it gives the surgical team pause, as they realize the consequences of their shortsighted actions. But Janet’s account is both generous and optimistic, as the doctor learns from this experience.

What can happen when nurses’ standpoint on patient-centred care is silenced within the dominant discourse, or special conversations, of medicine and/or administration? We see through Janet’s story, how holistic care can be overlooked within these dominant forces. We also see how the Janet’s standpoint on care can be pushed to the background within these conversations on care delivery as the standpoint of quality management and medicine dominate the discussion. I am attempting to show here that the standpoint of care espoused by nurses is mostly rendered silent in the textual form, or the many forms of textual discourse, on patient-centred care. As health care organizations, government agencies and the media define care from a medical and administrative perspective, the nurses’ standpoint becomes diminished. With the silencing of nurses voices or the eclipsing of their accounts of care work, their emotional wellbeing may be affected as they continue to manage their emotional frustration of trying to provide patient-centred care.
Chapter 7
Learning to Care:
Exploring a Space for Care Work

This thesis tells the story of how nursing care work becomes transformed through the socially constructed lens of Lean or QI. It is at this point we see how the forces of government, through its accountability to the public, has influenced health care organizations to make these changes. As senior executives of these organizations struggle to keep themselves viable, the option to resist a value for money approach to care no longer becomes feasible. And it is here, where learning to see becomes an education that all health care professionals must embrace in order to remain employed in their respective organizations. Accordingly, as care is practiced at the bedside in the nurses’ everyday/night world, nurses must consider the organizational value of their patient care activities as they focus on which strand or element of care is to be considered waste. As nurses mediate their activities according to this new way of learning to see, they, not unlike the senior executives in their respective organizations, become hooked to the larger system. But, what are the effects of this socially constructed version of care on the individuals implicated in direct care delivery? In the following chapter summaries, I will review what we have learned from the lens of IE

Chapter 3 explored how nurses’ care work has been socially reconstructed through the application of Lean and other quality improvement frameworks adopted by their organizations. As management learned to see nursing care processes through the lens of quality improvement, nursing time spent on anything other than efficient patient throughput came to be defined as waste. But, we saw, through Stephen and Sara’s account that this understanding of waste became socially constructed as the relational or inconvenient physical aspects of holistic nursing care.
Certainly the patient pre-packaged for transfer who requested a bedpan did not factor into the value and efficiency lens contrived by external business consultants. Thus in this chapter we began to see how the disjuncture between the holistic patient-centred care espoused by the nurse participants in Chapter 2 contrasted with the quality care or value for money quality care championed by their respective organizations. In fact, as health care organizations coordinated their care activities with Ministry guidelines or policies, local nursing care work became mediated by the temporal dimensions that originated within and beyond the walls of their respective institutions. These arrangements are similar to what D. E. Smith (1987, 2005, 2006) described as the social relations or the social networks that concert and organize the extended work processes of health care delivery. It is here we can appreciate the complexities surrounding the participant’s local care work, which are too extensive to fully cover in this research. Nevertheless, as we explored Sara’s world in a busy orthopedic ward, we got a sense of her frustration as surgical procedures were re-structured and aligned with the Ministry clock. In fact, as Sara described the added work tasks involved in performing medical procedures, which ensure that her organization becomes a centre of excellence, we got a sense of her frustration as the meaning and the practice of care became aligned with this mandate. It was here, we got a sense of how these mediated care activities increased emotional work as Stephen and Sara managed their emotions in order to get their work done. It is here we gained appreciation for their frustration of being caught in the middle of the contradiction between the organizational construct of care and of their own holistic patient-centred care values.

In Chapter 4, we looked more closely at the physical and emotional work of caring and the emotional management of those caught in the middle of the contradictions between competing visions of health care delivery. It is here we saw how the emotional and physical
elements of care are being reshaped by health care reform. As Janet struggled to manage her emotions while caring for her critically ill pediatric patients and their families, we saw how the daily/nightly incursions from documentation requirements draw her activities and priorities away from the bedside as she attempted to balance the needs of her patients and the organization. We also saw how these contradictions became so entrenched within organizational processes and in nurses care everyday/night work that when a nurse fails to deliver on all these fronts simultaneously, it is seen as an individual rather than a systemic failure. Moreover, as Janet attempted to educate her junior colleague on the importance of relational care in the pediatric ICU, the issue became problematized as an individual or generational problem rather than a problem rooted in the social relations that extend well past the local point of care. It was here we began to see what would otherwise not be obvious without the lens of IE and the social mapping that brought into view these extra-local influences, which lend to the complexities of the problem.

In Chapter 5, we explored how the strands or elements of physical and emotional care were wound to the Ministry scorecard, as organizations aligned with the quality and safety standards espoused by the system. As we entered Sharon’s world, a Patient Care Manager at a Toronto teaching hospital, we began to see how the standardization of care work through documentary practices such as checklists, pulls nurses farther away from holistic patient-centred care they espouse. As Sharon’s organization embraced Lean methodology in an effort to restructure care processes, we saw how it was problematic for the organization to focus on particular aspects of care work at the expense of care work deemed essential by the Ministry. It was here where we began to see how the arm of management, in the form of documentation standards started to pull all those implicated in providing care and the reporting of care work.
Moreover, we empathized with Sharon’s point of view, as a manager, as her organization was taken up by the measures and scoring required by the Ministry’s safety and quality standard matrices. In fact, we saw, from Sharon’s point of view, the organization’s altruistic intentions for the improvement of quality of patient care. But, extending beyond the walls of Sharon’s institution, there were a multitude of extra-local influences, far too intricate to explore in this research, which were implicated in the actual practice of local care work at the bedside. In fact, Sharon, a local actor in this social network, took up the discourse, inadvertently, as she queried the need for patient sitters, “What are we doing clinically, at the bedside, that's requiring it?” thereby problematizing the issue at a local or individual level. But, as we moved into Stephen’s world, an RN employed in an emergency department at a Toronto teaching hospital, we began to see how the ubiquitous, seemingly innocuous text actually connected all those involved in care work at the bedside to the larger organizational arrangements. According to Stephen, his care work was mediated by the temporal dimensions of computerized and standardized documentation, thus minimizing his autonomy in the provision of holistic patient-centred care. It was here where we began to see how the text, as defined by D. E. Smith (1987, 2005, 2006), becomes a way to coordinate and mediate the social actors located on each level of the organization. Moreover, it became clear at that point, that Sharon’s need for patient sitters to decrease the incidence of patient falls was not attributable to the lack of individual nursing attention, but rather the result of nurses trying to achieve this dual accountability. And, as we moved into Janet’s world, we began to see how the social and political hierarchy has subdued the nurses’ story of how care is being reshaped through the dominant medical and administrative discourse of care. Again, we can speculate about the impact of these arrangements on the
emotional health of those doing the care work in such an environment. But this problem bears much further systematic investigation than can be completed within the scope of my research.
References


Appendix A
Information / Consent Letter to Administrator Participants
(Phase Two of Sampling)

From Researcher Shelley Quinlan
Date ______________________________

Dear Administrator:

Thank you for considering participating in or contributing to my research project. As I explained in our first contact, I am currently enrolled in the Adult Education and Counselling Psychology graduate program at the Ontario Institute for Studies in Education at the University of Toronto. I am doing this research project as part of the requirement for the completion of my Master’s Thesis and for professional publication. The purpose of this letter is to provide you with information that you will need to understand what I am doing and to decide whether or not to participate. Participation is completely voluntary, and, should you decide to participate, you are free to withdraw at any time. Should you have any concerns about the research, you may at any time contact my thesis supervisor, Dr. Nancy Jackson at (416) 978-0890 or nancy.jackson@utoronto.ca, the Office of Research Ethics at (416) 946-3273 or ethics.review@utoronto.ca, or the researcher, Shelley Quinlan, at shelley.quinlan@utoronto.ca.

The name of my research project is: Invisible Emotions: Governing Emotional Labour in Nursing. The purpose of the research is to explore the experiences of registered nurses providing emotional care for their patients within a re-structured hospital environment.

I will be using institutional ethnography (IE) as a feminist mode of inquiry to explore the everyday experiences of registered nurses. From this perspective, I will examine how everyday emotional care of patients is shaped and coordinated by a network of institutions and organizations within the health care system. By using IE as an approach, I hope to illuminate organizational processes that may influence the experiences of nurses providing emotional care for their patients thus paving the way for advocacy.
I need 4-5 participants who are either a leader in health care and/or a subject matter expert who will be asked to reflect on their own experience of how organizations are linked to one another in the health care system and what type of information is shared between these organizations. I may also request these participants to bring any available public domain documents or reports (the interviewee is under no obligation to do so) that might help me understand the relationships between various institutions within the health care system (i.e. quality assurance or improvement reports). Your part in the research, if you agree, will be to participate in one informal interview for approximately one hour with myself, the researcher, at a mutually agreed location, date and time. I will ask you verbally, at that time, for your permission to be audio taped during the interview. You may decline being audio taped at any point before or during the interview without consequence. At the interview, if you agree, you may bring documents or records that you use in your everyday work to report on the quality of patient care.

We will be engaged in an open interview or dialogue.

Areas which I hope to touch on are in the interview are:

- Your professional role and experience (management, academic, and/or policy) in the re-structured health care system.
- The changes you have observed in your organization because of re-structuring such as: changes in processes; changes in documentation methods; and types of data gathered for statistical purposes.
- The types of nursing care activities captured in your organization’s workload measurement system and/or documentation.
- The types of information used to measure your hospital unit efficiency and/or hospital performance.
- The types of information used by your organization for measuring quality patient care.

Once the audiotapes of the interview have been transcribed, the original or raw data will be stored under lock and key at the university. Only my thesis supervisor Dr. Nancy Jackson and I will have access to this raw data. In the transcripts, names and other identifying information about you or your organization will be systematically eliminated. Identifying codes that could connect you or your organization with pseudonyms provided will also be encrypted and kept at the university. The timing for the destruction of the tapes and/or the raw data is 5 years.

As interviewee, you will receive a copy of the transcript of your interview by e-mail (encrypted). Any section that you request to have deleted from the transcript of your interview will be deleted. You are free to withdraw from the study at any time, and you may request that the entire transcript of your interview be destroyed. Additionally, you may choose not to answer any question.
As is clear from the foregoing, I will be taking measures to protect your confidentiality. Although highly unlikely, any unlawful activity (under the Criminal Code or Regulated Health Professions Act) that is disclosed during the interview will be reported to the respective authority. There is a possibility that a referring colleague may identify your comments in the research summary. Another limitation to confidentiality will be access to the data by my thesis supervisor.

While there will be no compensation, you may benefit from participating in this study by becoming more aware of your views on the emotional care of your patients and the systemic or institutional issues that influence this care.

There will be no direct or indirect risks or benefits to you of participating in this study. The expected benefit of this research is the creation of new knowledge that may contribute to improved professional nursing practice in the long term.

During the interview, I might ask you about what type of information (i.e. nursing care activities) is recorded in electronic or paper charts. I am trying to understand what types of documentation (current within the last two years) you routinely submit to senior management in your organization, to the Ministry of Health, or to other governing bodies. This information may assist me in understanding the relationship between your facility and governing bodies within the health care system. It will also assist me in understanding what type of information your organization submits to the Ministry of Health for funding purposes.

I will be sharing with you my initial analysis based on these interviews and seeking feedback. I will e-mail (this will be encrypted and I will send you the password that is required to open it one day before sending this information) this analysis with the research summary. If you wish to have any part of the analysis or research summary removed, please contact me by my U of T e-mail within four weeks of receiving it.

Below, there is a place for you to sign to give your consent, should you decide to do so. There is also a place for you to add any stipulations. Should you decide to participate, please return one signed and dated copy to me and keep the other for your reference. All participants will receive a summary report of the research findings. I will be mailing a summary of the research findings to all participants.

Thank you.

Sincerely,
Shelley Quinlan
shelley.quinlan@utoronto.ca
To Be Completed by Administrator Providing Permission

I have read through this document. I understand and am satisfied with the explanations offered, feel that my questions have been addressed, and agree to participate in the ways described. If I am making any exceptions or stipulations, these are:

__________________________________ (Signature)
__________________________________ (Printed Name)
__________________________________ (e-mail)
__________________________________ (Date)

I give the researcher permission to audio tape the interview:

__________________________________ (Signature)
__________________________________ (Printed Name)
__________________________________ (Date)

Please keep a copy for your own records.
Appendix B
Information / Consent Letter to Participants

From Researcher Shelley Quinlan
Date ______________________________

Dear colleagues:

Thank you for considering participating in or contributing to my research project. As I explained in our first contact, I am currently enrolled in the Adult Education and Counselling Psychology graduate program at the Ontario Institute for Studies in Education at the University of Toronto. I am doing this research project as part of the requirement for the completion of my Master’s Thesis and for professional publication. The purpose of this letter is to provide you with information that you will need to understand what I am doing and to decide whether or not to participate. Participation is completely voluntary, and, should you decide to participate, you are free to withdraw at any time. Should you have any concerns about the research, you may at any time contact Dr. Nancy Jackson at (416) 978-0890 or the researcher, Shelley Quinlan, at (647) 286-8970.

The name of my research project is: Invisible Emotions: Governing Emotional Labour in Nursing. The purpose of the research is to explore the experiences of registered nurses providing emotional care for their patients within a re-structured hospital environment.

I will be using institutional ethnography (IE) as a feminist mode of inquiry to explore the everyday experiences of registered nurses. From this perspective, I will examine how everyday emotional care of patients is shaped and coordinated by a network of institutions and organizations within the health care system. By using IE as a project of analysis, I hope to illuminate organizational processes that may influence the experiences of nurses providing emotional care for their patients thus paving the way for advocacy.

I need 4-7 Registered Nurses working in direct patient care within the hospital environment to participate in a one-one interview. I will explore the concept of emotional labour and examine every day experiences of nurses providing emotional care for hospitalized patients. I will be collecting information from an open interview or dialogue. Your part in the research, if you agree, will be to participate in one informal interview for approximately one hour with myself, the researcher, at a mutually agreed date, time, and place. I will also ask you for (this is
completely voluntary) names of leaders or subject matter experts within the health care system who may be interested in participating in an interview for the research project at a later time.

⑧ We will be doing a cross between an open interview and an interview from a schedule. Please see Appendix A for examples of questions that I have in mind but may or may not ask depending on priorities which emerge and how the dialogue evolves.

OR

⑦ We will be engaged in an open interview or dialogue.

Areas which I hope to touch on are in the interview are:

- What the concept of emotional labour and emotional care means in your nursing practice.
- Your experience providing emotional care for hospitalized patients.
- The responsibilities that get the highest priority in your nursing care.
- The changes in your organization after re-structuring. (i.e. work processes, documentation)
- The types of nursing activities that are routinely captured in your organization’s workload measurement system or documentation.
- The types of information your organization uses for measuring quality patient care.

Once the audiotapes of the interview have been transcribed, the original or raw data will be stored under lock and key in the researcher’s residence. Only Dr. Nancy Jackson and I will have access to this raw data. In the transcripts, names and other identifying information about you or your organization will be systematically eliminated. Identifying codes that could connect you or your organization with pseudonyms provided will also be kept under lock and key or password protection at the researcher’s residence. The timing for the destruction of the tapes and/or the raw data is 5 years.

As interviewee, you will receive a copy of the transcript of your interview. Any section that you request to have deleted from the transcript of your interview will be deleted. You are free to withdraw from the study at any time, and you may request that the entire transcript of your interview be destroyed. Additionally, you may choose not to answer any question. I will be sharing major aspects of my preliminary analysis with you and you will have the opportunity to provide feedback when I will mail you the research summary.

Pseudonyms and password protection will be used for confidentiality purposes and other information that leaves you vulnerable to being identified will be eliminated. I will be writing on the interview findings using pseudonyms. These pseudonyms will appear on the transcripts and in the final research project.
Only Dr. Nancy Jackson and I will have access to this raw data. Identifying codes that could connect you or your organization with pseudonyms provided will also be kept under lock and key at the researcher’s residence. The timing for the destruction of the tapes and/or raw data is 5 years.

I will be sharing major aspects of my initial analysis with you and you will have the opportunity to provide feedback. You have the right to withdraw at any time, including after the completion of the one-on-one interview, and you may decline to answer any question.

As is clear from the foregoing, I will be taking measures to protect your confidentiality. Although highly unlikely, any unlawful activity (under the Criminal Code or Regulated Health Professions Act) that is disclosed during the interview will be reported to the respective authority. There is a possibility that the colleague (health care leader and/or subject matter expert) that you refer, should you choose to provide this information, may recognize your comments from the research summary. Another limitation to confidentiality will be Dr. Nancy Jackson’s access to the data.

While there will be no compensation, you may benefit from participating in this study by becoming more aware of your views on the emotional care of your patients and the systemic problems that influence this care.

Although harm is highly unlikely, you may be disappointed in the research project results.

During the interview, I might ask you for documents that capture workload and measure the quality of patient care. I am looking for current documentation (within the last two years) that you routinely use to record your nursing activities. I am looking for the forms/documents themselves and do not require sensitive data. These documents will assist me in understanding the relationship between your facility and governing bodies within the health care system. It will also assist me in understanding what types of information are submitted to the Ministry of Health for funding purposes.

I will be sharing with you my initial analysis based on these documents, and seeking feedback. I will mail this analysis with the research summary.

You have the right to withdraw the writing, images, or pre-existing documents or artifacts at any time and ask that they and comments on them be excluded from the research.

©Subsection 1: For participants creating images or pictures (relevant only if ticked):

Reproductions of these images may appear in the research paper, though, short of you opting to wave confidentiality, only insofar as their appearance leaves the risk of your being identifiable minimal. Originals will be returned to you by: Specific measures, which I am taking to maximize confidentiality, are
Subsection 2: For participants involved in writing (relevant only where ticked)

If what you give me is an original, I will photocopy the writing and the original will be returned to you within 2 weeks. This raw data will be kept under lock and key in:

Only I will have access to it. I will type what I find. In the process, I will eliminate identifying features insofar as possible. Identifying codes that could connect you or your organization with pseudonyms will also be kept under lock and key in the place designated above. The timing for the destruction of the raw data is

Subsection 3: For participants providing pre-existing artifacts or documents (relevant only where ticked)

The measures, which I will be taking to maximize confidentiality and privacy, are lock and key and password protection at the researcher’s residence. The documents will be destroyed in 5 years.

Below, there is a place for you to sign to give your consent, should you decide to do so. There is also a place for you to add any stipulations. Should you decide to participate, please return one signed and dated copy to me and keep the other for your reference. All participants will receive a summary report of the research findings. I will be mailing a summary of the research findings to all participants.

Thank you.

Sincerely,

Shelley Quinlan  
shelley.quinlan@utoronto.ca  
(647) 286-8970

To Be Completed by People Choosing to Participate

I have read through this document. I understand and am satisfied with the explanations offered, feel that my questions have been addressed, and agree to participate in the ways described. If I am making any exceptions or stipulations, these are:

__________________________________ (Signature)  
__________________________________ (Printed Name)  
__________________________________ (Date)
Dear Colleagues,

I am looking for volunteers to participate in a research project I am conducting for my Master’s Thesis at the Ontario Institute for Studies in Education at the University of Toronto. The name of my research project is: *Invisible Emotions: Governing Emotional Labour in Nursing.* The purpose of the research is to explore the experiences of registered nurses providing emotional care for their patients within a re-structured hospital environment.

I will be using *institutional ethnography* (*IE*) as a feminist mode of inquiry to explore the everyday experiences of registered nurses. From this perspective, I will examine how everyday emotional care of patients is shaped and coordinated by a network of institutions and organizations within the health care system. By using *IE* as a project of analysis, I hope to illuminate organizational processes that may influence the experiences of nurses providing emotional care for their patients thus paving the way for advocacy.

I need 5-8 Registered Nurses with greater than five years acute care experience working in direct patient care at a tertiary care hospital to participate in a one-one interview. I will explore the concept of emotional labour and examine every day experiences of nurses providing emotional care for hospitalized patients. I will be collecting information from an open interview or dialogue.

This is your opportunity to participate in a relatively emergent mode of inquiry that may add to professional nursing knowledge and enhance clinical practice.

Please contact the researcher, Shelley Quinlan, at [shelley.quinlan@utoronto.ca](mailto:shelley.quinlan@utoronto.ca) if you are interested in volunteering or if you have any further questions.

Thank you.