European Nurses’ Life and Work under Restructuring: Professional Experiences, Knowledge and Expertise in Changing Contexts

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Summary

The Work Package 5 of the EU Sixth Framework programme project Professional Knowledge in Education and Health: Restructuring Work and Life between the State and the Citizens in Europe (ProfKnow) examines nurses’ experiences of work, work life and knowledge at work within the context of welfare state restructuring in seven European countries, England, Ireland, Greece, Portugal, Spain (Catalonia), Finland and Sweden. More specifically, it aims to (1) understand nurses’ experiences of work life changes and notions of expertise, (2) to compare these experiences and notions of expertise between generations and across the national contexts, (3) to analyse health care work and life with ethnographic descriptions in order to understand practical professional knowledge at work, and (4) to contextualise nurses’ life stories relative to histories of profession, restructuring of health, and social changes in Europe. This volume includes the national case study reports from the seven countries and the common comparative report that summarises and compares the findings of the national case studies.

These studies aim at finding out how restructuring impacts nurses’ work and lives and their professional knowledge. Restructuring refers to the changes in policy, regulation and administration of health care institutions, organisations and services. While it is admitted that the widespread neo liberal and new public management doctrines and policies often drive these changes, the case studies show how the process and outcomes of restructuring vary across the national/regional contexts. Moreover, it is not only the calls for economic efficiency and accountability, but also the rationalisation of administration (bureaucracy) and scientific/technological progress that contributes to the change of nurses’ work, work lives and professional knowledge. Even though there is convergence of the contexts due to the common trend of restructuring, the different histories and trajectories of the national/regional contexts contribute to how this trend refracts in each respective context, producing different outcomes at the level of various localities and nurses’ everyday work.

The studies focus on practical and situational aspects of professional knowledge at work in the context of restructuring of the welfare state institutions. Restructuring and knowledge are approached by looking at the issues that are meaningful for the nurses themselves. The case studies and the common report analyse these general issues through a set of common themes including conditions of work, control and autonomy, social relations, social position and status, education and learning, work-life balance and professional knowledge and expertise. The issue of generations is also looked at across the themes. By looking at the nurses’ actions, perceptions and experiences from a bottom-up perspective in their respective localities, we analyse how restructuring measures are materialized, enacted or even resisted by nurses. Moreover, we aim to analyse the extent to which these measures are re-contextualized as new conceptions of valued professional knowledge.

The national case studies draw on the life story and thematic interviews that were conducted in urban multicultural hospital or public health care settings in each study context. In each context, three nurses, who belong to different generations, were interviewed: one nurse with long professional experience (ca 30 years), one with between 8 and 10 years of professional experience, and one with about one year of professional experience. Fieldwork data was produced by shadowing each nurse for three days at their work sites. A focus group interview data in five of the case studies was also collected and used in the analysis. The case studies draw also on previous Work Packages 1 and 2, and on the ProfKnow survey, conducted in Ireland, Finland, Spain and Sweden, plus some additional sources. The comparative report was produced by comparing the case studies.

There are two general major sets of conditions that contribute to nurses’ everyday work, with different emphases in each national/regional context. Firstly, the contracting model of employment is becoming more general and the civil service model of employment is decreasing.
Secondly, the management and administrative models for hospitals, clinics and health care system as a whole is driven by demands for increasing cost-efficiency, throughput and results, accomplished through guidelines, standardization, evaluation and rewards. For practicing nurses these two factors mean precarious career and the tight resources contributing to increasing experiences of workloads and haste, stress and exhaustion.

Such conditions of work and life have implications for nurses’ professional knowledge and their notions of expertise. The comparative study investigates the notions of curing and caring, and theory and practice, as well as a number of other related categories. What the nurses consider that nursing knowledge and expertise, that is, the core of their professional self-understanding and self-definition, is often in contradiction with what is required by the changes at work, namely by restructuring. Particularly, they feel that they do not have time to care, to be with the patients and respond to their personal, social and emotional needs holistically. It is not the professional culture or rigid attitudes that cause inertia in relation to restructuring, rather the nurses may have internalised the new expectations and requirements well. Yet, they still may feel that they are not able to work according to their professional ethos, which is embedded in the idea of caring. Moreover, tightening of resources and increasing workload coupled with the shortage of staff may lead to negligence of required guidelines. Thus, expectations and requirements are often in contradiction with the real possibilities to realise guidelines in practice due to various shortages. Consequently, nurses are often in between the demands of the management that is increasingly concerned of economic standards, goals, and efficiency, and the patients, that are increasingly knowledgeable about health care and more demanding about their rights.

The findings also indicate that the centralized, external and direct managerial regulation and control with clear hierarchies between different professional groups has been replaced by more decentralised regulation and control operating locally and in-directly through various guidelines and instructions. The nursing profession has become more independent and functionally distinct with its special area of practice and expertise. Parallel to this is the increasing self-regulation and self-organisation in the form of planning and evaluating one’s activities. These regulative instruments are in many contexts connected to financial systems aimed to control the health care costs and increase efficiency and output. Many case studies, most clearly England, report on various restructuring measures, which can be characterised as neo liberal, being activated.

While there are notable similarities in the patterns regarding how the nurses experience the effects of restructuring, the case study contexts also vary, and different issues surface as focal and typical in each respective context. While the different emphasises of the case studies may contribute to which characteristics are stressed, the open-ended life story methodology and the common set of themes provide us with grounds for identifying what is pertinent and typical in each case. In the English case, the introduction of multiple career paths, flexible work arrangements and opportunities for professional development are the positive changes, while instability by fear of redundancies and uncertainty about the cost-efficiency driven changes contribute low working morale, and threaten work-life balance and coping. Also the load and pace of work has increased with consequences for nurses’ coping with stress and burn out and for their ability to work according to their ideals and the more official demands. In the Irish case, nurses voice discontents about intensity of work load, low salaries, about lack of resources and about some impracticalities regarding their decision-making power at work. Similarly to the English case, the consequent low morale is a concern for them. Formal education plays a significant part in the Irish context. In general, negative effects of restructuring seem milder than in England, and it seems that the nurses are highly responsive to the changes and have quite successfully adapted to them.

In the Greece case, gender roles and recent significant entry of men in nursing is a topical issue for nurses. It is expected that the entry of men having a positive impact for the image and status of nursing profession. Staff shortages and outdated attitudes are reported of creating hindrances of
acquiring and applying scientific nursing knowledge. Upgrading of nursing education at the university level and making nursing a more independent profession by legislation are also seen as significant change contributing to image and status of nursing. Development of nursing education plays particularly significant part in the Portuguese case. While new educational opportunities are seen as means for enhancing professional status, the nurses are frustrated by the lack of related economic and professional rewards. Also while nurses’ autonomous sphere is more clearly defined by legislation, as in the Greek context, the nurses still do not feel being fully recognised within institutional medical teams. Specifically, recent change into contracting model has made work life more precarious. The Spanish case brings forward how restructuring has affected the working conditions. Contractual conditions have been made more flexible which has meant more precarious work life. Everyday work has changed into more demanding with increased work load, due to increased through-put of patients, and stress on efficiency, economic criteria and cost control. These changes have made work lives more unstable and work more stressful. As in the Portuguese case, the Spanish nurses do feel that educating themselves does not translate into economic or professional rewards. Still, they feel pressure to educate themselves, while the administration does not foster education.

The Swedish and Finnish cases differ from other cases because their study contexts were health centres instead of hospital ward or clinics. This contributes to the relative autonomy the nurses enjoy in the both contexts. However, their work is regulated by computerised appointment systems, which is in the Swedish context connected to the financial system of reimbursement. A pertinent issue in the Swedish context is the demands the nurses face in between the administration, with its economic standards and goals, and the patients, with their increasing demands for cure and care. In the context of scarcity of doctor’s appointments, the nurses feel stressed in a position where they have to determine the patients need for care. Also the role determined by a purchasing procedure and the nurses’ own perception of their role may sometimes conflict. The case study notes how nurses’ professional “no” is weak, and they feel they just have to adapt to the demands. The Finnish case brings forward quite a trouble-free picture of its consultancy nurses work. They have enough opportunities to participate in decision-making concerning their unit. Further, they are able to train and educate themselves relatively independently. They are also quite satisfied with the conditions of their work, excluding perhaps salary which they consider too small in relation to the heavy responsibility, physical and mental demands of the work, and their long education. A recent change of broadening nurses’ area of activity by transferring some duties from the doctors is greeted by the nurses with hopes for higher professional status and wage level.

The case studies handle generations often in terms of nurses’ references, for instance, to the groups of ‘older’ and ‘younger’ professionals and their attributes. The experiential generations, in Mannheimian sense, are hard to discern with our scarce data of a single nurse representing a “generation” in each case. Yet, the initial assumption about the structural and regulatory conditions of the formation of professional habitus can be related especially to employment and educational changes. The previous generation that had benefited from the expansion of welfare state and related opportunities is contrasted with the recent generation experiencing short term employment and precarious careers. However, distinguishing between generational and career effects is difficult on a basis of cross-section design with a few individual cases. The transfer of nurse education to the tertiary level has created a corresponding division in the nurses’ perceptions and accounts into practical non-academic ‘older’ generation and theoretical academic ‘younger’ generation. Such division is sometimes a source of tension, with the ‘older’ generation of nurses claiming the ‘younger’ generation to be too theoretical and not practically capable to realize their tasks.
CHAPTER 1

Nurses’ Life and Work under Restructuring in Seven European contexts - a Comparative Report

Toni Kosonen and Jarmo Houtsonen, University of Joensuu

1 Introduction

1.1 Objectives

The overall aim of the FP6 project, Professional Knowledge in Education and Health: Restructuring Work and Life between the State and the Citizens in Europe (ProfKnow), is to examine teachers’ and nurses’ knowledge at work within the context of welfare state restructuring in seven European countries. This essay is a report of the work package 5 of the project. The essay has two main objectives. First, we focus on the experiences and perceptions of nurses. Second, we compare these over national contexts and generations. The report is based on the national case studies produced by each project partner.

Restructuring means the changes in policy, regulation and administration of health care institutions, organisations and services. There is evidence that the structures of national welfare state institutions tend to converge to an extent. Convergence of welfare policies and regulations is driven, at least partly, by the widespread neo liberal and new public management doctrines and policies. However, we would not expect that restructuring is a unitary process, but each country has its particular history, and thus the processes and outcomes of restructuring may vary. Consequently, we may argue that there is refraction of the common trend of restructuring in national/local contexts (Norrie & Goodson 2005b, 255). Moreover, not only economical changes (supposedly driven by neo-liberalism) but also bureaucratic, scientific, technological and societal developments may contribute to restructuring tendencies.

We focus particularly on practical and situational aspects of professional knowledge at work in the context of welfare state restructuring. We approach restructuring and knowledge from the bottom-up perspective by paying closer attention to the actions, perceptions and experiences of nurses who work in local health care organizations where restructuring measures are materialized. However, these particular perceptions and experiences are understood in relation to their social conditions.

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2 These studies are included in this volume: England (chapter 2), Ireland (chapter 3), Greece (chapter 4), Portugal (chapter 5), Spain (Catalonia) (chapter 6), Sweden (chapter 7), and Finland (chapter 8).
3 The objectives were specified in common grids and guidelines, and in the minutes of the consortium meetings. Some Guidelines for the Analysis of Life-Stories and Writing of the National Case-study Reports, Revised Guideline for the Analysis of Life Histories and Observations and the National Case Study Reports, and Life History Reports – Common Grid for WP 4 and 5 are unpublished working papers.
1.2 National Case Studies

The study sites of the national case study reports were typical urban multicultural public health care settings where nurses interact with clients. Thereby we could study the professional work and knowledge at the intersection of state and citizens. There were two health clinics and five hospitals. We selected three nurses from each country to participate in our study so that we obtained a representative of the following professional generations: 30 years, between 8 and 10 years, and about a year of work experience.

The national studies started with life story interviews to produce free flowing narratives of professional lives. These were followed by thematic interviews with a common set of themes, such as working conditions, work-life balance, knowledge sources, relations to colleagues and clients, and professional status and autonomy (see Appendix 1). Finally, ethnographies were produced by shadowing each nurse for three days at their work.5 In addition to this, the partners, except in Finland and Ireland, conducted focus group interviews with other nurses in order to cross-check the information obtained in the observations and interviews of individual representatives.

Although we had common guidelines for different stages of research, each partner was also encouraged to explicate their own conceptual positions. Hence, although the empirical themes are common, their conceptualizations and interpretations vary slightly in each national report. This diversity makes the comparisons more challenging, yet possible.

1.3 Theorizing Restructuring and Professional Knowledge at Work

We approach knowledge by distinguishing between cognitive processes and knowledge. The outcomes of socio-cognitive processes of perceiving, judging and acting on ideas, things and behaviour are items of knowledge. Thus distinction between cognition and knowledge is also a distinction between a process and a state. The objects of knowledge are potentially multitude and can range from ideas and facts to models and practices and so on and so forth. Knowledge can be tacit “know-how” or explicit “know that”, which actually implies that the former can only be observed indirectly. The distinction between tacit and explicit knowledge implies also that professional knowledge has aspects that cannot be found in professional guidebooks, but are learned through socialization into a professional culture (Bunge 1996, 76-77; see also Norrie and Goodson 2005a, 17; Polanyi 1967; Ryle 1949)

Although we focus on practical aspects of knowledge (Abbott 1988; Bourdieu 1990), we admit that explicit scientific knowledge, professional manuals and other formal rules have a significant bearing on professional work. Indeed, restructuring measures, such as re-organization of work, are purposefully formulated explicit plans and standards of action to change professional organizations and practices. However, in professional practice there is a constant interchange between these external and explicit systems and concrete work with practical urgencies. This interchange is mediated by the professional agent who has to find a balance between abstraction and concreteness in order to solve the practical problems she/he encounters in her/his daily work. Therefore, we argue that between objectified systems of knowledge and concrete tasks there is a space for professional judgement (MacDonald 1995, 165), which implies a degree of cognitive and social indeterminacy and professional creativity and innovation. This space of judgement is filled by the habitus of the professional agent. In addition to properties of professional agents, the space between systems and practices is mediated by social conditions. Therefore, the success or failure of new

5 A “compressed time mode” of fieldwork (Jeffrey and Troman, 2004) was applied, which involves producing intensive descriptions of events, within a relatively short, but continuous stay at the research site. These descriptions provide valuable insight when contextualized with other data.
restructuring measures depends on how realistic they are in relation to agents’ practical tendencies, skills and interests and organizational resources to satisfy or even resist the new requirements.

Indeterminacy and creativeness of practice is particularly pronounced in situations where standardized knowledge and procedures are not yet institutionalized or otherwise applicable. The weak institutionalization may occur for instance when new objectives and external clinical guidelines are not yet internalized as legitimate and taken for granted normative and cognitive models for action (Berger and Luckmann 1972). The difficulty to apply rules and models for action in practice may occur also if there is lack of organizational resources. For instance, due to lack of machines, qualified staff and time, health care personnel may not be able to apply recommended guidelines even if they wished to do so.

There is also a degree of freedom and chance because the “logic of practice” is to an extent inconsistent and illogical. According to Bourdieu (2000, 54-7; 1990, 200-270) practice unfolds in time, has its own urgencies and ends but is still only practically, but neither logically nor formally coherent. Therefore, from the external perspective of social science that can transgress the limits of time and place of the objects it studies, professional practices may seem to be occasionally contradictory and fuzzy not following the formal logic of guidelines. This articulation does not entail that formal guidelines, external models or systematic rules have no bearing on nurses’ work. Quite the contrary, nurses have to rely more and more on formal and legitimate models of action, perception and judgement, because they have to be accountable for their actions and decisions. However, the power of forms and explicit norms that aspire for control and co-ordination of practice in professional health care organizations is not deterministic, but it is realized in the intersection of agent’s dispositions, that is, their aptitudes and tendencies to perceive, judge and act, and objectified rules and models within the context of opportunities and constraints to act.

When we study the practices of nurses we also assume that their actions and perceptions are taken from particular positions with specific resources and constraints (Bourdieu 2005). These positions are located at three nested structural levels, which are the society, the field of health care and the organization of particular clinic or hospital. Nurses have a certain social standing in society, the dimensions of which can be measured by various indicators pertaining to their socio-economic status and respectability. Furthermore, nurses occupy a particular hierarchical and vertical professional location in the division of health care labour. Finally, nurses work in various health care organizations in which they occupy particular functional roles and hierarchical positions. In order to understand the perceptions and experiences of nurses we would need to analyse these multiple levels in detail, which would be quite impossible with our present study design and data. We should, however, bear in mind the larger nested structural spaces wherein our representative nurses occupy their positions.

Structural position does not, however, determine social action. This indeterminacy is partly due to the fact that professional practices are organized and informed by agents’ internal dispositions, or schemes of perception, judgment and action. There is also interplay between dispositions and social organization of positions with their particular opportunities and constraints (Bourdieu 1990). For instance, our data suggests that nurses’ perception and judgement is organized by opposition between the mental categories of curing and caring. These cognitive categories are obviously linked to the opposing and hierarchical positions between nurses and doctors in the division of labour in health care organizations. This mental and social opposition is manifested in various guises in nurses’ speech, for instance, in distinctions that they tend to draw between technical and human aspects of care or biomedical and holistic approaches to treatment. The two elements of this mental opposition are usually given different values when perceived from different perspectives tied to different positions. It seems quite natural that while the nurses emphasize care, the doctors speak for cure. However, the opposition is not straightforward, but can achieve various articulations in different social relations and conditions. Indeed, some nurses complain that they do not have
resources to put the evidence based models, which are actually premised on science, in practice. However, the principal opposition seems to organize discourse, and it may also modify professional identities, commitments and perception of valid and valuable knowledge at work (Bernstein 1996; Beck and Young 2005).

We understand professions as a process-like configuration, the shape of which is modified by the changing social relations between the state, regions, municipalities, citizens, firms, civic organizations and professional bodies (Rantalaiho 2004). This implies that there is a constant re-organization of social relations between different professions, which alters professional knowledge, identity and even status. For example, the institutional re-definitions of doctors’ and nurses’ tasks, such as the nurses’ potential right to prescribe certain common pharmaceuticals in the future, are not just administrative rationalizations that re-organize the division of labour. This change could also re-define and re-value professional knowledge and identity. From the doctors’ point of view nurses are probably given only ‘simple’ or ‘inferior’ tasks. These ‘inferior’ tasks may actually strengthen nurses’ self-perception and also their professional status within the society. However, this does not necessarily undermine the relative social distance between the doctors and the nurses, nor generate symbolic and material rewards to the nurses.\(^6\)

The idea of professional knowledge is a wider concept than the notion of expertise. From the nurses’ internal perspective, expertise consists of those core areas of knowledge that they regard as salient and distinguishable from other professions, occupations and lay-people. However, knowledge that is objectively or socially required to perform the tasks of the profession might be different from what the profession regards as valuable and unique. For instance, even though nurses consume lots of time in activities that require biomedical and/or technical knowledge, they often seem to regard caring and emotional labour as the most salient and gratifying element of nursing. Moreover, patients’ and nurses’ perception of valid care may differ from each other (Bassett 2002).

From the external viewpoint of laymen and other professions, expertise means particular professional group’s capability to apply some esoteric and complex knowledge for providing expert services to solve human problems. This knowledge is neither clearly understood nor allowed to be applied by the non-certified outsiders (Abbott 1988; MacDonald 1995, 134-5). Professionalism pertains not only to knowledge and expertise, but entails also a social recognition granted by the public at large for a particular social group in terms of social status and privileges.

Nurses’ notions of expertise and knowledge are shaped by the varying social relations and conditions in different national contexts. Nurses’ notions of expertise and knowledge may change as new policies, tasks and methods, such as evidence-based practice, documenting, or electronic patient records, are introduced. Then nurses may have to create new modes of practices and notions of knowledge and expertise through socio-cognitive processes of learning and adaptation. Yet again, nurses’ idea of knowledge and expertise may differ from what the patients, the public, the health care management and other medical staff recognize as belonging legitimately to the domain of nursing.

As mentioned above, there has occurred convergence in the major structural changes in the governance, finance and labour management of health care in each country during the past thirty-five years or so. The general pattern is the following. First there was the establishment of universal, centralised and state-governed free health care system\(^7\). Then there was a noticeable transformation

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\(^6\) Nurses also tend to shift dirty, ordinary and routine tasks to the periphery or outside of their professional core tasks, knowledge and identity. The washing and feeding of patients is given to nurses’ aides and other service staff. These divisions and processes do not exist only at the official institutional level, but are negotiated at everyday work settings between various fractions of health care staff.

\(^7\) It must be noted that “universal” does not necessarily reflect realities in the study contexts but rather the principle or ideal.
of the system due to neo-liberal tendencies of cost-efficiency, rationalisation, standardisation and accountability. However, this general pattern of change has different paths and paces in each national case. Therefore, we may talk about refraction of welfare state restructuring (Norrie & Goodson 2005, 255). In this respect the report for the work package 2 divided the countries into three types, the Offshore (England, Ireland), the South (Greece, Portugal, and Spain) and the North (Finland, Sweden) (Beach 2005)\(^8\). Each country has had different welfare state trajectories. For instance in England liberalization tendencies started comparatively early, in the 1980s. In Finland the welfare state began to emerge during the 1960s, took pace in the 1970s and reached its peak in the late 1980s. Portugal and Spain were under totalitarian regimes until 1974-5, and only after that welfare state institutions were properly established.

Considering the neo-liberal and new public management policies and discourse, England has been in the front line. Neo-liberal measures were introduced there already during the Thatcher era in the beginning of the 1980s. Instead, the Southern countries have never attained the scale of welfare services of England, Finland and Sweden. In addition, Finland and Sweden have been relatively slow in adopting neo-liberal policies in any orthodox fashion. Further, some of the neo-liberal tendencies, such as contracting of staff or financing of hospitals based on rankings in quasi-markets, have influenced more profoundly some case rather than others. However, the overall adoption of neo-liberal policies can be seen as in a process of convergence, indicating a broader European and global forces contributing to the change (see Beach 2005).

The transformation of welfare state institutions and professional practices is not only driven by neo-liberal or economic concerns, however, but there are at least three connected elements in operation. First, there is a neo-liberal ideology of free markets and economic efficiency. Second, there is an idea of rational administration. Third, there is modern medicine based on scientific evidence. Neo-liberalism is about economy, administration is about bureaucracy and medicine is about science. All these institutions have their own principles, expertise and authorities, which they may confront each other when the problems related to structures, policies and activities of health care are tried to be solved. Though these elements or institutions are relatively independent they all are aspects of general rationalization and modernization of the West (Weber 1978) and therefore they may also often go hand in hand quite well. Then formally rational administrative rules are used to obtain economic and social goals. Socio-technological management methods, such as best practices and benchmarking make it possible to enact certain efforts of cost cutting. Evidence based medicine can provide standards that area easier to relate to rational administration and economic calculation. Indeed, at present, it is very much the neo-liberal interpretation of economy that is dominating the administrative and scientific domains.

Often structural and policy reforms seem to be rather distant from the concerns of everyday work of the nurses. In this report we are interested in those institutional changes that surface as influential or significant for nurses’ work, lives and professional knowledge. We focus on whether and how the structural and institutional forces are re-contextualized in the everyday working world of the nurses in various European contexts. It is possible that some of the measures are totally ignored or that professional judgment produces outcomes that are contradictory to economic notion of efficiency, the administrative notions of rationality and the scientific notions of truth (Freidson 2001), or even the public expectations for trust, communication and safety.

Nurses cannot suffice with humanistic or medical knowledge and skills alone, but need also administrative, managerial and even financial competencies in order to maintain social legitimacy in the face of patients, colleagues, administrators and employers. Nurse’s everyday working life is surrounded by medical (science), economic (efficiency), administrative (bureaucracy), professional (nursing) and socio-cultural (patients/clients) demands and expectations. These demands may come in varying combinations and strengths in different national contexts. Furthermore, nurses differ in

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\(^8\) More detailed information about restructuring in each country can be found also in the national reports.
their tendency to recognize, activate or resist various demands and expectations and they have varying resources and interests to adjust to or resist institutional calls for order. The new regulatory and economic demands emerge in various guises, such as ‘goal definition’, ‘performance standards’, ‘clinical guidelines’, ‘evaluation of results’, ‘contracting schemes’ etc. We try to figure out how and to what extent these changes are re-contextualized as new conceptions of valuable professional knowledge?

1.4 Strategy for Comparisons

Our aim is to compare different countries as cases. The comparisons are based on the seven national reports. The original data of the national reports comes from the observations and interviews of three nurses in each partner country. In addition, focus group interviews were organized in five countries. Obviously, with just few participants from each country our view on reality of nurses’ work is rather restricted and it is difficult to make bold generalizations. However, previous work packages of the ProfKnow project, in addition to other secondary data and research literature, offer us additional information that may support the arguments presented in this report. In addition, although our observations are rather particularistic and hardly representative we analyze them with the general conceptualizations presented above.

There are two generic types of comparative study, which can be differentiated by the size of the sample, techniques of analysis and strategies for generalisation. First, there is the large scale social survey that is analyzed by statistical techniques and generalized on probability. Second, there is the qualitative case study with small N and that bases its generalizations on authenticity and credibility of results (Mills et al. 2006, 621-2). The application of qualitative methods to data analysis can be further divided into two types of orientations. First, there is a rather formal and analytical examination of data by using various tables and matrices. For instance, Ragin’s (1987) Qualitative Comparative Analysis (QCA) of macro social events and processes belongs to this type. QCA tries to analyze necessary and sufficient conditions, measured as a constellation of dichotomous independent variables, with values 1 if an item occurs and 0 if an item does not occur, in order to understand causal mechanisms that produce a particular outcome, which is also measured as a dichotomous variable.

Second, there is a less formal and analytical and more descriptive and interpretive understanding of the data. For instance, Lindblad and Popkewitz (2003) compare ethnographically educational systems in eleven countries and show how classifications and categories to distinguish people and social groups are constructed globally and emerge locally. This type of comparative understanding of cases does not mean empathetic understanding or interpretation of intentions of agents. Instead, it presupposes contextualization of primary qualitative case data with secondary evidence, which comes in various forms, such as official statistics, professional and administrative discourse, previous studies and the immersion of researcher in the socio-cultural context in which the cases are located. This type of understanding leans also on simplification and typification of cases as well. This means that each case that belongs to the studied set of cases is depicted so that only the pertinent characteristics are emphasized and thereby the case achieves a distinguishable place within the set of cases. The characteristics that best discriminate between the cases change when the topic and the focus of study changes. With this strategy we obviously lose some of the richness and complexity of details, but by highlighting the most pertinent differences and similarities between the cases our understanding both the broader forces, even at the global level, and the particular cases becomes more profound.
1.5 Participants

The main characteristics and pseudonyms of the participating nurses as well as the descriptions of the institutions in which our case studies took place are presented in the below. Further details can be found in the national case study reports.

England

- Jan (N1) (the experienced nurse), aged 52, with 27 years of nursing experience works in an administrative and management position with some consultation with the patients.
- June (N2) (the mid-career, specialized nurse), aged 36, treats patients and has some administrative and management duties. She has worked in the current hospital for 2 years and a few year elsewhere before.
- May (N3) (the early-career nurse), aged 20, with some 3 years of nursing experience. She has not decided her specialisation, and values her work-life balance, and thus, has not chosen to progress up the career ladder.
- The hospital where the field research was carried out has an independent status as National Health Service (NHS) Foundation Trust. 5,000 staff working in the hospital offer services for about 500,000 people in various service units that have been quite recently re-located in the centre site. The hospital has received poor ratings in the public national evaluations and hence it has had poor media coverage as well. The hospital has rather much debt and it has plans to reduce its staff.

Ireland

- Aideen is a divisional nurse manager with 18 years of experience.
- Ellen is a specialist nurse who works predominantly off the ward. She has 11 years of experience as a nurse.
- Nora is a staff nurse working in a surgical ward with 3 years of experience.
- The case study setting is a public hospital with wide range of specialties and services and training and research centres. It has 600 beds and a catchment area of 250,000 of emergencies. The bed capacity is mentioned to be insufficient to the present service needs.

Greece

- Despina, aged 58, works at Outpatient Services, and has 27 years of working experience in nursing.
- Konstantinos, aged 38, works at a blood donation unit. He has been working there for 14 years.
- Maria, aged 28, works at a women’s ward with 1.5 years of experience as a nurse.
- The case study setting is a university hospital that is smaller than other public hospitals but has according to case study quite typical working conditions in relation to other public hospitals. The hospital belongs to the Medical School of Athens University and has 160 beds.

Portugal

- Ana, aged 54, has been as a staff nurse in a blood donation service for 25 years.
- Paula, aged 36, works as a staff nurse on a medicine ward, and has been working in a same institution all her career.
- Alexandra, aged 24, works at oncology inpatient ward, which joined immediately after getting her degree and finishing her training at the same ward.
- The study setting, which is a mid-size clinical, teaching and research hospital managed as an enterprise. Moreover, the hospital is certified by Health Quality Service which is an external auditory body that uses pre-defined criteria to assess the performance.
Spain

- Jenny has been working as a nurse for 30 years. She also lectures at a University, and has been involved in administration, strategic planning, building up nursing services and exploring new terrains for nursing.
- Flor works in an administrative position, which she gained recently after 15 years as a nurse.
- Maite is a nurse who works as an interim with a part-time contract of 21 hours in a post-surgery ward. She has 5 years of professional experience.
- The case study setting, a research and teaching hospital is described as an exemplary case of neo-liberal reforms. In the Spanish system regions have autonomous control of health care system. Catalonia, the region of the case study, has had a leading role in neo-liberal reforms that combine public and private services.

Finland

- Helga, 50, works as a consultation nurse at a health centre. She has worked in health care for 25 years, but she started as a nurse assistant. She has also taken University studies in Nursing Science and taught nursing in a Polytechnic. Now she has 20 years of professional experience as a nurse.
- Leena, 42, works is a consultation nurse at a health centre with some 4 years of nursing experience. She, however, has health care related work experience for about 10 years.
- Jenna, 33, works as a consultation nurse at a health centre as well. She has about three years of professional experience.
- The study setting is a typical Finnish public health centre, run by a municipality (or consolidation of municipalities). It has separate units in several locations in a town that is described as being located in peripheral region where standard of living is below country's average, yet a centre of commerce, culture and administration for the surrounding region.

Sweden

- Nora, 60, works as a nurse at a health centre. She has worked in Sweden, Afghanistan and Tanzania. She has got a three-year long nurse education in the 60s, and has various specialisations.
- Nancy, 56, is a nurse at a health centre. She has been working also at hospital wards and clinics, as well as in a managerial position. She has had a five semester long initial nurse training.
- Nina, 36, has been a primary health care nurse for 4 years, but she has 15 years of experience as a registered nurse.
- The study setting is a public health centre that has 60 employees. The case study notes how the public health care centres are part of the purchasing procedure defining the agreed achievements and the reimbursement, and thus, not so different from private ones.

2 Conditions of Work

2.1 Work Overload and Lack of Resources

Most of the national case studies report that work overload, lack of resources and adequately skilled personnel, and time or money contribute to the nurses’ experience of stress and inability to apply knowledge that is regarded central to profession. We can depict a following relation between neo-liberal measures of cost efficiency and professional experiences. In the context of increasing aging of population and demand for quality services, the striving for economic efficiency contributes to increasing work load and shortening of resources. These are then experienced at work as stress and impossibility to provide care or follow the guidelines.
In the English report the informants are concerned of redundancies due to debts of the Hospital Trust, although there is already a shortage of qualified staff. In fact, the Annual NHS Staff Survey (2005) reports that 74% of nurses work extra hours due to the pressure and demands of the job. Also the Irish nurses talk about staff shortages, limited resources and intense workload. Nora comments that as a result of staff shortages her work is very busy and intense. Ellen feels that her service is so busy that the completion of her duties often requires working outside official hours. Also Aideen, who works in a managerial position, refers to the lack of resources accompanying the increased workload and greater demands for documentation. Shortage does not only contribute to stress and fatigue, but also to the nurses’ experience of not being able to care according to their ideal standards.

Greek nurses also suffer from staff shortage that many consequences on work and career. First, the management occasionally is forced to deal with the shortage by distributing duties not only according to qualifications but also according to service needs. Consequently, occasionally assistant nurses (with only two-year training) are the only ones on duty during some evenings or nights, which might jeopardise patients’ safety. In addition, the staff shortages bring about frequent evening and night duty for the professional nurses (with university training). The nurses are concerned about the quality of the services they are able to provide under these conditions because they sometimes do not have the time to apply their scientific knowledge. It is not surprising, therefore, that in 2005 there was a 24-hour national strike, as the nurses’ union asked for more nurses to be hired in public hospitals to relieve the staff shortage.

There are not significant staff shortage mentioned in the Portuguese report, but the particular hospital setting is an exceptional case in Portugal. It has a good reputation as providing quality services. The potential shortage has been dealt with an extended working schedule, which increases the weekly workload to 42 hours and 37% increase in salary to compensate this. This is an attractive option that compensates for the lost benefits because there is no shift work available for the participant nurses. As a fixed schedule, it offers a possibility for a more stable family life. However, nurses also consider that 42-hour workload could be rather exhausting.

In Spain (Barcelona, IMAS) efficiency requirement to increase the through-put of patients imposes time pressures that the nurses think make it impossible to carry out their work according to their professional standards. Nurses complain about having no time to care, put new knowledge into practice and difficulties to provide quality service.

The case studies of Finland and Sweden do not report about serious shortages, at least in terms of lack of adequately skilled staff. But the sites were health centres and not hospital wards or clinics as in other partner countries. The schedules, shifts and autonomy of nurses’ work may differ in these two types of settings. However, in the Swedish case there is shortage of appointments for the doctors, which have consequences for nurses’ work as well. The nurses in Swedish context are between the needs of the users and the limitations of service supply. This might increase the tension between clients and nurses in some instances.

The Swedish case illustrates the different strategies that nurses can use when they encounter tensions at work created by scarce resources. Nora seems to be dealing with her feeling of inadequacy as a personal question by embracing and stating it out aloud. A member of the focus group talked about keeping a professional distance by doing the necessary under the given

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9 The Institut Municipal d'Assistència Sanitària is the local health care provider in Barcelona with an autonomous juridical status independent from the local government. The case study context of Spain is unique in a sense that the health care providers are relatively independent in each municipality or town, within the autonomous communities – our case study context belonging to Catalonia. In this context, national level may be less significant than regional and local levels. Further detail will be found in the case study of Spain in this volume (chapter 6).
conditions. These two strategies illustrate well the tension between the professional and personal aspects embedded in nurses’ work.

Shortage of staff has consequences on professional further education and knowledge too. Greek and Spanish reports mention inadequate possibilities to professional further education and training. Also the English report mentions that the management doesn’t support further education as it used do. In Finland and Sweden nurses participate in further training, or at least do not mention there are serious problems related it.

The shortages of adequately skilled staff and time relate to professional knowledge at work. Basically the nurses see that the lack of time restricts them to fully realise their professional commitment to deliver quality care for the patients, which is one of the leading concerns across cases. Indeed, they have no time to care but only to carry out the necessary technical and manual tasks (Spain), or to provide the kind of care they would like to (Ireland, Sweden). Sometimes they have not got time and qualified personnel to practice their profession according to recommended guidelines (England). These issues will be discussed in more detail later in the chapter on Professional knowledge.

2.2 Temporary Contracts and Precarious Work

Temporary work and new contracting schemes relate to staff shortage and management of costs discussed in the previous chapter. Temporary contracts without civil servant status are used mostly to obtain flexible work-force that could remedy efficiently the staff shortage and help to move the labour smoothly to locations where it is mostly needed. Permanent contracts and civil servant status would hinder the flexibility demanded by rationalised administration. Thus, the use of temporary work force and enforcing more flexible contractual schemes is one of the means for dealing with challenges that health care organisations are facing, namely to meet the increasing demands of the quality service supply in tightening economical conditions.

We cannot assess exactly the extent to which the concern for economic cost efficiency contributes to temporary work and new contracting schemes in different contexts. We rather examine the matter from the nurses’ perspectives and experiences. First, we will discuss about the influence of temporary work to professional lives, careers and work-life balance. Second, we will look at how temporary work contracts affect practices and organisation of work.

The consequences of greater number of temporary employment are intertwined. The case studies report similar patterns of the organisation of work of the temporary staff and their circulation in different units and specialities. This may restrict individual professional development, which then leads to working conditions where staff is not adequately qualified to provide safe enough services to patients. This vicious circle causes stress, pressure and additional work for permanent staff of constantly training and looking after changing temporary nurses.

The consequences for lives and careers are referred in the case studies of Portugal and Spain as precarious work, which refers especially to generalized uncertainty in individuals’ life planning. English report does not refer to temporary work as precarious work, but the issue is also an important in English context because it relates to nurses’ fear of redundancies. However, the case study doesn’t report about the extent and span of temporary work. The Irish report does not mention temporary work specifically, but talks about more flexible working arrangements to meet the service demands. According to the Profknow survey results, nurses in Ireland do not have difficulties securing a permanent position. 87% of Profknow survey respondents stated that they had a permanent post. However, anecdotal evidence suggests that many nurses working in Ireland
choose to do temporary contract work for agencies so that they can decide their hours and in a sense dictate their terms of employment.

The case study of Greece reports that up to now the government has resorted to contractual hiring of nurses rather than to permanent positions because of financial constraints. It must also be noted that despite the availability of nursing employment opportunities in private hospitals, some men and women nurses opt for contractual work until they find a permanent job in a public hospital, because they prefer the stability of the civil servant status. This trend of contractual employment can cause difficulties “for efficient hospital management as well as for smooth performance of nursing duties”. Because these eight-month contractual appointments are not continuous, some units may experience shortages of adequately trained nursing personnel for some months and may have to resort to assistant nurses staffing on some of the evening and night shifts. According to Maria, short-term contracting is problematic, because once the new contracted nurse has finally adjusted to his/her work, he/she has to leave it. In addition, she complained that because of this system of contractual hiring, she has to assist new nursing personnel at least twice a year.

Portuguese case study brings up the recent change in nurses’ contractual scheme. Nurses are not pointed to permanent offices as civil servants anymore, but they sign an indefinite-term contract with the employer instead. In Spain (Catalonia) civil servant status has not been granted since 1983, which has increased flexibility in the contract management. The new contracting scheme supposedly makes the firing easier than before, but we do have specific evidence whether this is the case. The Spanish report argues that:

These new strategies are inevitable linked to the liberalization, privatization, and flexibilization of the National Health System carried on during the last 15 years. And this reform was conceived pretty much in line with the WHO criteria. The rationale has been creating a more efficient system –modernizing it while expending less.

From the nurse’s perspective precarious position can be very upsetting. For instance, Maite describes the condition where temporary interim nurses are recruited by unpredictable phone calls from the hospital. This type of contracting leaves little room for long term life planning and professional development. Maite notes that because one has to rotate between different specialties without getting sufficient knowledge of any of those, one “can’t work with much security”. In addition, Maite says this running from unit to unit makes it impossible to establish trusting relationships with the patients, which is, according to her, a prerequisite for holistic care. Putting an inexperienced nurse in this stressful and difficult situation jeopardises the quality of attention. “Shift running” causes physical and psychical exhaustion for a nurse and alienates her from the work and its goals due to the difficulty to establish stable relations with the patients and colleagues. Contrary to Maite, Flor, who has a permanent position, does not consider interim position particularly bad. Frequent changes from specialty to another offers a broad knowledge base. Flor regards also precarious conditions in the early career as a normal state of affairs, especially in comparison to other occupations.

The notion of precarious work refers to all-embracing consequences of temporary work and the implementation of flexible contracting for the employees. Spanish report defines “precarity” as referring to “worsening living conditions, generalized uncertainty, exclusion, […] a global category that aims at tracing relationships between work, life, housing, etc. rather than describing work conditions.” The precarious work puts nurses in an uncertainty situation, as they are not able to predict their future employment. They are consequently unable to plan their lives ahead, to start a family or to buy a house.

In Spain (Barcelona), temporary work dates back to the beginning of 1990s, at the time of the Olympic Games in 1992, when the liberalisation of the labour market took off. In Portugal, it is a
quite recent phenomenon, but the change has been swift. The nurse *Alexandra* tells when she started her nursing studies a job would be guaranteed, but as she graduated the situation had changed so that nurses had to start their careers with temporary contracts. Although up to now the Greek government resorted to contractual hiring of nurses because it did not want to increase the number of civil servants, at present, it has been decided that this year 2,000 nurses will be hired as civil servants but it is not certain that this number will help alleviate the problem of nurse shortages.

Both the Spanish and the Portuguese case studies bring up the usual career of a nurse after leaving nursing school. There is first a period of precarious work through which a permanent post is eventually reached. In other words, there is a career ladder. In Portugal, a usual career consists of a couple of fixed-term contracts, from half a year to a year, before a nurse if offered an indefinite-term contract. In Spain, a period of precarious work might extend even to five years or more. There are three types of contracts: temporary, interim and permanent. The career ladder goes through these successive phases so that first a nurse has to live on temporary contracts for quite many years. After this she can get an interim post, which is more stable than temporary contracts but doesn’t provide the stability of a permanent contract. After an interim period a nurse eventually gets a permanent post. The career ladder is a rigid structure, and it is very hard to jump to a phase.

The key informants in the case studies of Finland and Sweden do not surface the issue of temporary and precarious work at all. In both countries the labour market situation for the nurses has been reasonably good during the past few years, and the nurses haven’t had difficulties in getting a jobs or a permanent post.

*Generation* becomes a meaningful category with respect to temporary and precarious work. Cohorts and generations can be used as means to understand and analyze social change by locating individuals within the historical, social and cultural conditions (Mannheim 1952). A group of people can be regarded a generation to the extent that they share the same objective location within the historical time and the related social and economic factors (*generational location, cohort*). Individuals are not necessarily aware of these social necessities, yet generational location renders individuals certain patterns of perception, though and action. Within the same society cohorts can fall apart into many sub-groups depending for instance on the class fractions. Thus, the same cohort can produce several and even antagonistic *generational units (experiential generations)* with their own distinctive ways of being, acting and thinking. Finally, generational units can become *actualized or mobilized generations*. This means that some individuals participate in the common destiny of the social units by organizing and mobilizing social and intellectual movements.

Different generations of nurses have gone through different structural and regulatory conditions and consequently have divergent experiences of labour contracting. The national case studies suggest that particularly younger nurses experience short-term contracting and uncertain careers today. However, it is difficult to distinguish between generational and career effects. We do not have information about the changes in employment opportunities for different generations at the beginning of their careers.

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10 However, the Finnish national ProfKnow survey shows that the temporary contracts are more common among the youngest age group of nurses (born in 1971 and after) than among the other age groups. In addition, the members of the youngest and the second youngest (born between 1961 and 1970) age groups have experiences relatively more “over three month unemployment periods” than the two oldest age groups (71% and 72% versus 87% and 86% respectively). This is just one indication about the fact that the national case studies are really case studies in particular regional and local contexts, and therefore do not allow us to make straightforward generalizations.
3 Control and Autonomy

Next we will pay attention to control and autonomy of nurses’ work. What are the main sources of control? How have the nurses responded to various means of control? What is the scope of autonomy and decision-making power in nurses’ work?

3.1 Control of Work

The national case studies reveal a common pattern that shows the movement from the direct managerial control to indirect means of control such as guidelines, evaluation and documentation. In addition, the priority of management control is on the performance at work according to some administrative rational such as cost-efficiency and service quality. The case studies show that not only managers, but also colleagues, peers, clients and their relatives are important agents of control. Indeed, both the indirect means of control and the other agents than managers are often regarded even more significant sources of control by the nurses.

The studies note that the nurses’ overall experience of autonomy has increased. However, at the same time the indirect control mechanisms, various control technologies and the integrated use of these, have objectively increased. For instance, standardisation through computerised appointment system and patient records can be used to make the task allocation and medical communication more efficient and precise. But here restructuring of control is not only based on neo-liberal grounds, but includes aspects of technology, medical science, administration and management. Standardisation is advanced by scientific, administrative and management concerns and there are new technological means to do it. The information that is stored into the memory of the computerized system can be used for various purposes such as rewards and punishments based on the evaluation of performance and output.

Starting with managerial control, the English case study notes that non-clinical managers and supervisors tend to replace doctors in the managerial positions. These new types of managers are often contracted for relatively short periods of time. Nurses are concerned that the new managers make plans only for the short-term financial standing of the hospital and ignore the long-term issues that are more relevant to nursing and caring.

As mentioned above, the case studies report on various more indirect means of control. The English study mentions about evaluation and ranking of hospitals based for instance on the meeting the various pre-set targets and procedures. This control through competition may exacerbate the social relations between members of the staff and increase work-related stress. In addition, benchmarking accompanied by public evaluations, comparisons and league tables may actually lower working morale among the staff. In addition, evaluation and benchmarking has increased paperwork, which is regarded among the nurses as remote from their core tasks, and thus irrelevant. The so called Payment by the Results scheme requires the nurses to record every procedure and intervention so that it would be possible to assess the cost of every treatment and procedure. The increased demand for documenting practices may partly be related to increasingly knowledgeable and litigious clients, or to an underlining cultural change. The English nurses experience constant need to be aware of their own actions.

The Greek study notes how provisions for formal evaluation have not been implemented. Even if such evaluations had taken place, the existing evaluation forms do not refer to scientific standards of nursing performance or to the level of scientific knowledge; and supervisors tend to give high marks regardless of the real quality of performance. Moreover, the report argues that there is generally a widespread critical attitude towards evaluation among all Greek professionals.
One of the Irish participants criticises management for having unrealistic expectations. Ellen argues that the management’s wish for service development in the context of inadequate resources is an unrealistic objective. Nora expresses concerns about too much flexibility in the management of the ward sometimes. She feels that too many visitors at beds early in the day may threaten patients’ privacy and the quality of care. Nora is also unhappy about the number of bed moves, which intensifies her workload, as she has to write progress evaluations for each patient. The nurse manager Aideen states that nowadays there is much more bureaucracy and red tape (as well as meetings to attend) than there used to be. The Irish nurses emphasise the importance of strong management that shows that they value nurses’ work. According to the nurse participants, feeling valued motivates nurses to deliver high quality care.

In the Irish case study hospital ward, nurses have an evaluation discussion with a ward sister once a year, which covers in a rather general manner issues such as how they are getting on, what progress they will make and which courses they will take. Ellen insists that she has never had a performance review in any of her roles. She feels that performance reviews are only used for those people with whom management have a problem. Yet she would like to have more monitoring and reviewing by a person who understands her role. She comments that the new clinical nurse specialist roles are innovative in practice and thus require considerable steering. Ellen’s experiences may be somewhat similar to that of other clinical nurse specialists. According to a report by the National Council (2004) it was the exception rather than the rule that clinical nurse specialists and clinical midwife specialists received formal feedback on their performance from their line managers. Aideen’s performance as a division nurse manager is monitored by the director of nursing who gives her feedback, and, she assumes, checks staff turnover. In addition her performance is monitored by staffs who complain if beds aren’t being managed properly.

The Irish case study findings suggest that the nurses consider that the control coming through obligation to document is more influential than the direct control of managers. In general, the nurses do not feel strictly controlled by managers. The nurses remarked on the increase in documentation, its relation to accountability and threat of litigation and the impact of these factors on their practice. For instance, Aideen declares that a formal procedure for dealing with accidents is an increasingly time-consuming process: “[d]ocumentation must be filled, insurance people informed, risk management informed, families informed”. Despite the demands on time, Aideen feels that documentation and accountability help to raise standards.

The Portuguese case study shows that the work of the nurses under observation is rather autonomous. There is not much managerial control in the accounts of the case study. The management seems to be somewhere away from the daily concerns of the nurses. Similarly, the case study of Spain notes that there is rather high degree of “auto-control” at work in the study context. There is no central authority that would determine nurses’ activities. Despite of that the Spanish case study also reports tightening management with stricter control of working hours and awareness of costs. The management is especially criticised by the Spanish nurses for giving too little support for learning and training and also not for recognising different kinds of knowledge produced by the nurses.

The control of the work in the Finnish context comes, according to the report, rather through the possible complaints of the users than through the direct or even indirect monitoring of the supervisor and management. The nurses’ performance is not yet monitored and measured by the computerized appointment system, as is the case in Sweden. As the overt control is loosened in the Finnish context, the nurses emphasize the importance of self-control and responsibility as they are not monitored by the others. The ideal of being a responsible nurse who knows her limits is predominant in their accounts.
Both in Finland and Sweden a computerized appointment and patient record system is one potential means to control of nurses’ work. The computerized system works in both countries as a main framework of the nurses’ daily work. The system distributes the tasks and is used as the main interface for planning the work and communication between health care staff and units.

In Sweden, there is so called VIPS system, or advanced standardized documenting system in use. Communication has become more efficient since there is the standardized system of concepts with clearly defined meanings. Nora sees that the improved standardization of documentation since the 1960s and 1970s as very positively, because it improves patients’ safety. This is a consistent view with an orientation emphasising patients’ advocacy, which is deeply embedded in the Swedish nurses’ professional ethos.

In the Swedish case the financial system is connected to the appointment system, which logs each patient call and visit. The results of each unit and nurse can be measured and monitored by the number of logs. Nancy is critical of the overemphasis of economic issues at the expense of patients and their care. This is an instance, according to the author of the Swedish report, where the priorities of the management and demands of the clients are potentially conflicting. Moreover, at the nurses’ everyday work these tensions might become critical, because the nurses are the intermediaries between the system and the patients and have to receive the direct negative feedback of the unhappy customers.

3.2 Autonomy and Decision-Making

From nurses’ point of view, the question of professional autonomy is an important issue. Autonomy can be regarded in terms of doing and in terms of governing. The former refers to nurses’ control over proper nursing and caring tasks at work, whereas the latter refers to nurses’ control over administration and management of the conditions of doings. A significant aspect of autonomy is an opportunity to participate in decision-making. We can distinguish between clinical decision-making and administrative decision-making. Clinical decision-making is about exercising professional judgement at work, the extent and form of which varies in different contexts. Administrative decision-making concerns for instance the allocation of tasks and resources and planning strategies.

Thus, we can distinguish between the formal and codified scope of decision-making and autonomy and the everyday autonomy, namely how an autonomous sphere is created, maintained and claimed at work. Here our main focus is on nurses’ perceptions and experiences of autonomy and decision making power.

The case study of England reminds that the nurses are educated to work as independent professionals. Thus, over the years nurses are granted more recognition as an autonomous profession with a distinctive domain of expertise and responsibilities. But on the other hand nurses’ autonomy has been reduced by new methods of control, such as various guidelines and inspections noted in the previous section. Furthermore, it seems that nurses feel that they do not really have power to influence those decision that pertain to how health care in general or their work in particular is controlled and managed. These questions are decided somewhere far away from the daily concerns of the nurses who feel rather hopeless in their possibility to influence those larger issues individually or by collective political force.

Nurses also feel that they have been deprived of their control of auxiliary work force, because most of these tasks, such as maintenance, cleaning and catering are outsourced for private contractors. Nurses complain that these workers of the private companies often have poor attitude and motivation, which may lead to risky situations. The working relations with the nurses and outside contractors are rather distant and do not facilitate smooth communication and trust.
The Irish nurses have slightly different opinions about their general level of (and desire for more) autonomy. This may be related to their varying levels of experience. *Nora* for instance is reluctant to have the authority to prescribe medicine because of the possible legal consequences. She is also unwilling to take prescribing rights without appropriate remuneration. *Ellen*, on the other hand, would like to have the right to prescribe medicine, and to refer patients for scans and other investigations, but only following further education, changes in law, discussion on liabilities and remuneration for the role expansion. The fact that she cannot perform these tasks by herself is a source of frustration since it makes her work more difficult. A similar sentiment was expressed by nurses in a recent study (see National Council, 2005). The nurses in study described how they had had to wait for doctors to come to their practice setting to write prescriptions for their patients and who were delayed for various reasons. These situations were seen to result in less than optimal patient/client care, frustration for nurses and an under-use of their expertise. Subsequently, an implementation group has been established by the Minister for Health and Children to oversee the roll-out of nurse prescribing on a national basis in autumn 2007. It has also been recommended that an explicit legislative basis be provided for the supply and administration of medicinal products (using medication protocols) by nurses and midwives in hospital and community settings (National Council, 2005).

The *Greece* a law that that granted nurses more professional autonomy was enacted in 2004. The Association of Greek Nurses was granted public power to regulate the nursing profession. Hence, authorization for nursing is only granted for the nurses with tertiary level professional education. This means increase in professional autonomy and wider possibilities for self-employment because it clarifies and differentiates nurses’ tasks clearly from other medical staff.

The Greek case shows that the nurses regard their general autonomy very differently according to their professional position and conditions of work. *Despina* who works as a nurse supervisor and is an active member of the nurses’ syndicate, thinks that nursing is not an independent profession, because the physicians delegate unimportant and time-consuming tasks to nurses without giving them credit for that. In reality, nurses often have to perform treatments that belong officially to doctors’ work, and therefore cannot be classified as part of nursing. Consequently, nurses are not given official recognition for actually managing these medical tasks. On the other hand, co-operation with doctors works well, and the doctors often rely on nurses’ judgements.

However, *Konstantinos*, quite contrary, feels that, although he cooperates with the other nurses in the unit and has supervisors, he has considerable autonomy in decision-making and “*a certain degree of responsibility and power*”. This is most probably due to his specialized knowledge and position in a blood donation unit in which he is a member of a smoothly working team. Finally, *Maria* states that she would not like to have more autonomy since it would mean more responsibility.

The Portuguese case study also brings up a legislation, enacted in 1996, that defines the scope of autonomous practice for the nurses. The law did not, however, change things dramatically, because it rather codified and officialised the situation that had existed in reality already for many years. But the law touched some aspects of nurses’ autonomy more profoundly. For instance, performance was since then only to be reviewed by the peers. The topic of professional status in terms of autonomy divides the informants relative to their work settings, as did the *Greek* case study. *Ana* argues that there is no real autonomy in her work because it is the service chief, always a doctor, who decides about blood transfusions. Whereas *Alexandra* and *Paula*, who work in a ward, say that there is more autonomy in nurse’s work now than before.

The case study of *Spain* concludes that the nurses’ practical functions in the examined health care settings are relatively autonomous from the control of doctors. The case study attributes nurses’
autonomy to such instances like interpreting the patient’s behaviour in relation to medication and making arrangements for commissioning a medical analysis, which, however, has to be signed by a doctor. The report also mentions new tasks of nurses, such as strategic planning and building up nursing services, where nurses work relatively independently.

Regarding the management and administration of health care in Finland, the decision structures and bodies are increasingly brought down to the grass root level. Administration is decentralised so that more decision making power is granted to local actors. There are regular meetings in which the decisions concerning the work units are made among all the health care staff, including the nurses. The nurses, however, have differing views about whether they really have a real influence on common decisions. The most experienced nurse, Helga, seems to be most confident in this respect, the observation which supports the argument that nurses have obtained more autonomy during the past thirty years or so.

The case study of Sweden does not specifically handle the issue of nurses’ autonomy and decision-making. It, however, notes how nurses determine the patients’ need for care, and thus act as “gatekeepers”, controlling the access to health care. The study illustrates also how nurses can plan their work days, but within a determined frame. The so called purchasing procedure, which means that the region purchases the care from the health centre, determines what kinds of activities are included in care, and how much time is allocated to their execution. The reimbursement is determined by appointments. The nurses cannot include new activities outside the purchasing procedure. This is problematic, for instance, for the primary health care (PHC) nurses who cannot provide health promotion or preventive care, the areas they consider focal to their work, because of the current arrangement. For instance the PHC nurse Nina especially interested in health promotion and eager to develop that aspect of her work. She cannot, however, develop the activity as such, within a given frame.

The Swedish study also reports that all the nurses at the centre participate in formal meetings, handling management information and continuing education. The PHC nurses and the nurses have their own distinct meetings with their respective networks. Regarding the control over resources, the case study concludes that the nurses can only control them by adapting to the defined achievements.

The national case studies also illustrate how the autonomy and decision-making of nurses is enacted in their everyday work. The Irish nurses state that most decisions are made in collaboration with colleagues and other health care staff, rather than independently. Nora mentioned that she is able to make independent decisions about basic patient care, but not anything beyond that. She can, for instance, make decisions with regard to pain control but all medication has to be prescribed by a doctor. In an emergency she can get verification for administering certain medications over the phone. She also notes that she makes decisions about who is the appropriate person to ask certain questions. Therefore, she can use discretion to a certain extent.

The Portuguese study locates nurses’ autonomy to the area of contact with the patients. While it is perceptible that the nurses have a quite broad area of autonomy, their perceptions regarding it differ. Thus, the case study concludes that “the construction of professional autonomy is mediated by personal history and by the action context where nurses work”. So, being autonomous as well as seeing oneself as autonomous is also about being willing to take the autonomous sphere within given conditions. While, for instance, Ana regards herself having no autonomy at all, Alexandra states that she has considerable autonomy regarding the patient’s daily life activities, excluding the medication.

The Spanish case study describes how the supervisor does not interfere with nurses’ work even though she is on the spot. There is a social norm that says that nurses should be able to regulate
themselves without an external coercion. The same study illustrates also how nurses’ professional autonomy is accomplished through “small struggles” (Flor), or even refusing to give the care the doctor has ordered (Maite).

The Finnish nurse Helga regards her work very independent and autonomous since it involves making decisions in every turn. She presents herself according to case study as sort of a “gate keeper” as well as an advocate of the patient, similarly to the Swedish case, which may be attributable to the fact that both case study contexts were health centres. This kind of a perception of one’s autonomy illustrates how experienced autonomy is related to how it is perceived and from which position, as the Portuguese case study noted. Number of things may contribute such ranging from real working conditions of one’s unit to one’s ideals of what it should be. Thus, it is rather subjective matter. A more objective demarcation line was drawn by the Finnish nurses as they described more specific interventions. For instance, hypodermic local anaesthesia was not permitted for nurses to carry out instead they could use anaesthesia cream. Prescribing medication was a common demarcation line noted by nurses across cases.

4 Relations, Positions and Status

This chapter focuses on two related areas. First, we look at nurses’ relations to colleagues and clients/patients. Second, we examine nurses’ social and professional position and status relative to society and other health care occupations and professions.

4.1 Working with Colleagues

The case studies dealt with in their respective analyses the social relations between nurses and doctor, nurses and managers, nurses and nurses, and nurses and auxiliary staff, and nurses and some other related professionals. These various social relations are seen in all case studies in somewhat hierarchical terms. This does not mean that closer collaboration and team work approach has not brought different professionals together and transformed the hierarchies in many aspects. The proliferation of specialities in the field of medicine diversifies nursing categories which has a significant bearing on social relations at work. Furthermore, the number of assistants, auxiliary nurses and various other (new) professional groups with whom nurses have to collaborate has increased during the past few decades.

Starting with nurses’ relations to doctors, the English case states that since the nurses have become more autonomous with advanced and specialized skills and knowledge, the doctors have been forced to change their attitude toward the nurses. The study renders relations as relaxed and equal, but notices some instances which create frustration and tension among the nurses, because of experiences disdain from the part of the doctors. Altogether, the study states that there are lesser hierarchies between nurses and other staff today because of increased team work. Also in the Irish context, Ellen feels that healthcare professionals have adopted a team approach whereby they amalgamate information, pool resources, and strive for better plans on the basis of service needs rather than individual needs. Ellen works closely with consultants on a daily basis and notes how doctors and nurses today refer to each other using first names. Apparently, nurses were more deferential to consultants in the past. The Irish study notes how doctors respected and had faith in Ellen’s expertise thus suggesting that relationships are mutually respectful. However, each nurse participant commented that some consultants are a bit “God-like” and unapproachable and Aideen, a nurse manager, states that there is not as much team spirit as there could be.

The Greek case reports also that team work between nurses and doctors works well in the study context. A problem exists sometimes when the physicians, who also have teaching and research
commitments, are late for the appointments with external patients and the nurse supervisor has to cope with unsatisfied patients. The Portuguese case reports on good, friendly and close relationships between nurses and doctors. However, formal power relations are clearly distinct, since service director is always a doctor. So, Alexandra and Paula argue that the nurses do not have real autonomy in their unit. Furthermore, since the doctors take the “crucial” decisions, broad independent efforts and activities of nurses are claimed to be often unnoticed. The Spanish case states that even though the doctors and nurses work in same teams, their routines rarely coincide. They are functionally distinct, both having their own domains and thus distant. However, the study notes that relations are often cordial, but it depends on their personal affinities and, for instance, their ages, how well a nurse and a doctor come along together. However, the case study holds that a general gendered and historically formed image of nurses as doctors’ assistants prevail. The study argues that these gender relations, with more women in nursing and more men in medicine, are reinscribed and reinforced in professional divisions.

In the Finnish study context, doctors were mainly quite functionally distinct from the nurses’ activities. Cooperation was frequent, but indirect in most instances. Only the nurse Leena engaged in direct cooperation with doctors, assisting them in some minor medical procedures. The relationship was, in these instances, rather formal, and functions were distinct and clearly defined. The nurses of the Swedish case ally themselves with doctors as they voice concerns about how doctors cope with the tight schedule. They are also worried about doctors’ health and doctor turnover in general. The study reports how the nurses work in favour of the doctors, for instance, giving them 30 minutes instead of recommended 15 for an appointment.

As was mentioned, the English case reported on diminished hierarchies also between nurses themselves. While this was seen as a mostly positive thing, the experienced nurse Jan noted how it lead also to diminished respect for older colleagues. Informants also made a division into practical nurses of older generation and young academic nurses, which will be looked at in the next chapter on education. In addition, the nurses voiced serious criticism about their colleagues having poor practices and motivation. So, divisions according to ideas about appropriate standards of work were made in the study context. The study brought also up the issue of multicultural work with problems related to different work cultures, since increasing number of nurses from other countries work at health services. Thus, in the English study context, nurses name distinctive groups among themselves by using various properties, such as age, education, skills, working morals and ethnicity. These distinctions are potential sources and means of internal conflicts, particularly in the conditions of cost-cutting and lacking resources.

The nurses in the Irish case described their nurse colleagues as supportive and a good source of knowledge. Nora comments that there are always very senior nurses from whom she can seek support and advice. However, there are times when some nurse colleagues don’t pull their weight, and that puts a huge amount of pressure on Nora. Ellen comments that she had many good role models as a student nurse, and has learned a lot from her nurse colleagues. Aideen, the nurse manager, has been told by colleagues that she is very diplomatic. Finally, we do not find similar distinction in the Irish material as in the English case study.

The nurses in the Greek case study state that there are differences and hierarchies between different units and specialties as well as between nurses with different educational backgrounds. For instance the nurses working in a blood donation unit have relatively high social status because they are irreplaceable as they possess specialized knowledge and expertise. The Portuguese case notices, similarly to the English case, a division into informal groups of “older” and “younger” nurses. There is informal training and performance control at work, with the “old” looking after the “young”, which will be examined further in the next chapter on education and learning. In general, the nurses are co-operative, and there is lots of sharing of information and smooth rotation of work
and schedules among them. Thus, Portuguese case study includes both distinctions (divisions) and sharing (supporting) among the nurses.

While the divisions between doctors and nurses, in the Spanish case, were looked at as related to historical and gendered power relations, the divisions within nursing collective were connected to different professional ideals and ethics the nurses have. The case study notes how Jenny makes a clear division into patient-centred care and the approach she names as ‘getting the job done, faster the better’, preferring the former. Maite draws a somewhat similar division into those “bad” nurses who just apply technical nursing knowledge and those “good” ones who integrate that with medical knowledge and care. Furthermore, since nurses are engaged in close cooperation in organising their work, negotiating, distributing tasks and evaluating results within a “complex social microcosm”, the Spanish study notes how there might be more conflicts among nurses than between nurses and doctors, related to different ideas about work and ethics as mentioned. The study reports on instances where personal “goodwill”, solidarity and friendship resulted in distribution of the workload evenly. Instances of lack of will to use the autonomy, engage in collaboration and support the colleagues, as well as of gossip and resentment were brought up by the focus group. These were attributed to the fact that “we are too many women”. All in all, the Spanish report captures nicely the potential positive and negative aspects of the social relations between the nurses, and suggests some reasons for these different qualities.

The Finnish case notices also how the nurses carry out tasks together and distribute them flexibly. There is constant change of information and collective organisation of work among the nurses. The nurses of the case study assessed co-operation and work community in positive terms, which was also apparent according to the study. There were no visible contradictions or conflicts.

The nurse Nancy in the Swedish case study recalls how relationship between a nurse and a head nurse was hierarchical in the 1970s when she was starting her career. In addition, the relations to the head nurse and doctors as well as to assistant nurses were distant. The nurse Nina also points out a problem in a relationship between nurses and assistant nurses in her former job, namely that the assistant nurses did not have understanding for her job. The case study concludes that the nurses talk about and identify themselves as nurses that are different from other health care professionals. Thus, the identity and cohesion of the group can be seen in terms of how it differentiates itself from the others.

The English case points out the increased number of health care assistants and also other assistant staff, with some of them from out-sourced services. The external assistants were particularly a concern for the focus group, since their actions may lead to risky situations with the patient’s safety of which nurses are responsible. In addition, as assistants take care of tasks close to the patient, such as bathing, the nurses note that they loose a good opportunity to gather information about the patient’s situation. The Irish case reports a similar increase in the number of care attendants and also of cleaners. When nursing moved to an all-graduate profession in 2002 the students were no longer on the ward because they were in college. Hence, they were replaced with health care assistants and more cleaners were employed. The nurse Nora thinks that some of the attendants are brilliant, while others may lack initiative. The study notes that the introduction of care attendants/health care assistants to Irish hospitals is evidence of the evolving role of the nurse. Tasks that were once the responsibility of nurses have now been transferred to care attendants. For example, making beds is now a care attendant’s task. Such tasks can be considered inferior (requiring no expertise). Thus, they re-position nurses’ roles as experts.

In the Greek context, the nurses’ relationship to the nursing assistant is problematic, because there is no clear differentiation between tasks of the professional groups, which is attributable to the shortage of adequately qualified professional nurses. There are occasions where the nursing assistants are in charge in situations requiring a qualified nurse. The supervisors assign tasks on the
basis of needs instead of qualifications in the prevalent situation. The case study notes how this coexistence of nurses and nursing assistants with different educational levels may be a source of tension. The study reports of a tendency of, especially, the older nurses to downgrade nursing assistants. However, no important tensions were observed despite the occasional delays caused by the assistants. The nurses separated themselves from the nursing assistant by emphasizing their professional training and higher professional (technical) knowledge.

The case study of Portugal does not discuss much about the nurses’ social relations with other occupational groups than doctors. However, the report notes how some social relations, like between nurses and laboratory technicians may be problematic because of poorly defined roles and the division of tasks, similarly to the Greek case. The case study of Spain does not bring out the issue of nurses’ relation to auxiliary occupational groups.

The nurses of the Finnish case appreciated assistants highly. They did not make any explicit distinction to them either. Helga talked about them as if they were equals. The Swedish case study reports on some problems with understanding each other between assistants and nurses, as mentioned above, but also on the introduction of a new category of workers in the health care, namely health coaches. The primary health care nurses regard that the health coaches have entered their area of health promotion and preventive care. However, they have not entered the health centre. Due to distribution of tasks at the health centre the primary health care nurses are not able to realize their professional expertise as health promoters. The issue will be discussed further later.

4.2 Working with Patients

The function and role of a nurse is dependent on the role of a patient. Then it is quite self-evident that most nurses, all over, feel that the patient is the focus of their work and source of their professional motivation. Nurses form a social group within the health care system that spends the longest time and form closest relations with the patients. However, the quality of nurse-patient relationship varies across time and place. The case studies note changes and variability in the patients, the subject population, and their perceptions and expectation of health services, and in the approaches the nurses take dealing with the patients. The patients are said to be, for instance, increasingly active, knowledgeable, and critical “consumers”. They are more ready to litigate, often even aggressively initiative regarding their own health. The nurses are, or are suppose to be, more holistic, patient-centred, humanitarian, sensitive, caring, professional, service-oriented, and accountable. These emerging qualities of patients and nurses have consequences at everyday work. For instance, patients’ increasing expectations concerning the quality of care and nurses’ strong orientation on patient centred services in the context of cost-efficiency may have contribute to negative experience for both the patients and the nurses. The relationship of nurses and patients is also closely connected to knowledge and expertise of nurses, and especially to the nurses’ professional ideals and orientation. These issues will be discussed later in the chapter entitled as Professional Knowledge.

The case study of England points out how the patients are more aware, than before, of their rights and more ready to litigate, partly due to increased consumerism and choice agenda, as well as to negative media attention and critical public perception. This state of affairs causes fear of litigation among nurses, making them more self-aware, self-regulative and possibly even overly cautious. The phrase frequently uttered “it is my pin-number on the line” is very telling in this respect. Related to this is the increased documentation of nursing practice and emphasis on professional accountability. The study also brings up the physical and verbal threats of aggression the nurses increasingly face at work. The older generation nurse in the focus group interview has noticed increase in verbal abuse. She attributed the increased demands by the clients to the wrong
impression they have been given about the health service by the actors from the very top who bring forward certain targets and supposed related rights of the clients.

Maria, in the Greek case, complains about the patients’ lack of appreciation toward nurses, in comparison to attention the doctors get. Despina is proud of the fact that the patients recognize her work commitment and express their recognition to her. Also Konstantinos is very satisfied from the fact that a patient, who in the process of his illness needed 2-3 surgeries and lots of blood, a month after his recovery came to thank him. The Spanish case notes also how the patients question nurses’ competencies, as they reflect the subordination of nurses in relation to doctors. The Swedish case tells how the nurses in the study context are in between the demands of the management and the demands of the patients, in the context of scarce appointment times. They have to occasionally refuse care that the patients ask for, which they find problematic. The case study reports also that the people’s anger at social services is sometimes directed to health care staff. In addition, local press notes the availability of health care frequently. Because the nurses have the closest relations between the patients – nurses are between the system and the patients – they are the obvious target of criticism made by patients towards the system. This criticism is fuelled by patients’ personal experiences and often negative publicity of health care services.

There is, however, a positive change as well pointed out by the English case study. The patients of today have often a new collaborative identity. This means that patients are often better informed and accountable on their own health than in the past. The nurses of the study referred to “expert patients” who are knowledgeable and involved in their own care. Basically, such observation along side with the emphasis on patients’ self-care, health promotion and preventive care is found in many case study contexts, sometimes with notes on varying possibilities to realize these expectations. For instance, the Finnish and the Swedish cases illustrate how the nurses try to foster patient’s initiative and to advance self-care, instead of just giving care, and they also find patients’ own initiative as motivating for nursing work.

The nurses across all case studies share the view that the relationships with patients and activities that focus on patients are the core of their professional identity and motivation. The English case notes how, especially, the younger nurses have a holistic and collaborative approach with the patients. Ellen, an Irish nurse, commented that it is nice for a patient to have the same person doing everything rather than five different people coming to do different things. When she was working on the wards she felt that if she could deliver everything for the patient it would be more efficient and the continuity of care would be better. She also thinks that being patient-centred and caring are necessary qualities of a good nurse. Nora talks about the importance of taking an appropriate approach when dealing with different kinds of challenges such as aggressive patients. Aileen values being courteous, caring, sensitive, empathetic, and treating people, how one would like to be treated oneself.

Similarly, the nurses of the Greek case find the work with the patients most rewarding in their work. Moreover, nurses are eager to provide quality care. The Portuguese case study notes how the nurses value social and personal relationships over medico-technical activities. Nurses regard these relationships in terms of continuity, proximity and mutual trust. The motivation and commitment of the Spanish nurses to keep “human beings at the centre” is hindered by difficult working conditions, as mentioned earlier: they have no time to care. Even though the Finnish nurses describe their relationship to clients as close and in emotional terms, the nurse Leena emphasises keeping certain professional distance to them and maintaining nurses’ social status. The Swedish case is no different in terms of bringing up nurses’ perception of the relations and related ideals as their professional focus. The participants also prefer focusing on a patient’s whole situation in life, with regard to continuity, instead of simple “task oriented nursing”.

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Nurses orientation to patients can be regarded a very positive thing, but it may have potential negative outcomes both for nurses and patients within the conditions of cost-efficiency, lacking resources and increasing expectations of diversifying populations of patients in each country. The potentially negative outcomes could be intensified by the fact the nursing and caring are “emotional labour” (Hochschild 1983), that is, a labour that tries to “induce or suppress feelings”, or produce “the proper state of mind in others.”

4.3 Social Position and Status

In this section, we will look at nurses’ social position and status. With the term social position we refer to vertical and horizontal position in the distribution of power and division of labour with related material rewards and resources. Status refers to the recognition, honour and prestige of a social group or an individual granted by the others. Consequently, a social group or an individual may have a relatively strong social position without much external recognition and vice versa. Think about a celebrated poet who does not sell much of his anthologies.

Social position and status are related to social relations, since position and status are rendered in relation to other social and professional actors in the field of health care and a society at large. The notions of expertise and professionalism are also related to position and status, since the claims for expertise and professionalism on a particular domain of activity are expressed in relation to various other professional groups and potential clients. Professions occupy a certain relative position in a vertical and hierarchical division of labour that grants them certain powers, rights and obligations. The question of expertise in relation to knowledge and professional ideals will be looked at also in a following chapter on professional knowledge. There we place emphasis on internal perspective with special attention to knowledge. Here, we will first look at nurses’ status and position in general (external) terms, its public and media perception, and second, we will look at nurses’ claims for position and status in material (salary) and symbolic (respect, prestige) (internal) terms.

The participants of the English case think that the public and the media have a wrong idea about the nursing profession, which is a reason for negative perceptions, undermining and belittling. The nurses regard that general respect for the profession has declined because of the negative media attention. The study suggests that the state of affairs goes back to historical conception of nursing knowledge as inferior knowledge of women. In the Irish context, while previously the nurse Nora felt that nursing (in comparison to other occupations) was a relatively low status job, she feels that perceptions are changing. She attributes this change to nurses’ higher qualifications (degrees and masters) and their increased involvement in decision making. Aideen the nurse manager thinks that certain tasks and responsibilities (such as cleaning the sluice) may have diminished nurses’ efforts to be taken seriously as a profession in the past. With regard to the impact of higher qualifications, Ellen wonders if staff nurses regard their roles as less important following the introduction of the clinical nurse specialist and clinical nurse manager roles. Nurse Maria in the Greek case study thinks that that the lack of recognition of nurses’ considerable knowledge gain from university training is due to a past image of nursing as an activity that does not require much knowledge. She also states that nursing profession is treated unfairly because the doctors get attention of the public, although nurses do most of the work with the clients.

The both male and female participants of the Greek case also think that increasing presence of men in the nursing profession helps to improve its image. Maria thinks also that men are more

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11 Interestingly there is a huge difference in the general publics view about the nurses’ work in Finland compared the UK. According to a recent survey carried out by the Union of Health and Social Care Professionals in Finland about 90% of Finns think that the nurses are well educated, take responsibility of their patients, and are competent in their work.
ambitious and career-oriented as well as engaged in continuous learning. Konstantinos sees that patients, relatives, and also colleagues confront male nurses differently than female ones. Overall, he regards the change as positive. The focus group states also that men have different mentality about work and are able to dedicate more time to it than women. The Greek report emphasizes that men’s entry into the nursing profession can help the nursing profession escape the marginal position usually accorded to "women’s" occupations.

The case study of Portugal attributes general improvements in the image of nursing to higher academic and professional education, to the establishment of a national nurses’ association, and to well-defined autonomous area of practice by the legislation of 1996. However, these developments have not, according to the study, translated into, for instance, higher wage level. The Finnish case reports on a recent redefinition of nursing within a classification of occupations scheme: the social position of nurses had been brought down one level in the hierarchical scheme in 2001. However, this was not referred to by the participant nurses. The study also suggests that the scientific knowledge base of nursing science has meant a basis for claims over particular expertise and position. The Spanish case summarises what the professionalization has meant in the study context, namely “it has meant the process of breaking with the philanthropic-religious/vocational past of the profession and the establishment of a “professional definition”, that is, a definition based on technical and educational criteria and a complex relation with other groups such as doctors”. This is also applicable to the observations of the other reports, and summarises the general pattern very nicely. In sum, the struggle over professional status and position is across the contexts related to the historical burden of nursing as low, un-skilled and un-educated women’s work.

If the public perception and institutional perception of nursing, especially in terms of low respect and low economic gain, is caught up with the past, according to the reported views of nurses, what then is the basis on which nurses’ claim their professional quality, expertise, position and status? We will discuss the issue in rather general terms here, but it will be elaborated under the section on Ideals, Orientation and Expertise of nurses.

The complaints about the low salary run across all the case studies. In the English case nurses argue that they are paid too little in relation to the hardness, high demands and responsibilities of their work. However, in material terms, the nurses of older generations have secured themselves quite good pensions and early retirement, and the cuts in these social policy systems concern mostly the younger nurses. The Irish nurses voice a similar complaint about their salaries. Ellen thinks that it doesn’t correspond to her level of responsibility, and therefore she is unwilling to take on new responsibilities, such as prescribing, on her current salary. Nora comments that a nurse can make good money by working a lot of extra hours and nights. Aideen refers to the fact that administrative personnel receive better pay despite their lower level of responsibility. Notwithstanding the recent pay increases in the Irish context, the nurses remain dissatisfied with their pay because it is not on a par with other degree level health professionals. Furthermore, it seems that the nurses work more hours for less pay. Currently, Irish nurses work a standard 39 hour week while all other health professional staff work a 35 hour week. These were two issues that caused nurses to strike in recent weeks. In addition, the case study notes that the high living costs in Dublin may also contribute to some nurses’ dissatisfaction with their salary.

The Greek case study points out how the distribution of tasks between nurses and other staff diminish the value and status of nursing profession in the study context. University trained nurses feel dissatisfied by their inability to transfer less important, routine or dirty tasks to less prestigious, auxiliary nurses and service personnel, which obliges them to perform these tasks themselves. The Portuguese and the Spanish cases place emphasis on holistic, patient-centred orientation as a source of value for nursing. This topic will be discussed further in Ideas, Orientations and Expertise. In the Finnish case study nurses frequently state that the salary is too low regarding heavy responsibility, physical and mental demands of the work, and the long professional education. Also
independence and autonomy of the consulting nurses’ work was strongly emphasized by, for instance, Helga. She presented her position as autonomous and functionally distinct from doctors’ work, and as equal to it at least in that sense. She also pointed out, as mentioned earlier, how nurses are “gate keepers”, deciding whether a patient needs a doctor’s appointment or not. A similar functional position is noted by the Swedish case study.

The case study of Sweden does not specifically look into the issues of social position and status. However, the study points out that the specialist roles with their specialist training bear significance in the Swedish context, because the patients are directed to specific providers according to their needs. Thus, the roles of different categories of nurses are functionally distinct, and they can, supposedly, claim expertise on certain, relatively well-defined area. The case study also reports on how the local press talks often about availability of health services. Also politicians are reported, by the nurse Nora, to be blaming the health care staff instead of recognizing the limited resources.

In Swedish context, the case of PHC nurses illustrates a kind of a loss of status as their profession is “reconfigured”. They are forced by the organization of work according to the purchasing procedure to give up their activities of health promotion and preventive care that they regard focal to their profession, and carry out the tasks of nurses, such as waiting room work.

5 Education and Learning

In this chapter, we will first look at the basic nursing education, its change and its significance for nurses’ professional work, lives and knowledge. Second, we will examine learning at work, and how further education is organised in different contexts.

5.1 Basic Nursing Education

There is a general pattern of restructuring in basic education of nurses in all the partner countries. The education of nurses is upgraded into tertiary educational institutions and universities. Another related significant change is the introduction of Nursing Science as an academic discipline in the 1970s and 1980s. The Nursing Science was included in nursing curricula of the training institutes, providing nursing with its own scientific knowledge base in nursing care.

The transformation depicted above has meant also a move from practically oriented education to more theoretically or academically oriented education. Consequently, such disciplines as sociology, psychology and education are included in nursing curriculum. Scientific nursing also endorses evidence-based nursing practice and best practice rationales. The structural transformations of the education of nurses are explored in more thoroughly in the ProfKnow work package 2. Here, we are interested in how the changes in the education of nurses contribute to nurses’ professional work, lives and knowledge.

In all case studies involve such participants who have differing lengths of professional experience, and who were trained in different educational systems. As it seems that the general trend has been advancement of nurses’ education by bringing it into universities or other institutions of higher education, corresponding divisions are apparent also in nurses’ accounts. In many contexts, the nurses seem to fall quite naturally in two categories: the older generation of nurses with non-academic practical training and the younger generation of nurses with a theoretical university education.12

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12 The case studies talk about generations in three senses. First, the informants can be regarded as representatives of particular age categories. Second, informants talk about different generations of nurses and attach divergent objective properties to them. Third, the informants represent a particular experiential generation, because they share common
The English case study talks specifically about the division between the (non-academic) older “generation” of nurses, who emphasise practical aspects of work, and the younger generation of academic “new professionals”. The older generation and the wider public have been claiming the younger nurses to be “too posh to wash, too clever to care”. The case study regards that the issue is connected to the theory-practice gap within nursing profession. The Irish case does not refer to difference between generations in this sense. The Irish nurses acknowledged the importance of both formal education and practical experience in their professional development. For instance, while Ellen cites the method of “see one, do one, teach one” as her preferred way of learning, she appreciates the role of formal education also. The Greek case study reports on nurses with three different educational backgrounds in the study context. While the existence of nurses with different levels of education creates a hierarchy among nurses that could lead to tensions, such tensions were not observed. The Portuguese case notes also a division into “old” and “young” nurses. The study illustrates how the division is related to competence recognition and unofficial sanctioning at work, where the experienced nurses control and supervise the work of the younger ones, in a shared and open work space. The division parallels to some degree with the division between “academic” and “practical” career paths. The case study of Spain does not report of such divisions. While the Finnish nurse Helga states that nurse education has become more theoretical, the study does not notice such division at work in terms of generations or other classifications. The nurses may place more emphasis on practical aspects, but they regard theoretical education as a necessary base for nursing practice across “generations”. Also the Swedish case study mentions that formal education is highly appreciated in the study context.

The “academization” of nursing education has contributes to different composition of nurses’ professional knowledge. As the case study of England explicitly notes, it has meant introduction of psychology and sociology in the curriculum, with emphasis on evidence based practice, but also on holistic care. The study also states that academization has created greater theory-practice gap, with above-mentioned consequences for nurses’ work communities. However, according to the report, there has been a turn back with more practical courses introduced in the curriculum. The consequences for professional knowledge run across all the cases in quite similar manner, probably because of the supposedly general nature of nursing knowledge embedded in universal disciplines of nursing science and medicine. Yet we can expect to find differences on the level of everyday work life and nurses’ perceptions of the value of different kinds of knowledge, in different study contexts. The question of what kind of knowledge nurses value and regard as crucial for nursing and as constituents of their expertise will be discussed in the next chapter on Professional knowledge. Here, we concentrate on their views on professional education.

The value placed on more “academic” education by the nurses themselves and by the public at large was looked at in the case studies. As mentioned, in the English case study, the older generation nurses regard the knowledge of the younger academic generations as too theoretical. This concern was voiced also by wider public. The observations noted a related “generational” issue concerning the nurses’ different approaches in patient care. The study notes how the professional style of the oldest nurse was more “brusque and business” like, while the younger ones were more holistic and closer to the patients with their approach. The latter ones had, supposedly, internalised principles of patient advocacy, holistic care and evidence-based practice.

The nurse participants in the Irish case study connected the public perception of nursing to their education and training. Nora implied that gaining formal qualifications enhances the overall status of nurses. A report claims that the improvements in education and in the quality and broadening experiences. However, the case studies found it difficult to discern generation, especially due to the scarce data with only one nurse representing a “generation”.

skills of nursing in general have not only enhanced the status of nurses within the caring professions but have also increased their self esteem. Interestingly, Ellen suggests that the creation of new roles (e.g. nurse specialist and nurse manager) could make staff nurses more aware of (and in some cases dissatisfied with) their status and position. Her observations lend further credence to the idea that increased educational qualifications are associated with higher status.

The *Greek* case study brings up an ambiguous picture of nurses’ values concerning knowledge: it reports on widespread negative cultural attitude towards scientific knowledge and research. The nurse Konstantinos, however, appreciates research knowledge. In general terms, the case study claims that upgrading the education of nurses has meant improved status and image of nursing profession. The nurse supervisor, Despina, thinks that the upgrading of nurses' education has improved considerably the status and image of the nursing profession but feels that in spite of this, nurses are not paid what they should be paid.

Also *Portuguese* case study suggests that while higher academic professional education may have improved nurses’ status, the rising expectation, of especially the young nurse graduates, have not been met. The nurses also have different perceptions about the value of academic education: while the younger nurse Alexandra appreciates university training highly and is motivated to educate herself further, Paula, a mid-career nurse, perceives it quite differently, seeing it more in context and related to practical work. The participant and also the focus group members agree on, that higher academic qualifications do not necessarily translate into higher status or higher wages. In the case study of *Spain*, the nurse Flor notes about a similar thing: while higher education has resulted in a higher intellectual level for nurses, it has not brought with professional development in terms of real status and pay.

The *Finnish* case study does not specifically talk about the meaning of the higher education for the nurses. It rather speculates that the nursing science provides grounds for the nurses’ claims for expertise. The *Swedish* case states that formal education is required officially and appreciated highly by the professionals. Especially specialist education was regarded as important means of negotiating salaries and getting professionally and also institutionally solid knowledge base. The nurse Nora states how specialist qualifications are now strictly required in distinct specialties in the study context. Before, it was possible to work in a specialty after a practical training period.

In sum, the nurses of the case studies seem to connect the formal education with the status and rewards. It may also, as in the English case, be connected to the ideas of good nursing that may conflict with nurses with different kind of education coexisting. So, there is on the one hand concern over status of nursing and on the other hand concern over the quality of patient care related to education.

### 5.2 Further Education, Training and Learning at Work

In addition to basic professional education, the case studies investigate the issue of professional further education, training and learning at work. Here, the main points are participation in training in general terms, the possibilities and hindrances to participate in training and further education, nurses’ views on the significance of training and further education regarding their career advance, and achieved social and economic recognition and rewards, and the forms of learning and knowledge transfer at work, referring to unofficial, autodidactic learning and to learning promoted by the work community.

The *English* case study shows that a lot of professional further training is taking place there. The report talks about lessening support of organisation towards further education. Concretely, it is not possible, as it used to be, to get for instance a day off per week without loosing pay in order to
undertake an MA course. The case study brings also up the finding of the NHS Staff Survey (2005) where 96% of the nurses had received training in the previous 12 months. The Irish case study presents the findings of the ProfKnow survey, where 77% of nurses participated in courses and conferences organised by their employer during the previous year. The survey also indicates that 39% of nurses have additional education at university level, and “more than a year” was cited as the most frequent length of study. According to the Irish case study there has been a proliferation of post-graduate programmes in recent years and some additional funding for continuing education has been allocated. The report states that the ProfKnow survey results highlight nurses’ commitment to lifelong learning in the Irish context.

The Greek case study reports of an increase in graduate nursing degrees. This may be partly accounted by the existing civil servants’ model of career advancement and promotions that in addition to years of service also takes graduate degrees into consideration. However, the civil servant model does not provide incentives for quality of performance and is viewed negatively by the nurses for professional development. However, despite these disadvantages of the civil service model, many nurses clearly prefer being civil servants because they can work relatively less hard than as private employees and cannot be fired when their performance is not satisfactory. The Portuguese case study reports on the recent urge of young nurses to get post-graduate training. This has meant educational inflation, according to the report. A related issue is that, recently, there has been a huge increase in nurses in general, which has meant decrease in nurses’ social status. The case study of Spain brings up the fact that the management in the study context does not show much interest to encourage and support acquisition of knowledge or research among nurses. Therefore, nurses have to take care of their professional learning themselves, and they resort to “autodidactic” learning. Maite notes that, along side with lack of management, the working conditions, the lack of resources, time and money and heavy rotation between service units create hindrances for learning and putting new knowledge into practice. Actually, in order to participate in training, a nurse has to use her leisure time or take non-paid days off.

The nurses of the Finnish case are able to participate in various kinds of training, even though Jenna complains that she not always able to participate. The transfer of duties from doctors to nurses is expected, by Helga, to increase training. The Finnish survey shows that last year about 85% of nurses have participated in training organized by the employer. The case study notes, however, that nurses have limited access to evaluate their knowledge base. The nurses of the Swedish case place special emphasis on specialist education, as it is both institutionally required and valued by the nurses. According to the Swedish survey about 72% of the nurses participated in training offered by the employer last year.

The nurses of the English case study feel a constant pressure to update their skills in order to attain positions as specialists. There is also a re-registration required to be taken every third year and therefore nurses have to keep up with the latest skills and knowledge. The study notices that the nurses of older generations are naturally not as eager to learn new things, as this is not anymore valuable for their career advancement. Considering practical and theoretical learning, the nurses prefer the former according to the English case study. The nurses in the Irish case study saw formal learning opportunities as a means of furthering their careers, diversifying their jobs and improving their prospects of promotion. Pursuing further education has become more significant since the introduction of clinical career pathways. Nurses and midwives no longer need to become managers in order to be promoted. There are now clinical nurse/midwife specialist positions. The participants were also aware of the importance of keeping their knowledge up to date, in order to work effectively and according to evidence-based criteria. The importance of showing initiative and taking responsibility for professional development was voiced as well.

In Portugal, young nurses urge to get post-graduate training, often straight after finishing initial training. The factors contributing this are the work instability in the beginning of the career and the
higher basic qualification and hence motivation for further education. The nurses have differing views about the value of further qualifications. For instance, Alexandra tells that her team members did not accept that she went for post-graduate degree right after graduation. Paula was critical of taking a specialty for specialty’s sake, and of the practical value of the further training. She saw that her further education has been meaningful in terms of personal fulfilment, but did not affect her professional performance. The nurses also note for their disappointment that further education does not really bring in career advantages. The expectations fostered during a course are not realised in the career progress and rise in salary. The nurses of the Spanish case have differing opinions on the value of learning in terms of professional profit. According to some, the qualifications acquired do not result in better pay, position, respect and recognition. An engagement in life-long learning and constant skill update is increasingly seen as means of just to stay in the job. However, while the training opportunities are not available, there still is a need to stay informed and keep up to date among the nurses of the case study.

The Finnish study notes how nurses differed in their eagerness to participate training: the youngest nurse Jenna was most eager to get training, while the more experienced nurse were less. Helga was critical of some of training sessions, claiming that they were quite useless and poor in their contents, and the trainer was most interested in her/his own voice. The nurses, however, regarded training as an important part of their professional growth, and emphasised the constant need to update their knowledge on recent practices and modes of operation. The focus group members of Swedish case study valued university courses because they provide means of negotiating salaries as well as keep up to date with current knowledge.

In addition to formal education and training, there are other unofficial and self-directed forms of learning and knowledge transfer at work. According to the results of the Irish ProfKnow survey, 40% of nurses consult scientific journals at least once a month, which is an indication of self-directed learning or at least information seeking. The Portuguese case talks more specifically about unofficial practices of educating and learning that take place in shared open work space. The more experienced nurses teach, guide, control and supervise the younger ones. This observation is probably applicable also to other contexts to the degree that the work space is shared and makes this type of learning and professional socialization possible. The knowledge transferred is not only, if at all, codified, theoretical and official knowledge, but rather unofficial, practical knowledge, not knowledge of best practices but instead knowledge of immediate practical usefulness. Also the Spanish case notes how the nurses learn in practice from their colleagues or independently. It also saw conditions of high flexibility and rotation between services enhancing “internalisation” of continuous learning. Also is noted how the nurses are producers of knowledge in the study context: Jenny and Flor have been involved in building up services, strategic planning, nursing research and management issues among others. The nurses in the Finnish context had professional journals, guidebooks and instruction, and also certain data bases on the internet available, which they studied during the observation in order to keep up with the new practices. They also received occasionally information and instructions which they quite immediately read. The study points out also how the nurses use creatively and flexibly various knowledge sources, such as their colleagues and patients, in addition to more conventional sources. This type of learning is embedded in practice and conditioned by organizational opportunities and resources. Thus nurses’ knowledge is integrated in their work activities and their professional identities.

The key differences between the study contexts regards to professional learning can be posited on the axis of self-learning and learning supported by organisation, and on the axis of formal and informal learning. While nurses emphasise the need of learning self-initiatively or talk even about pressure to learn, the administration might not provide sufficient opportunities to attend to training events, as Spanish case study reports. Thus, the nurses resort to auto-didactic learning. In contrast

14 According to the Finnish survey 27.5% of nurses use scientific journals or books, 54% use the internet, and 81% use colleagues at workplace at least once a week as sources of knowledge and information.
in Ireland, the nurses avail formal learning opportunities since there is no time to learn at work more informally. In Portugal, the young nurses strive strongly to gain further qualifications, but learning also takes place in informal settings. In sum, there seems to be two basic conditions for learning, the support from management for formal training and conditions of work determining opportunities for informal, on-the-job learning. While the conditions limit learning, it is encouraged or even forced by initiatives for evidence based practice, lifelong learning, nursing research and dynamics created by new nursing roles. As already mentioned in the previous section, the nurses across the cases seem to connect their learning to two separate areas. On the one hand, they show concern about the quality of the care they can provide with their up-to-date knowledge and practices, on the other hand, they hope their learning and acquired skills would translate into (or maintain) higher status and pay.

6 Professional Knowledge

In this chapter we will first focus on nurses’ duties and tasks and domains of professional knowledge. General observation in the case studies is that the scope of nurses’ functions, tasks and roles have broadened with the increase in the number of different specialist roles and administrative duties. While the category of a nurse has become internally more varied, new professionals, such as assistants, health coaches and so on, have entered the health services contributing to the configuration of professionalism in nursing.

Secondly, we focus in this chapter on nurses’ professional ideals and orientations. We examine how the nurses themselves perceive the relative value of various domains of knowledge. The notions of orientation and ideals refer also to professional ethics. We examine what are the things that the professionals themselves perceive as valuable, essential and distinguishable knowledge of their profession. Thus expertise is a part of professional distinction from other professions, and it is an integral part of professional strategy to gain and maintain the monopoly and value of professional knowledge domain.

We focus on practical knowledge at work, namely the knowledge captured by the case studies through listening to and observing the professional actors. The case studies, in spite of some differences in their conceptual orientations, approached professional knowledge by making various divisions between the aspects of knowledge and between the domains of knowledge.

We propose that there is fundamental opposition between the mental and social categories of “curing” and “caring”. We regard this opposition as two domains of knowledge that are objectified into the division of labour in health care with particular duties, tasks and expertise. In addition, it is attached divergently to different health care professionals, particularly nurses and doctors. We also propose that this same division is embodied, through socialization, identification and learning, into dispositions of agents. Thereby it organizes actions, perceptions and judgements of social agents. Consequently, through the various practices this fundamental opposition produces outcomes that form a cluster of parallel and homologous oppositions visible in health care settings, such as technical and human, biomedical and holistic, task orientation and whole patient, biomedical machinery and human touch. This fundamental opposition between mental categories and domains of knowledge is not only related to the division of labour between doctors (who principally “cure”) and nurses (who principally “care”), but also to institutionalised knowledge bases of medical (biomedical) and nursing (philosophical, psychological, pedagogical and socio-

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15 The idea for this comes from Pierre Bourdieu’s book “The Logic of Practice” (1990), particularly the chapter “The Kabyle House or the World Reversed”, pp. 271-283.

16 The following oppositions emerge too: impersonal and personal, formal and informal, scientific and clinical, instrumental and non-instrumental, material objects and spiritual objects, hard and soft, rational and emotional, mechanistic and organic.
emotional) sciences. Finally it relates to nurses’ claim for professional expertise in the domain of “caring”.

The opposition between the two fundamental aspects of knowledge, the theoretical and the practical, is also prevailing in the national case study reports. This opposition between “know-that” and “know-how” has various parallel oppositions, such as explicit and implicit, official and unofficial, codified and tacit, and public and private, and so on and so forth. Practical knowledge, if it is at least partly implicit and tacit, cannot be fully exposed, but is rather in the process of exposure. In professional life, there are many skills and knowledge that are not fully explicit or explicable, but are rather learned by imitation and socialization into the community of professionals (Bunge 1996, 77).

<table>
<thead>
<tr>
<th>Table 3: Dimensions of nurses’ professional work and knowledge</th>
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<tr>
<td><strong>Domains of Knowledge</strong></td>
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<tr>
<td>Aspects of Knowledge</td>
</tr>
<tr>
<td>Curing</td>
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<tr>
<td>Theoretical</td>
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<td>Medical Science</td>
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<td>Practical</td>
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<td>Technical skills</td>
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Above is a four-field diagram (Table 3) that combines the domains of knowledge and aspects of knowledge. Domains of knowledge are curing and caring and the aspects of knowledge are theoretical and practical. We propose that these domains and aspects are observable both in nurses’ accounts and practices, and in the institutionalised divisions of labour, education and knowledge domains. The purpose of this ideal type scheme is to offer a point of reference to which nurses’ actual actions and accounts can be compared to so as to make them understandable. Furthermore, the distinctions are not to be considered as visible in purely logical and consistent fashion in the work practices of nurses. Finally, the table does not include administrative, managerial and organizational tasks and duties that are becoming more and more prominent in nurses’ work.

### 6.1 Duties, Tasks and Knowledge

Case studies report on increasing number of different career paths, positions and roles for nurses. The roles can be grouped roughly into three categories, namely that of a staff nurse, a specialist nurse and a nurse manager. The case study of England points out especially the new specialties with their distinctive technical and clinical skills and knowledge. It attributes this change to increasing number of medical specialties. There is related significant change to evidence-based medicine and to best practices rationales since the beginning of the 1990s. These changes are mostly driven by medical science, but also nursing and science and both dimensions. Now, the question is whether these, new expectations codified into models of best practices, are applicable in the conditions where resources seem to be scarce. In the chapter that dealt with working conditions, the English representatives argued that in the present conditions there are not necessarily always real possibilities to put the models in practice. In addition, do these new published models meet resistance from the part of the practicing nurses who perceive these models from their current perspectives formed in the past? There is some evidence that, for instance, in the Greece report
nurses are reluctant to adapt evidence based medical and nursing models as part of their nursing practices.

The case study of Ireland reports on new specialist roles available for nurses. The different career stages, roles and responsibilities of the participating nurses illustrate this. For instance, Ellen is a clinical nurse specialist, whereas Aideen is a divisional nurse manager. The case studies of Portugal and Spain bring also up a great variety of different roles, with their highly specialised knowledge domains, without, however, explicitly referring to the change. The case study of Finland reports on a transfer of duties from doctors to nurses in the context of the health centre. This means for the participating nurses that they have turned into so called consultation nurses with their own reception and accompanied duties, tasks and knowledge. The nurses also take increasingly part in the common decision-making processes. The nurses in the Swedish case study have different roles: Nora is a primary health care nurse while the other two are nurses. The case study brings up specifically a concern of the primary health care nurses over their role as health promoters. The issue will be looked at in the next section.17

Since our participant hold varying roles and positions as staff nurses, consultation nurses, specialist nurses and nurses in managerial positions, in differential contexts of wards, clinics and health centres, the general picture drawn by the case studies altogether is that nurses’ duties, tasks and related domains of knowledge and skills go well beyond the activities of patient care. The nurses of the case studies and the case study authors group nurses’ tasks and knowledge in two broad categories. First, there are medical, technical, and manual tasks of delivering patient care, or rather “cure”; and second, there are personal, social and emotional tasks of interacting and communicating with patients giving, or rather “care”. The knowledge and skills related to these categories are first, manual and technical skills, and biomedical, clinical knowledge, and second, interpersonal and communicative skills, ability to get along with people, and educational-psychological-social knowledge. These two groups are brought up, specifically, by the case studies of Greece, Portugal, Spain, Finland, and Sweden, but they are applicable in other study contexts as well.

The English case study points out that in addition to evidence-based nursing practice, with clinical knowledge, “holistic care” bears significance to the participant nurses. The Irish case study notes how particular job descriptions and guidelines determine the basic nursing duties for the nurses that give direct care. These duties include assessment, planning, delivery and evaluation of patient care. Moreover, Aideen, the nurse manager, has her own specific job description. The Greek study states that the nurses vacillate between technical, professional and formal knowledge and the humanistic and emotional components of their role. It draws an ambiguous picture of nurses’ responses to this division, which will be looked at in the next section. The Portuguese study also embraces specifically the division into technical activities and the social and personal contacts with the clients. The Spanish case study does this too, but it does not regard this division as straightforward, but detects an intermediating category, in which a nurse is seen as a mediator between the health care institution and the patients. This intermediary role requires interdisciplinary knowledge of medical and humanistic domains of knowledge.

The case studies report on a great number of different tasks, knowledge and skills, embedded in various positions, roles and work units, which go beyond the “basic” patient care. Within and beyond the above mentioned basic tasks of “curing” the patient with manual and technical procedures, and “caring” the patient with psychological, social and emotional sensitivity, there have been changes in the make-up of nurses’ tasks and knowledge originating from various

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17 We must remember that the case study contexts in Finland and Sweden were health centres, whereas in other countries they were hospitals.
The case studies report on an exhaustive list of novelties, such as teamwork, multidisciplinary approach (cooperation between different professional groups), extensive use of ICT, evidence-based practice, nursing research, prescribing medicine, health education and preventive health care, (strategic) planning, building up nursing services, exploring new terrains for nursing, administrating, managing, teaching, educating student nurses, and increased documenting. These activities require equivalent, advanced knowledge both about the contents of work, such as about new practices, clinical issues, technologies etc., and about the contexts of work, like about the activities and practices of other professionals on the field, about the organisation, and about wider societal context. Critical, analytical, reflective and problem solving skills as well as subtle interpersonal skills are required. Nurses who work in more autonomous positions in many study contexts require also skills of being initiative. Then nurses act increasingly as producers of their knowledge in practice and for practice, but also backed up by research in nursing science and more explicit and evidence-based practice.

The case study of England reports on growing use of ICT and consequential quick circulation of information, including more knowledgeable and demanding clients. The nurses are also increasingly required to work in teams with allied health care professionals and actors from outside their immediate work unit or organization. The multidisciplinary team demands that the members of the team develop awareness and understanding of various areas of professional knowledge. The experienced nurse, Jan, voices the need of “Trust knowledge”, that is, knowledge about the hospital, plans, targets and political agenda. Her view is that nurses’ knowledge is combination of clinical knowledge, people management skills and the above-mentioned “Trust knowledge”. As also mentioned above, the case study reports on “explosive” growth of evidence-based practice as a part of nursing knowledge since the 1990s. The nurse June states that the clinical knowledge must keep updated constantly. To work as an autonomous professional within increasingly litigious society, judgement and decision-making knowledge are critical, as well as skills of documenting practices. The case study of England states an internally contradictory trend in nursing knowledge. While the nurses are now encouraged to “construct” their own knowledge and act holistically on the basis of it, the increased importance of evidence-based practice and best-practice rationale runs counter to this by tightening the control over innovative practices.

The Irish case study emphasises that the nurse participants are at different stages in their careers and have differing roles and responsibilities. Hence, there is variation with regard to the knowledge and skills that they require in their jobs. For instance, Nora’s skills include analysis, critical thinking, problem-solving, and reflecting on practice. Various interpersonal skills and personal coping mechanisms to maintain motivation for work are also mentioned. As a specialist nurse, Ellen’s skills include listening, counselling and communicating. Clinical knowledge of her area of specialty and an awareness of the limits of her practice are also considered important. Knowledge gained from her holistic individualised and patient centred approach to assessment is used to inform the delivery of care. Ellen’s delivery of care also includes educating patients and their relatives about how to manage their condition. Pedagogical skills are needed to educate nursing students. In addition, she needs organising, planning and prioritising skills. The case study notes that she is constantly required to keep up to date with current clinical knowledge. She regards the increase in evidence-based practice as a positive development. As a manager (though previously a nurse) Aideen no longer engages in direct patient care and thus her role requires a somewhat different...
combination of skills and knowledge. Yet she still needs clinical knowledge to do her job effectively. Her knowledge of the area of specialty is particularly important. For example, from her nursing experience she is aware of the kinds of conditions the patients have and the resources that are necessary to care for them. Such knowledge is particularly relevant when developing a staffing plan based on patient census, case complexity and staff experience. Aideen also referred to the importance of organisation and planning skills such as prioritising. Knowledge with regard to what is practical and realistic is also relevant to her responsibilities. Interpersonal skills are especially important for Aideen since she has to negotiate with, influence and reassure people. She emphasises the importance of being supportive and diplomatic in the context of a busy work place and staff shortages. Aideen regards evidence-based practice as a progression benefiting the patient.

Konstantinos, in the case study of Greece, works at a blood donation unit, and is involved in activities requiring scientific knowledge and research. But the case study reports also on an alarming research finding that studied nurses were unaware of current methods and had not an access to read research findings, and if they have, did not often understand the content. However, because this research study did not distinguish between university trained and 2-year trained nurses and the number of nurses with 2-year training is much larger than the university trained ones, it is not possible to assess whether these negative findings also apply to university trained nurses. If it does apply, then there is a serious problem with the diffusion of knowledge on best practices. In Greek case study context, documentation is still done by hand. This is regarded as a very negative aspect of work by the participant nurses. It was observed to be time consuming, and causing storage problems as well as difficulties for information retrieval. Maria argues that it is a serious waste of time, and documentation could be made easier by computerisation. According to her, this is not done, however, because the older nurse supervisors are not interested in it. There is an apparent generational division in the study context regarding this: the younger nurses are more comfortable with computers and have more positive attitude towards them, while the older ones have negative disinterested attitude.

The Portuguese case study brings up two functional areas of nurses’ duties, which are “giving global treatment for the inpatients”, and “the medical round support”. Paula’s, who is the oldest in the service, tasks in the latter area include coordinating schedules and managing therapy changes, also across services. In addition to her administrative duties, Paula also helps her colleagues in their nursing duties, orients and educates younger nurses, helps customers, gives information to the patients and their relatives. The study reports that, at the wards, there were at sight specific descriptions of tasks belonging to each nurse, who is in charge of a specific area. The case study also notes how the nurses are engaged in working as advocates of the clients. Then the nurses act as mediators or decoders between the medical technosystem and the patient. The Portuguese case study places emphasis on the division between contacts (caring) with the client and technical activities, and on the nurses’ ideals and orientations regarding professional knowledge.

The Spanish case study notes that a nurse has to know a little bit of everything, ranging from medical to social knowledge. This is illuminated by observing Jenny: “she has to judge from the patient’s medical history, social relations (family), and the “general appearance” if he/she and the patient’s immediate environment are stable enough to undergo outpatient surgery”. Jenny has also engaged in strategic planning, building up nursing services, exploring new terrains for nursing that previously did not exist, which require rather advanced knowledge and creative solutions for practical problems. Other nurses of the case study were also found to be engaging in activities of strategic planning, conceptualizing ICT services and doing some nursing research. The case study reports that the tasks such as measuring blood pressure, handling injections, administering medication, and reading and writing medical documentation are regarded as taken for granted medical base of nursing by all three participants. But the Spanish report argues that more important for the nurses are tasks involving contact with patient and giving “holistic care” to them.
The area of nurses’ functions is broadening in Finnish study context as some of the duties of the doctors are being transferred to the nurses in the context of public health centres. Some of the tasks that only the doctors have been allowed to carry out till now are now made possible for nurses to do, as well. As the duties, for example, possibly the writing certain general prescriptions in the future, are transferred to the nurses, they also get equivalent training. The nurse Helga sees broadening functions as a good progression for nurses’ professionalism and it also gives nurses means to negotiate the rise in salary. The case study also reports on some additional tasks, such as documentation, administrative tasks, increased participation in decision-making, organising and planning, that no doubt require versatile knowledge.

As the case study of England, the Swedish and Finnish case studies report on extensive use of computers in storing up, retrieving and exchanging information concerning patients, distribution of tasks and professional practice. For instance, there are electronic patient records and the appointment systems in Finland and Sweden. These are also connected to the financial administration system enabling the management to assess and reward the system efficiency in the Swedish context. This is much criticized by the Swedish nurses of being unfair because it does not take into account how difficult the patient cases are.

In the Swedish study context, which was a health clinic, the nurses have three basic areas of tasks and functions. First, there is sorting and channelling patients to the treatment. Second there is a duty of an acute nurse who assists the doctor during the procedures. Third, there is so called TeleQ service, which means answering the phone and sorting patients for doctors’ appointments. Specialised nurses have their own consultation hours. In the study context, evidence based practice and knowledge production is perceptible in various instances: use of check list (important aspects to be paid attention), providing feedback for the patient, and the use of different kind of measures, guidelines and tools (clinical guidelines). Nowadays also research methodology is part of nurse education. In Swedish context prescription rights have already been granted for the primary health care nurses. This change is significant as the right to prescribe has been part of doctor’s core expertise. In the Irish context an implementation group has been established by the Minister for Health and Children to oversee the roll-out of nurse prescribing on a national basis in autumn 2007.

The nurse Nora of the Swedish case study describes her practical work: “I must know how to ask the right questions and all the time read between the lines” She sees her knowledge in a broad, “holistic” sense. The case study also notes how the nurses’ sometimes improvise in the frame of given guidelines. However, in some cases, concerning for instance patients with e.g. suicidal thoughts and chest pain, the guidelines are clear. These cases have to be prioritised.

In sum, the case studies, apart from those of Finland and Sweden, in which, the study contexts were health centres, report explicitly, or strongly imply that different specialties and roles have increased. The different roles of staff nurses, specialists and managers have their equivalent knowledge of which case studies bring forward a versatile picture. The nurses are reported to be engaged in research-like activities in all the study contexts. Indeed, in certain roles, they are producers of their knowledge. However, for instance the case study of Greece reports on hindrances for evidence-based practices and use of more scientific knowledge. These are attributable to cultural disregard of scientific knowledge and to the working conditions, where there are no clearly defined roles for specialists. Also other case studies report on hindrances for realising ideal patient care, which commonly stem from scarce resources and limited time.
6.2 Ideals, Orientations and Expertise

As noted above, all the case studies discussed, to varying extents\(^2\), about the division of nurses’ domain of knowledge and activity into categories of curing and caring. These core categories refer to two domains, related to technical/biomedical and social/emotional activities, skills and knowledge. Without necessarily subscribing explicitly to this suggestive opposition, that connects domains of activity to their base of knowledge and expertise, most case studies found that such a general division was a significant means for nurses to make their work, knowledge and expertise meaningful. Some of the case studies argued that by referring to this opposition nurses could claim specific field of expertise, so that they embraced one area of knowledge and expertise over the other.

Before discussing further about the division above and analysing the nurses’ expertise in terms of what they regard distinctive in their profession, we will take a broader look at some more general ideals that the nurses have about their work. These ideals are like orientations that the nurses prefer or are inclined to follow. The orientations are materialized if there are resources and opportunities to put them in practice.

The nurses across the study contexts tell that people are, first and foremost, the focus of their work as nurses. This seems rather self-evident, but it is worth taking a closer look at the issue since this orientation is by no means unproblematic in current conditions in health care systems and organizations. The difficult working conditions, particularly due to experience of haste and shortage of staff, contribute to the experience of limited time that the nurses can be with patients. When these conditions come in contact with nurses’ ideals about long term relationships with patients and holistic care we often observe something of a frustration. The ideas and ideals of patient care may also collide with other professional demands. There seems to be a widely shared idea among the nurses in all study contexts that nursing care is rather a personal, in some cases even innate, un-learnable, ability than a fixed package of knowledge that can be learned through formal education. Instead technical and medical knowledge is often considered something quite external to the real personality of the nurse. Consequently, it could be argued by the nurses that everyone can learn these tricks. Often these two aspects of nurses’ work and knowledge may not go well together, but rather they represent conflicting orientations, that are sometimes perceptible in the nurses’ accounts and activities.

The English case study notes that when nurses are encouraged simultaneously to be holistic and to take care of the needs of the patients (within given conditions), they are demanded a lot. According to the nurse N9, emphasis of holistic approach puts nurses to work harder, but in the end they fail, since it is impossible to meet all the needs of the patients. It is hard for a nurse to clarify the limits of her professional activity to herself and to the others. This can be considered as a dilemma of emotional labour. Nurses’ holistic ambition, encouraged by their professional culture and demanded by the management, collides with the real conditions of work.

The opportunity to deliver nursing care motivates Ellen of the Irish case. She refers to the importance of a holistic individualised and patient-centred approach to care and lists being caring and patient centred among the qualities of a good nurse. Nora is motivated to work for the patient’s benefit by delivering basic nursing care. Sometimes Nora takes on others’ responsibilities for the benefit of the patient. For instance, she helps the care attendants make beds. Aideen strives to treat people how she would like to be treated herself, with ultimate respect. She values being courteous, caring, sensitive and empathetic.

The nurse supervisor of the Greek study states that the people are the focus of her efforts. The case study draws a positive picture of her and her devotion to work. Her patients have showed their

\(^2\) The Swedish case study evaluates the division critically, and it has no role in the actual analysis.
gratitude by writing newspaper letters about her. Also the male nurse states how he initially liked
the most in nursing the direct contact with the patient but because his current position (in the blood
donation) does not include much of that, he states that he feels satisfaction for contributing to the
patients’ recovery – however, now more indirectly. Thus, he emphasises the most the specialised,
scientific and technological aspects of his work.

The nurses of the Portuguese case study also assess and evaluate their work in terms of the contact
with the clients rather than a bunch of technical activities. The positive feedback of the patients is
also the main source of professional motivation for the nurses. Paula and Ana, who are both nurses
in charge, that they feel best with the patients though their main tasks are managerial and
administrative. Indeed, Paula says that she has lost the essential part of being a nurse after she
entered into a managerial and administrative role. Paula describes her idea of nursing and her
related nursing knowledge in quite emotional terms.

[M]y role is always, my (role) nurse… is there in caring till life comes to an end, in that if I
don’t have, if I don’t have any hope to offer him, I have kindness, I have support, I have
pain and suffering soothing. You name it, many things. This is my idea of nursing, of nurse.

The issues of proximity, continuity and trust are considered as essential in nurses’ relationships
with the patients. The commitment toward patients and being a sort of intermediating persons
between the patients and the health care institution is nurses’ professional driving force in
Portuguese context. The nurses of the focus group interview stated that education and work culture
of nursing has changed so that now there is more emphasis on care and working with the people.

The nurses of the Spanish case bring up the patient’s holistic care that takes into account emotional,
psychological and social needs, and puts these in the centre of the professional values and
motivation of nurses. This view is contrary to purely biomedical, instrumental and task-oriented
practice. The professional ideal revolves around ‘human touch’.

The nurses of the Finnish case talk about themselves as professionals who do not treat only the
physical side of the patient but take into consideration also the mental and psychological side. The
nurses generally refer to users as clients which tell about the service-orientation. They also
acknowledge their role as clients advocates. According to Jenna, “nurses are important in
delivering information” from the patients to the managerial and administrative level. Furthermore,
while the close emotional relations to clients are emphasised, the nurses do try to keep a clear
professional distance to the clients as well. The authors of the Finnish report state that as the nurses
present themselves as professionals who work closely and holistically with the clients, they distinct
themselves professionally from the doctors who have supposedly more distant and bio-medical
relationship with the clients.

According to the case study of Sweden, the nurses’ professional ideals are being good for the
patients, maintaining continuity in nurse-patient relationships and not taking initiative away from
them, but promoting their self initiated handling of their own health issues. A focus of the nurses’
work is on the patients’ whole situation instead of task-oriented nursing, and this holistic view is
preferred to task-orientation, according to the study. However, the case study notes that talk about
the patient’s whole situation is not to be interpreted as exclusion of biomedical, and also task
orientation refers to other aspects than purely biomedical issues. Thus the division is not
straightforward, and according to the case study author, such division is difficult to make.

The case studies placed various attributes to what the nurses consider as “ideal” nurse and “good”
nursing practice. These consideration are often connected them the opposition into bio-medical and
instrumental task orientation and holistic patient-centred nursing. This opposition between “cure”
and “care” was mentioned already above when we discussed about the more general ideas, ideals
and orientation in nurses’ work. Now, we will elaborate the opposition a bit further. We will investigate how the nurses perceive their distinctive knowledge, the “core” knowledge of nursing, on which the claims of expertise can be placed.

The Irish nurse Nora values being diligent, conscientious and responsible. She states that without real motivation and commitment to nursing one cannot cope with the demands of the work. According to Nora, “basic nursing care” is the core of nursing and having the ability to provide such care is the quality of a good nurse. Ellen values “fair access health service for all public people [as well as] high standards in nursing and medical care”. In her view, a good nurse is “knowledgeable, accountable, autonomous, responsible, a good observer, communicator, caring, patient focused, holistic”. She is particularly motivated to deliver nursing care, and jobs that don’t require such care do not interest her. Aideen, the nurse manager, is conscious of minding her “own patch” and being proactive as a manager rather than focusing on the actions of others. She treats the staff as peers and in a supportive manner. She tries to make sure that they are progressing and developing in their careers. Aideen states that she is “terribly loyal to nursing”. This is why she is reluctant to apply for a general manager or an administrative post even though it might be considered a good idea from an “ambitious personal career development point of view”.

The Irish case study found no evidence to support the notion that increasing the academic aspect of nursing has a negative effect on traditional caring and interpersonal skills. While the nurse participants recognise the importance of clinical knowledge, their comments indicate that the caring patient-focused dimension is paramount in both their practice and motivation.

The Greek report brings forward an ambiguous picture of nurses’ perceptions of “curing” and “caring”. Konstantinos places strong emphasis on technical and scientific knowledge, though he also appreciated direct contact with the patients at the beginning of his nursing career. Other nurses’ declare too that they would like to apply more often the technical medical knowledge that they have obtained in their education and work. The nurse supervisor, Despina, states that people are the focus of her efforts, as already mentioned. Furthermore, the case study regards nurses’ emphasis on professional education as a means of distinguishing themselves from assistant nurses. Again, this is an important point, because nurses try to achieve a distinctive position, not only in relation to doctors, but also in relation to auxiliary nurses and other professional groups. Furthermore, nurses have to achieve an expert position in the eyes of the patients as well. However, nurses cannot compete in the doctors’ domain, and the auxiliary nurses also carry out caring functions. Therefore, nurses emphasize the uniqueness of nursing science and that sort of holistic care that combines medical and human knowledge.

The Portuguese case study conceptualizes the forms of nurses’ knowledge explicitly as biomedical model and holistic model, and refers the growth of nurse professionalism and thus strengthening of professional autonomy. Yet, the authors say that holistic caring may be more nurses’ internal work motivation and professional public discourse rather that what is really going on at the hospital. Care of patients is very time consuming and the health care is run by efficiency criteria. In addition, there is a lack of informal and formal social recognition of caring. Consequently, institutionally evaluated and valued knowledge seem not to cover nurses’ idea of their work.

The Spanish case study characterises the nurses’ knowledge in terms of three categories. First, there is task-centred biomedical knowledge and knowledge of nursing techniques is theoretically learned. Nurses of the study context stress that these areas of knowledge can be learn by anyone. Second, there is person-centred caring knowledge, which the nurses regard as an innate tacit personal quality and ability to work with people. In the study context nurses put this type of knowledge in opposition to doctor’s practice that often reduces patients to mere objects of medical treatment. The third kind of knowledge is a combination of the two. It is referred holistic knowledge, connected to the nurses’ role as a mediator between the health care institutions and professionals and the clients.

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and their relatives. In this position nurses must use various kinds of knowledge sources including clinical knowledge of medicine, knowledge of social workers, psychologists, socio-cultural knowledge etc. The nurse is a translator and mediator between professionals and laymen, between health care institutions and people. In this role nurses argue that they are also protectors of patients’ needs and advocates of their rights, often against the doctors and system.

The case study regards the nurse Jenny’s talk about “practicing empathy towards the patient” as an instance of care-oriented tacit knowledge. The kind of knowledge, including ability to be responsive to the patients’ emotional and psychological needs, is according to Jenny, hardly learnable and possibly innate. She stresses how this type of knowledge is about communicating, and “placing yourself in the situation of another person”. Similarly, Maite puts the words “heart” and “personal attitude” in the centre of nursing, and says explicitly that that kind of knowledge is an innate capacity. Flor argues that nurse’s work requires “a very wide-ranging scope of knowledge”, which goes beyond mere biomedical or technical activities to the broad needs of the patients.

However nurses in the Spanish case study see the distinction between curing and caring in various ways. Care has different emphases in their accounts: for Jenny, it is personal, psychologically oriented. For Flor, it is social, not only a part of nursing, but a part of wider social context of care. For Maite, it is a combination of these two aspects.

The authors of the case study of Spain discuss also about the problem of emotional care and emotional labour. As the preverbal nature of care places it on the personal level of one’s identity, consequently evaluation of and division to ‘good’ and ‘bad’ professionals is made according to personal qualities, as Jenny puts it: “There are two types. There is the good nurse who is concerned and there is the other type of nurse who is a technician. Only doing techniques is not nursing.” Technical skills and knowledge don’t account for real merit because supposedly everyone can learn these. Ability to care is, thus, connected to strong character with emphasis on ability to sacrifice oneself.

The case study of Spain also notes that care is, however, not necessarily conceived as traditional feminine, mother-/nun-like role but as professional care. According to Jenny, nurses should see themselves at the first place as professionals, rather than for instance as women. The dilemma is how to combine aspects of care, which are culturally so closely connected to femininity, with professional care. The case study states that the dilemma of Jenny is about that once the profession would be able to claim its status, it threatens to go against professional ethics of meeting the patient on equal grounds. On the one hand she states that caring is something that cannot be learned and that is connected to personal qualities and character, and on the other hand she emphasizes the importance of making professional boundaries more clear in order to break the old stereotypes. Care should, on the one hand, be defined as professionally and functionally significant knowledge and activity on which nurses’ professionalism and legitimate status could be based. On the other hand care is knowledge that defies definitions, and as such it cannot explicitly legitimate nurses’ status. The Spanish report illustrates how professional ethics and professional status can be conflicting in nurse’s work. Professional service as emotional labour may be a contradictory conception. This contraction is obviously intensified by the cost-efficient measurements introduced in health care administration and management.

22 In the Spanish focus group interview, the dilemma was further uttered for instance as a division between ‘being a nurse’ and ‘working as a nurse’. The nurses were critical of perceiving a nurse in a framework of mother-nun, which was seen as a widely held perception among the doctors and the general public, and which hinders the attainment of strong social and profession position for the nurses.
The Finnish case study notices also the prevalent distinction between curing and caring. This distinction is clearly visible in the nurses’ talk and activities. According to the report, it is closely connected to certain parallel oppositions, such as biomedical and holistic, task-oriented and patient-oriented, technical and humanistic etc. The nurse Helga labels the technical side of her work consisting of ‘tricks’ that a nurse has to command. These cannot be learned during initial professional training though, but they are learned through exercising them in countless repetitions in practice. The nurses consider the technical skills as self-evidently prerequisite skills that have to be mastered. The care is brought up as another central domain of knowledge. It is an ability to be with the people, listen to them, and have a right attitude regarding their problems. Thus, nurse Leena talks about an importance of having “quite sensitive radar” and “a certain touch with people”.

The case study interprets the fact, that the nurses did not mention diagnostic skills, administrative skills and related requirements such as documentation, evaluation, planning, and so on as part of their essential skills when asked specifically about the skills, but brought these up in other contexts of the story, as a sign of relative value of these skills in nurses’ struggle for making themselves distinct from other professionals, especially from the doctors. For instance, the diagnostic skills can be considered belonging to the doctors’ professional domain and, thus, are not significant for nurses in terms of making themselves distinct. Rather, the emphasis on interpersonal skills and holistic could be the means making nurses distinct from doctors who, supposedly, lack these qualities and expertise. However, nurses use medical skills and knowledge to distinct from patients and laymen.

The Swedish case study states that making a division between task-oriented nursing and holistic nursing is difficult, because the two areas may be overlapping and intersecting, and thus they are not purely distinct.

In the Swedish context, the performance measurement according to patient calls, which generate countable logs, is considered as difficult in several respects by the public health care nurses. First of all, the measurement system doesn’t account for different types of patients, as was mentioned earlier in the report. Some patients demand relatively more time than the others, yet they are seen as equivalent by the system. Second, the nurses have to pay closer attention to their performance, and to how they are able to fulfil the standards. They are worried about their jobs if they are not able to meet the requirements.

There is also a disparity between the standards and what the public health care nurses consider their work being about. Thus, the standardised measurement actually gives a definition of the officially valued the expertise of public health nurses. Certain tasks are given reimbursement according to care plans of the system. These do not, however, include as much preventive work, health promotion and community information activities as the public health care nurses would like it to include. Nina says that as there are no resources she has to give up health promotion in her daily work. The purchasing procedure determines which activities are included, and nurses cannot include activities outside it. Also the nurses in the focus group state that accountability for results of the health centre hinders health promotion, namely what they feel their work should be about. Furthermore, there is another occupational group, health coaches, that is taking over the preventive care and health promotion, which the public health care nurses are unable to do since they have to give service to the health centre. The Swedish case is an example of the professional configuration which in a continual process. Alterations in the institutional rules re-define and re-divide the tasks and rewards between various health care professionals, often in ways that are contrary to the established identities and ideas about the core aspects of profession.

Especially the Spanish case illustrates how nurses may be concerned about making their professional boundaries clear in order to distinguish themselves as professionals. This may be conflicting with the idea of caring, related to personal qualities and character. The caring is namely
the area around which their claims for recognition and status revolve, but it is also an area where the “old stereotypes” may be nested. As referred to in the previous chapter, the nurses relate their learning and knowing on the one hand to quality patient care and on the other hand to the hopes and claims for recognition, status and pay. There are also difficult working conditions with scarce resources which contribute.

7 Conclusion

On the basis of these national case studies, restructuring of health care has two major general implications with neo-liberal connotations for professional work of nurses. First, the contracting model of employment is becoming more general and the civil service model of employment is decreasing in many case study countries. Second, the management and administrative models for hospitals, clinics and health care system as a whole is driven by demands for increasing efficiency, throughput and results, accomplished through guidelines, standardization, evaluation and rewards.

In the practice of nursing these two factors mean precarious career and work, particularly at the beginning of one’s career, and the tightening of resources and thus increasing workloads and haste, stress and exhaustion among the nurses. Now, it is interesting to observe how the efficiency requirements relate to the social-cum-mental oppositions of cure and care, and the nurses’ definition of their professional core tasks. Nurses often complain in their interviews that they do not have time to really concentrate on caring the patients and to relate to them and their families. Nurses feel frustrated of not being able to work according to their ideal standard about caring. In short, they have time only to do the ‘biomedical tricks’. In addition, some nurses claim that there is no possibility to be innovative and creative because there is only time and resources to apply the routines and standardized procedures.

For sure, ‘biomedical tricks’ are important, indeed they could save lives. However, as we have explained above, some nurses have a tendency to identify more strongly to the caring than the curing side of their professional knowledge. This identification may vary according to educational background and present position. For instance, there are plausible differences between the specialized nurses and general nurses, or between those working in a hospital setting and a nursing home, or between the older nurses and the younger nurses. Certainly the efficiency requirements can also be felt in the biomedical side of the profession as well. The complaint about increasing routine-like work and lack of innovativeness could be one indication of increasing necessity to apply rigid standardized models even in situations that would need flexible adaptation of models and innovation of new practices. In addition, in some instances, the lack of resources can restrict the nurses to apply the recommended medical models in practice.

What is a notable observation here, however, is the fact that most nurses that were interviewed seemed to feel that the lack of resources, time and man-power affects especially the caring aspect of their professional tasks, skills and knowledge. Or that the efficiency requirements are experienced particularly strongly in the caring side of their professional identity. And this could be interpreted as an indication of the fact that caring and not biomedical aspect or techniques are at the core of nurses’ professional self-understanding and self-definition. Caring and the human touch are regarded as matters that make a difference between the nurses and the doctors. Caring is at the core of nurses’ professional identification, it is a reason to become a nurse and stay in the profession. It is also as related to the scientific knowledge base of the nursing care a basis for the claims for

23 We should be very careful when we name various factual changes as neo-liberal changes. It seems that there are changes that take some aspects of neo-liberalism, but yet retain some of the old structures and ideas as well. Thus neo-liberalism can be observed in various combinations of privatization, quasi-markets, users’ choice, and new contracting schemes, standardization of practice, rankings, and evaluation of productivity, efficiency and effectiveness of health care systems.
expertise. Furthermore, it may be that many nurses are not so much interested in technique and science that are on the bases of the biomedical aspects of their work. However, the health care sector is becoming more and more dominated by science and technology and therefore expectations involve much more than mere ‘human touch’. Consequently, for many nurses the subjective hopes when choosing the profession may not match well with the objective professional expectations at work.

There were, however, observations, where the nurses try to find a right balance between cure and care, or between bio-medicine and human touch. The finding of right balance between the two domains of knowledge is, in addition to the worry of an adequate care, a great concern for some nurses. While care may be with which the nurses identify and regard as a core to quality patient care, they may also regard it as problematic since it may seem to be a poor way for professional progress, gaining status and higher salaries. The caring is sometimes perceived as harbouring the “old stereotypes”, connecting role of a nurse to a feminine role of a mother/nun. The status question was frequently brought up alongside with the concern for the quality patient care. A Spanish nurse, Jenny mentioned explicitly the importance of making professional boundaries clear.

It seems quite clear that from the nurses’ perspective the present conditions that are strongly shaped by cost-efficiency make it quite difficult, even impossible for the nurses to achieve the standards of their ideals in care. In addition, sometimes nurses have to bypass the medical guidelines as well, not to mention the difficulty to find a right balance between curing and caring. Of the national cases this general observations is visible everywhere, except perhaps in the Finnish study setting. We can explain this anomaly by the fact that the Finnish case study was about three consultancy nurses who receive their own patients with general illnesses.

In addition to the division between curing and caring, professional knowledge of nurses can be further divided into theoretical and practical aspects of knowledge. The former type is regarded by nurses as something learnable (explicit) whereas the latter type is more innate (implicit) quality of personality that is more difficult to explicate analytically and verbally. It is more like a general impression that the nurses have about their “sensitive radar” to establish and maintain caring relations with patients.

The opposition between “know-that” (theory) and “know-how” (practice) has various parallel oppositions, such as explicit and implicit, official and unofficial, codified and tacit, and public and private, and so on and so forth. Practical knowledge, if it is at least partly implicit and tacit, cannot be fully exposed, but is rather in the process of exposure, so it could be only partly narrated. In professional life, there are many skills and knowledge that are not fully explicit or explicable, but are rather learned by imitation and socialization into the community of professionals. All the models, rules and re-organizations that are externally imposed on nurses’ work necessarily come to grips with these existing practices, not to mention the ideals of caring. Therefore it is the utmost of importance that, for instance, the formulation of evidence based models for best practices or the imposition of efficiency monitoring technology takes into account the existing aspect of professional knowledge. The well intended reforms may produce unintended consequences that are not in anyone’s interests.

The domains of nurses’ professional knowledge do not exhaust in curing and caring. We can highlight a third domain of knowledge, that of administration, management and organization of work. This domain contains both the theoretical (official, explicit, formal) and the practical (unofficial, implicit, informal) aspects too. In this domain, self-administration, self-management, self-organization have probably come forward due to restructuring measures that have substituted various external regulation instruments for self-regulative agents. In some contexts and roles, nurses are required to plan, execute and evaluate their own work as the regulation has become more and more de-centralized. There are clear indications of increasing demands for being self-initiative
and proactive in decision-making at various working units. There is, however, another aspect of management and organization going on in health care units. Nurses often have to improvise and device new solutions into practical problems encountered in the real conditions of work, which do not necessarily correspond to those conditions that the ideal models of evidence-based medicine and best practices, require in order to become fully realized. Therefore nurses often have resort to informal and unofficial modes of regulation and organization of work. These efforts often produce innovative solutions that could have a wider applicability in the field.

We can see that there are notable similarities across cases regarding how restructuring has affected conditions of work and professional knowledge of nurses, and how these issues are related to each other. Some commentators (Gordon and Lahelma 2004; Nermo 2000) have noted that similarity can easily be overlooked when looking for differences in cross-national comparisons. Nurses’ work, tasks and functions, are to a large extent similar, at least across Europe, as are the health care institutions, hospitals and health centres, and their functions. Our descriptive and interpretive approach of comparison has contributed to understanding what the changes are about across the cases, instead of just bringing up the pertinent differences and leaving other details out by reducing the data to the features that distinguish the cases. Thus, we have tried to understand how the cases, on the one hand, converge especially due to global influences, and on the other hand, refract due to local particularities and histories. Refraction is most visible in the variable timing of adaptation and re-organization of welfare state and health care measures, but can also be seen in various local emphases and constellations.

Now, we will look at differences and compare the cases by looking at what are the most pertinent characteristics and distinctive features of each case. We resort here to simplification of cases, in order to render what comes up as most typical or distinctive in each case study context. One could argue here that the different conceptual emphases of the national case study reports may have contributed to what is brought up as distinctive. Yet, we think that these features are not brought up by coincidence, but they tell us about what is pivotal in each case study context.

In the English case study, the most pertinent pattern in which restructuring measures and nurses’ experiences meet is, on the one hand, introduction of more career paths, flexible work arrangements and opportunities for professional development, and on the other hand, more instability, uncertainty about how the NHS is dismantled and fear of redundancies. Instability is seen, by some nurses, as contributing to the low working morale. It also has consequences for more fragile work-life balance and coping as well as for increasing difficulty for nursing according to one’s ideals and also according to official requirements and guidelines. While nurse education has developed, and roles and functions, with related knowledge, have widened, the work load and work pace have increased, making working conditions more difficult, and causing stress and burn out for the nurses. More demanding public, media, patients and their relatives are also notable features that make work more demanding and stressful. Patient’s greater awareness of their rights and readiness to litigate has meant increase in documenting and related activities as well as nurses’ awareness of their accountability. While there are less hierarchy between professionals and more collaborative teamwork, there is more regulation and targets to meet that aim at greater efficiency, and also ratings, Payment by Results Schemes and privatisation. While there is frustration among nurses by the new initiatives, the English case study reports on the failure of collective action, due to increased individualism and feeling of powerlessness to stop changes, especially among the younger generation who are most affected by the changes.

Intense work load with consequences on morale is an important concern for the nurses of the Irish case study as well. Also similarly to the English case, the Irish nurses seem to be confused about what the changes are about. The nurses feel important to take on the learning opportunities available that are more often formal ones because clinical case load takes the priority during regular work, leaving less time to attend to professional development events or study independently. So,
the nurses avail formal learning opportunities, such as Diploma and Master’s courses. The proliferation of programmes for postgraduate training has facilitated nurses’ pursuit for education. The dissatisfaction was voiced about intensity of work load as mentioned, low salaries, lack of resources and some impracticalities regarding lack of independent decision-making and reliance on doctors’ prescriptions. Yet, the Irish case study concludes that “the nurses are highly responsive to change and have successfully adapted to different working conditions”.

The case study of Greece notes how gender roles and the entry of men was one of the most vividly portrayed issues in the nurses’ accounts. The significant increase in men entering nursing is experienced by nurses contributing positively to the nursing profession to escape its marginal position as “women’s occupation”. The nurses voiced also a concern over the use of their advanced scientific knowledge, which they cannot always use in the context of staff shortage. Yet, the study tells about a negative cultural attitude towards scientific knowledge in Greece. The case study notes how upgrading the nursing education at the university level has been important change regards to image of nursing and its status. Moreover, a new legislation, enacted in 2004 providing nursing with a body that has control over the profession, has been a significant for the professional empowerment.

The case study of Portugal identifies the evolution of educational paths as the single most meaningful structural factor in the development of nursing. The high educational level and further education are perceived by the nurses as enhancing social status and means for professional advancement. However, the lack of related economic and professional rewards frustrated nurses. Yet, especially younger generation was eager to get further qualifications, which has lead to inflation of degrees, and older ones are critical of the young taking qualifications for qualification’s sake. Another, notable issue, pointed out by the study, concerns nurses’ specific sphere of action and their autonomy. The personal experiences and the functional role were seen as features contributing to how autonomous sphere was perceived. While nurses were objectively functionally distinct from other health professionals, they experienced not being fully recognised within institutional teams. The study noticed how a culture of collaboration was maintained not only by formal rules and definitions, but by an informal plan for monitoring and supervising the less experienced nurses in a shared, open work space. The Portuguese nurses placed interpersonal relationships at the core of their activities and their professional knowledge. The type of knowledge embedded was difficult for them to express explicitly as it was regarded something that is “sensed” and “shared” rather than theoretically grasped. The new flexible contractual conditions and precarious work are also significant in the case study context particularly for the youngest generation of nurses.

The Spanish case study points out two fundamental issues that characterise nurses’ experiences related to working conditions. First, the contractual conditions are flexibilised with severe consequences for careers and work-life balance. The work life has become precarious with periods of instable, temporary contracts at the beginning of the nurses’ careers. Second, everyday working dynamic has changed into more demanding, with increased work load causing burn out and inability to work according to one’s ideals. The intensified managerial insistence on efficiency, economic criteria and cost control contribute to this. The nurses consider professional learning and acquisition of knowledge as very important, not only to gain promotions, but often just to stay in the job. Similarly to the Portuguese case, the Spanish nurses state that the further qualifications do not translate easily into economic or professional rewards. Yet, they feel pressure to educate themselves, and they have to resort to autodidactic learning, in contrast to e.g. the Portuguese and Irish cases, because the administration does not foster education or research.

The Swedish case study shows how the nurses’ work is in the study context widely determined by a computerised system that is connected to financing system, and by a purchasing procedure. The appointment times, functional areas and roles are clearly defined, by various contracts and
guidelines, in a way that does not always match with the real demands at work. A nurse’s role as a
gatekeeper, deciding who can enter treatment and who cannot, is difficult in the context of too tight
appointment times and lack of appointments for the doctors. So, the nurses find themselves in
between the demands from the administration, often emphasising economic standards and goals,
and the demands from the clients, sometimes even expressing their discontents with aggression.
Relating to the economic goals in general is problematic and confusing for the nurses, and they are
cconcerned about their jobs if they do not meet the demands. The official definitions of certain roles
and the professionals’ own perception of their role are not always parallel, as the case of Public
Health Care nurses illustrates. PHC nurses are not able to provide health promotion and preventive
care that they consider as core of their role, because their job description at the health centre does
not allocate time for these activities. Moreover, a new occupational group, health coaches, has been
created to take care of these functions. The case study of Sweden concludes that the nurses’
professional “no” is weak. They feel that they have no other choice but to fulfil the demands.

The Finnish case study points out how nurses’ tasks and duties are being broadened, and
transferred from the doctors to the nurses with high hopes for higher professional status and salaries
by the nurses. As in Sweden, the nurses work schedules are determined by a computerised
appointment system that is connected to a network through which the information is circulated. The
nurses emphasized the importance of acquiring knowledge and participated occasionally in
training, and had also time for professional self-development. They did not suffer from lack of
resources or time, but their working environment was rather comfortable, and they were quite
satisfied with the conditions and their autonomy. Their main discontent was their insufficient wage
level considering the heavy responsibility, physical and mental demands of their work, as well as
their long education. Again, it must be noted that similarly to the Swedish study context, the
studied Finnish nurses worked in a health centre, and as consultancy nurses, whose work is quite
different from and independent compared to nurses’ work at wards for instance. In the study
context, the nurses reported of taking more than before part in common decision-making bodies
and processes about the issues of the health centre. This is a consequence of a more general policy
that underlines the local discretion, planning and evaluation and the withdrawal of centralized
planning. Yet, the three Finnish nurses had somewhat different views about whether they really
have an influence on issues.

One of the goals of the work-package 5 was to make comparisons across the different generations
of nurses. Therefore, the selection of the three nurses in each country was based on a formal
definition of generation in terms of years of professional work experience. We assumed that
because different generations have lived through different structural and regulatory conditions with
their implications for the formation of professional habitus, we could make distinctions between
professional generations. However, a general expression coming through the case studies is that
generations are rather hard to discern, especially with such a scarce data, a single nurse
representing a generation in each case.

References to the generations in the case studies were more often connected to nurses’ references to
different groups, such as the “old” and the “young”, rather than experiential generations
(Mannheim 1952). National case studies suggest that younger nurses experience short term
contracting and precarious career opportunities. However, it is difficult to distinguish between
generational and career effects. We do not have information about the changes in employment
opportunities for different generations. Yet, we may suggest that generally the period of expansion
of the welfare state is most favourable for employment. Thus, presumably present generation of
younger nurses, who try to secure their employment in the period of re-structuring has fewer
opportunities than the previous generations. This argument must be qualified by the size of various
cohorts. Moreover, as the timing of the emergence of welfare state and the re-structuring of
services has varying timing and pace in different countries, we may assume that the formally
defined age groups do not equal to experiential generations.
There are some findings in the national case study reports that touch particularly on generations, or perhaps more properly speaking, age groups. In addition to possible weakening of employment opportunities and increasing competition in labour market, the nurses of older generation have a comparative advantage of having secured good pensions schemes and early retirement plans relative to younger nurses. The tightening of welfare state budgets is coupled with more restrictive rules for employment contracting and pension plans for public officials.

There is also some indication in the national case studies that the upgrading of nurse education to the university level correspond the division that the nurses make in their accounts between the practical and non-academic old nurses and the theoretical and academic young nurses. Particularly, English case study reports that the old generation of non-academic nurses emphasizes the practical aspects of their work, while the young nurses are the generation of new professionals. The older generation of nurses and the public at large has argued that the younger nurses are too theoretically educated and academically ambitious to get down to real practical work with its complexities. Finally, the pursuit for further academic training and education seems to be the concern of the younger generation, which is quite natural given their career stage and ambition to advance. Yet, in the Finnish and Swedish case study contexts, one cannot find differences between various generations of nurses.

Given the scope of our data in this work package we are not arguing that the results in this report have unambiguously strong external validity. However, given that the structural organization of health care is to large extent the same in every country, the amount of secondary data in the form previous work packages and research, and the in-depth quality of our data, we can argue that in their reference to reality, our findings, arguments and conclusions are trustworthy and authentic. Moreover, despite the different conceptualizations in national reports the shared themes in interviews and analyses offers credibility of our findings concerning differences and similarities between the national cases. We must admit that with this study design and type of data many of the relevant issues cannot be thoroughly studies. Yet, this report, we believe, functions as a basis for future research and publications with more carefully planned comparative designs and data.

References


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Appendix 1 - Thematic Grid for Interview Guidelines

1\textsuperscript{st} area: Working conditions, professional status and autonomy
- employer, place of work and site, work organisation or unit and setting
- job title, official rank, hierarchical position in the work organisation or unit
- main tasks, duties and responsibilities
- skills and knowledge at work
- degree and content of independent decision-making
- supervision and control of work, instructions, orders and regulations
- interaction with colleagues and other staff, patients and other people
- how positions oneself, i.e. how sees oneself relative to others
- use of machines, instruments, tools, materials and other artefacts

2\textsuperscript{nd} area: Historical content
- I am not quite sure what does this mean, but I presume that we try to ensure that the interviewee describes her life-course and career path in the context of historical change

3\textsuperscript{rd} area: Work life balance
- family relations (spouse, partner, children, relatives at home)
- housework, duties at home
- atmosphere and support at home
- free time, hobbies, interests, friends
- way of life, rest

4\textsuperscript{th} area: Key experiences – critical incidents
- in any area of life and activity, not only at work
- turning points in life, problems, crisis
- solutions, lessons, effects and significance in the life course

5\textsuperscript{th} area: Gender
- I presume that gender passes through all the other areas

6\textsuperscript{th} area: Knowledge sources (opportunities to learn)
- in any area of life and activity, not only at work or at formal education and training
- shortcomings and needs
- significant other people

7\textsuperscript{th} area: Relation to clientele/people, sense of their professional mission
- actually this area consists of two divergent, though related topics in Barcelona minutes
- I moved the relation to clientele and other people in the 1\textsuperscript{st} area
- thus here is covered professional ideals, mission, vocation, reasons and motives to work
- how these have changed throughout the career
- this area relates partly to the next area

8\textsuperscript{th} area: Job satisfaction
- satisfaction with various aspects of work, such as tasks, autonomy, salary, atmosphere etc.
- good and bad features and things
- has ever considered changing occupation, work place or unit
- has ever regretted the choice of a career or profession

9\textsuperscript{th} area: Important to consider “knowledge at work” in all areas and in relation to restructuring
- knowledge is defined broadly (not only technical and functional knowledge), but also knowledge about values, norms, people, symbols etc.
- knowledge at work is often tacit and situational, therefore difficult to convey
- try to keep in mind the country specific restructuring processes and events, such as major changes in policy, regulations, laws, economy, education, work organization etc.

10\textsuperscript{th} area: Other information
Appendix 2 – Thematic grid for WP 4 and 5 reports

1. Introduction (researchers’ conceptual position, research process)
2. National and local context useful for interpreting the findings in the case study
3. Each collaborators life course in a nutshell (family and professional career)
   - Social background (childhood family)
   - Educational background (primary and secondary)
   - Choice of a profession, professional education, qualifications obtained
   - Professional career and current job
   - Family relations, hobbies, friends and networks
   - Work-life balance in its own chapter 4.4
4. Thematic Analysis (combining observations with interviews and other data and WPs)
   4.1 Working conditions
      - Organization of work (arrangements)
      - Management of work (control, supervision, autonomy, decision-making, meetings, planning, evaluation, documentation etc.)
      - Social relations and co-operation with colleagues, pupils, parents, patients, doctors and other people
   4.2. Professional Knowledge (What is your conceptual position here?)
      - Tasks, requirements, demands
      - Knowledge
      - Skills
      - Learning (formal and informal, practice and experience)
   4.3. Social position
      - Symbolic aspects: respect and prestige
      - Material aspects: earnings
   4.4. Work-life balance (related to the themes at chapter 3)
   4.5. Emerging themes
5. Conclusion
   - Restructuring and 4.1, 4.2, 4.3, 4.4., 4.5
   - Restructuring and professional strategies
   - Restructuring and generations
   - Restructuring and periodisation
CHAPTER 2

English nurses' work and life under restructuring: Professional experiences, knowledge and expertise in changing contexts

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1 Introduction

1.1 Conceptual position

The aim of the Profknow project is outlined in the proposal:

Our overarching ambition is to understand knowledge “at work” among professional actors situated between the state on one side and the citizens on the other side. This is a way to consider opportunities and constraints for change as well as a means to capture issues of social cohesion and integration in Europe of today.

The area between the state and the citizens is the provision of services that has been under a process of restructuring in England and in Europe. It is the process of restructuring of this provision and the role of professionals in it that is of interest to the Profknow project. The term restructuring includes the dynamic interaction between 1) societal issues such as increased technology and greater consumerism 2) national government inspired changes affecting healthcare especially since the 1980s 3) changes occurring from within the nursing profession.

This report is composed of subjective and objective data taken from interviews transcripts, observational fieldnotes, local and national websites and previous ProfKnow work packages. A Bourdieuan approach was used for this report. Nurses’ biographies are seen as illustrative of the different experiences of habitus-specific individuals but also vividly highlight their shared experiences in the field. Bourdieu's concept of habitus involves the aspects of culture anchored in practices of individuals and groups including learned habits, bodily skills, tastes, dispositions and beliefs. It is ‘an acquired system of generative schemes objectively adjusted to the particular condition in which it is constituted’. (Bourdieu 1977a, p95, quoted in Grenfell and James, 1998).

Here the field is defined as the hospital that participated in this research. However this is intersected by the structured structures of professional, national and local healthcare fields. Nurses are seen as possessing different combinations of capital (economic, social and cultural). However, capital is only valued to the extent it is recognised in a certain field. Knowledge is viewed as constituted in a nurse's cultural capital and so includes the accumulation of personal characteristics, dispositions, institutions they have attended and artifacts used. Fields are "lubricated by forms of knowledge which are only partially consciously known; have their own self-referential legitimacy and to a large extent operate in a tacit manner" (Grenfell and James, 1998:24). The changing social practices or praxis in nursing described by the nurses of different generations combined with my own observations of procedures will be focused on as an attempt to illuminate changes in nurse habitus. The dichotomies of structure and agency combine and influence each other in a dynamic process of *internalisation of the external* and *externalisation of the internal* that makes up the construction of a professional habitus and this means different generations of nurses have different professional identities (Bourdieu, 1977, Grenfell and James, 1998). This approach will be used for analysis of WP4 and WP5.
1.2 Research Process

This report aims to look at the dynamics of health care restructuring in England and nurses' working experiences, their expertise and professional knowledge. This report focuses on observations and 6 life history interviews carried out with 3 nurses, belonging to different generations, working in the same hospital. The nurses were observed at work for 2-3 days each. It also includes data from 6 other nurses working in the same hospital, collected during a focus group and additional interviews and observations. Access to the hospital depended on gaining NHS ethical approval through a national computerised system. This process took 3 months and involved filling in a large online document, gaining university insurance to cover the fieldwork period as well as nominating a university sponsor who is unconnected to the Profknow project. The principle applicant and the researcher were then invited to attend an ethics committee meeting in a local hospital where an ethical board, made up of around 15 healthcare representatives and lay members, asked questions about the project. Having been granted ethical approval, nurses were recruited to the project with the help of the Director of Nursing of the case-study hospital who e-mailed staff asking for volunteers. A consent form was signed by nurse participants and the researcher. Transcripts were returned to interviewees so they could make comments or amendments. Interview transcripts were coded using NVivo.

A life–history approach was chosen as the best methodological technique for illuminating different professional *habitus*. The first interviews were conducted in an unstructured way. Participants were asked about their life histories and that told that the researcher would try not to intervene as it was the nurse's story that was of interest. In the second interviews, themes arising from the first interviews were discussed as well any discrepancies and omissions that had been identified. The focus group was carried out at the end of the data collection and participants were asked briefly about their lives as well as addressing thematic issues. A life-history approach was used as it contextualises the professional experiences of a narrator within their whole life and within a time period. Goodson (1992:6) has noted the importance in differentiating between individualistic life stories and *life histories* - where narratives are linked to structural changes in society and the "historical context". Following this insight, the participants' biographies are explored to see to what extent they are representative of their generation and of how they have experienced changes over time. It is also noted that the transcripts produced from these interviews are viewed as socially constructed texts produced from the interaction between the researcher and the participant. The observations allowed better understanding of the nurses' work practices, knowledge and expertise and placed their interviews within the context of their current job situation.

My role as an 'outsider', being un-qualified as a nurse, has advantages and disadvantages. Nurses may have felt they could speak more candidly to someone from outside the hospital and profession, but interviewees could feel they could not discuss technical aspects of their jobs. The extent to which interviewees behave naturally while being observed is also of relevance. One nurse mentioned practicing extra carefully the first day I visited, for example scrupulously washing hands between patients, but subsequently behaving more naturally. Another example, taken from my fieldnotes, documents how nurses were discussing the condition of a patient when one of them made a risqué joke. The participant nurse bantered back "I've got someone following me. Don't make inappropriate jokes in the staff room!"

2 Contexts

2.1 National – NHS restructuring in England

The following section outlines the restructuring on the National Health Service (NHS) in England. An NHS, free at the point of delivery and according to need, has been a foundation of the British
welfare state since 1948, but it is now argued that the population of England is sleep-walking into the dismantling of the NHS without political discussion. Successive governments have been restructuring the NHS according to Neo-Liberal shibboleths of the market and consumer choice. This restructuring of the NHS started under the Conservatives in the 1980s under Margaret Thatcher with the introduction of ‘new-management’ and the contracting out of non-clinical hospital services, dentists and opticians. Long-term care for the elderly and chronically ill was transferred from the NHS to Local Authorities who were in now in charge of contracting services out to private companies. Under Prime Minister John Major, the ‘internal market’ was created in an effort to make the NHS more economic with Primary Care purchasers commissioning services from hospital Trust providers.

New Labour originally committed itself to continue the spending plans of the Conservatives for their first two years in power. After that time spending on the NHS has increased significantly, but it has not brought about the quick improvement in services New Labour was hoping for. New Labour introduced the NHS Plan (2000) and this has signalled the start of ‘significant change’. “The Government has set out a new vision for the NHS where instead of being a monolithic structure that both commissions and provides care, it is to be a set of rights to treatment, at specified and assured standards, from a widening base of diverse suppliers, public and private” (Whitfield et al., 2005:11).

Labour has aimed to reform the NHS to introduce more competition into the system, with the target of 15% of services to be provided by the private sector. Private Diagnostic and Treatment Centres have been introduced to compete with the NHS treating specific areas such as orthopaedics, elective surgery and pathology. High performing hospitals have been given independent status and re-named Foundation Trusts and regulated by their own newly created quango Monitor. Foundation hospitals are allowed to enter into joint ventures with private healthcare companies like the American United Health Group, South African Netcare or BUPA. Payment by Results was introduced in April 2006 where costing and payment for every individual patient’s treatment has to be calculated against government benchmarks for procedures. For elective treatment, the government wants patients to choose which hospital they are treated in and book this on a centralised computer system. Funding for treatment will follow patients, so that ‘poorly performing’ hospitals will be forced to raise standards or close. However, the implementation of this ‘choose and book’ scheme and the delivery of planned digital patient records and prescriptions has been hit by failure of the private contractors (including US giant Accenture) to deliver and as yet this system is not up and running. New Labour have attempted to address the varying standards of care around the country by the introduction of National Service Frameworks (NSFs) laying out guidelines of best practice and the establishment of an independent inspectorate, The Healthcare Commission to set targets, regulate and enforce standards of care. The controversial PFI (Private Finance Initiative) scheme has been introduced in an effort to build new hospitals. Contracts are awarded to a consortia of private companies to build and run hospitals for 30-60 years with a guaranteed income to be paid by the Trusts. Money for PFI schemes is borrowed from the private sector rather than the government.

In Primary Care restructuring has also accelerated under New Labour with the formation of Primary Care Trusts (PCTs) – groups of GPs commissioning services together rather than as individual ‘fundholding’ surgeries as under the Conservatives. GPs had traditionally been run as independent businesses. Under a 2003 Act control has been passed to the PCTs which may now make ‘Alternative Provider Medical Service’ contracts with commercial providers for all aspects of

24 A private company known in the USA for a ‘catalogue’ of fines in various States including defrauding the government insurance system and cheating patients (Pollock, 2005: 14).

25 The computerisation of NHS patient records is one of the biggest current global IT projects and is controversial in the UK. Costs are set to rise to three times the previously stated £6.2 billion. The Telegraph, 31st May 2006. Accessed 7th August 2006, available: http://www.telegraph.co.uk/news/main.jhtml?xml=/news/2006/05/31/nfarce231.xml

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primary medical services such as out-of-hours, cancer screening, family planning or minor surgery. Newspaper reports recently stated that a government notice had been secretly advertised inviting tenders for Primary Care Trusts for outsourcing of areas such as management, administrative, HR and health services. A PFI type scheme called NHS LIFT (Local Improvement Finance Trust) where primary care providers can collaborate with private investors to build facilities majority owned by the private developer has also been introduced. Changes in primary care have brought new roles for nurses such as working in the new walk-in centres as nurse consultants or nurse prescribers in surgeries or for the telephone service NHS Direct.

The NHS has received more money in the second and third terms of the Labour government in line with Tony Blair’s vow to raise spending to match average EU expenditure. However some hospital Trusts have run up deficits and been plunged into debt. The Labour government are now lambasting Trusts accused of mismanagement and overspending on their budgets. Turnaround teams from international consultancies have been rushed into hospitals to make savings. These have been made by cutting staff including nursing jobs (Craig and Brooks, 2006). Despite nurses reporting staff-shortages, nursing jobs are at the present scarce and many newly qualified nurses are struggling to get posts. After a decade of reliance on overseas recruitment, lower grade nurses have been taken off the Home Office ‘shortage occupation list’ meaning work permits will be granted only if a job cannot be filled by British or EU applicant. Labour MP, Frank Dobson has commented:

*The main cause of deficits, cuts, closures, job losses and reductions in patient care in the NHS is the latest round of re-organisation. If the Health Department pays out hundreds of millions of pounds of taxpayers’ money to private hospitals and management consultants then it’s not available for the NHS. Even more damaging is the paper chase and bureaucracy of the new system which is costing upwards of £12 billion – three times what it cost under the old system. The Payment by Results experiment threatened from 1 April is just that – an experiment. The NHS is too important to be experimented on – people’s health is at stake.*

Pollock (2005) writes that in England today New Labour have elected to follow the market route in health care and the un-declared policy is to free up the NHS to a degree of multinational privatisation. Labour appears to feel that under secretly agreed GATS (Global Agreement on Trade and Services) arrangements it is only a matter of time before health care is forced to be opened up to the global market and in this case, it is best for the newly formed UK companies be able to operate internationally (Pollock, 2005:65). Privatising sections of the NHS, introducing an insurance-funded system and contracting out of services, leaving the NHS as an overarching logo only, is seen to be one vision of the future.

### Local – The case-study hospital

The following is a description of the hospital in which the ethnographic observations and interviews were carried out. Information is taken from my own observations as well as national and local websites. The hospital is in a city in the South of England. The original buildings of this hospital were built in the early 19th century. Over the years, the site has been expanded with new buildings added, so there is a wide variety in the type of wards. Previously, some hospital departments were scattered around the town, for example the nursing school and nursing accommodation. Many of these sites have been sold off to raise funds and consolidate services since the 1980s.

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26 The Times, Friday June 30th 2006, p4
27 The online Times, July 4th 2006, Available: [http://www.timesonline.co.uk/article/0,,8159-2254529,00.html](http://www.timesonline.co.uk/article/0,,8159-2254529,00.html) Access date, 1st August 2006

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Today, the hospital is part of an NHS Trust established in 2002. The Trust also provides a range of other services in other hospitals and satellite locations. The case-study hospital is involved in many of the national restructuring initiatives that affect the work lives of nurses. The hospital is currently undergoing building works with the construction of a new unit, funded by a PFI scheme. The money to fund, build and possibly run the new unit has been provided by the private sector and guaranteed contracts will be paid by the hospital Trust, for example to lease back the building for a stipulated time period. It can be seen that the trend for relocating and accommodating services in one site has been accelerating. This is often contrary to the wishes of the public, who prefer local services and do not want to travel for treatment.

The Trust provides hospital services to a population of 500,000. It also provides a range of specialist services including cancer, neurosciences, cardiac surgery, renal services, HIV medicine and Intensive Care for adults, children and babies for a population of approximately 1 million. The hospital recently became a teaching hospital with a new medical school being attached to the Trust. The Trust has around 5000 members of staff.

A new privately funded Orthopaedic Treatment Centre has been opened in the Trust. This is due to take 85% of the orthopaedic caseload from the case-study hospital leaving it with only the most costly and complex cases and emergency work. NHS work will be contracted out to this centre. The aim of this is to create a market in healthcare and cut waiting times for these operations. However, staff are being seconded into it from the NHS so will still be on the same contracts with associated benefits and pensions. Consequently, at present this is an expensive way of providing the same service in a new building at a different location, which is less convenient for many patients. Cases are also currently contracted out to a local private hospital if patients have been waiting for a long time for their operations.

The Trust has received a poor rating compared with Trusts nationally and has been awarded no stars (in a 0-3 rating system) by the HealthCare Commission. The peformativity agenda is obvious from the following key targets listed on the NHS and Healthcare Commission web sites. Key targets passed are:- 12 hour waits for emergency admission via A&E post decision to admit and all Cancers: 2 week waits. However the hospital Trust significantly under achieved targets such as Elective patients waiting longer than the standard, Financial management and Out-patients waiting longer than the standard. The Trust also 'under achieved' on a crucial target - Total time in A&E: 4 hours or less. The quality of human resource management practices within a trust is also graded and here the Trust achieves an average grade. This selection of targets illustrates the atmosphere under which nurses are working. The hospital has also received poor media coverage which has also highlighted that it has a problem with the superbug MRSA.

The Trust is in debt of over £10 million and has been investigated by international accountants. The Trust has appointed a Turnaround Director who is working with a different international consultancy firm to reduce the deficit. This has led to staff redundancies. The hospital paper reported in April 2006 that over 300 posts would be lost, but many of these would be due to natural staff turnover. This is in total contrast to the early New Labour pledge in the NHS Plan (2000) to increase the number of nurses working in the NHS by 20,000 by 2004 (Whitfield et al., 2005). The local paper has reported that in order to save money the Trust is considering out-sourcing the typing of patient notes and letters to India or South Africa. The role of international consultancy firms 'plundering' England’s public sector without producing savings has been attacked (Craig and Brooks, 2006).

Quantitative data from a national Annual NHS staff Survey for 2005 is available on the internet on the Healthcare Commission31 web-site and sheds light on working conditions and attitudes of the case-study nurses. It also offers triangulation with the information gained from my observations and interviews. Results show that around 150 nurses from the case-study Trust replied to the survey. Work life balance is obviously an issue for these respondents with around three quarters of the nurses working extra hours due to pressure and demands of the job. However, more positively around two thirds of nurses are using flexible working options. A 1999 NHS campaign to Improve Working Lives (IWl) aimed at improving flexible working arrangements, childcare support, support for carers and team-based self-scheduling. However, according to Skinner et al. (2004) this initiative has been criticised as 'at best' only 'partially delivered.'

The degree to which the hospital is a ‘learning environment’ is addressed by various questions. Positively, nearly 100% of nurses received training, learning or development in the previous 12 months. However, only 22% of nurses were appraised with personal development plans within the previous 12 months, demonstrating an environment lacking support or mentoring.

The emotional labour (Smith, 1992) of the nurses is pointed to by the fact that almost half of the nurses reported suffering work related stress in the last 12 months. Nearly a fifth of nurses experienced physical violence from patients/relatives in the previous 12 months. 40% of nurses experienced harassment, bullying or abuse from patients/relatives in previous 12 months. Again lack of support from colleagues is highlighted by the over a fifth of nurses who experienced harassment, bullying or abuse from staff in the previous 12 months – although none of this was physical violence. Around half of nurses witnessed potentially harmful errors, near misses or incidents in the previous month (the huge majority of which were reported).

Nurses working in the Trust answered questions about:- Quality of work life balance, extent of positive feeling within organisation (communication, staff involvement, innovation & patient care) and Nurses’ intention to leave jobs. Very average responses to these questions were received putting the Trust results within the lowest 20% in England. It would also be expected that results would now be lower than this due the new pressures created by fears of redundancy.

Generational Biographies

The following nurse biographies were gathered at the case-study hospital during this research and will be examined to see in what ways they are representative of their generation and how they have experienced structural changes over time. Notter (2000) has identified 4 generations currently in the workforce, although the boundaries between them can be fuzzy. His conclusions are interesting to note and use for comparison. He finds workers can be divided into – Maturers (aged 62-82) Boomers (aged 42-62), Generation-X (aged 22-42) and Millennials (under 22). Maturers (interested in family and religion, dedicated to hardwork, duty, education a dream); Boomers (optimistic, interested in personal gratification); Generation X (experienced downsizing and redundancies of their parents' generation and consequently work to live not live to work and value worklife balance); Millennials (characterised by IT knowledge and confidence). It can be seen that some of these characteristics do ring true in the following biographies of nurses. So to what extent can the nurses life-stories be seen to be representative of their generation and is this reflected or not in their professional practices, knowledge and expertise?

Jan* – Experienced nurse – knowledge and expertise is 'part of her'
Jan is in her early 50s. She has been nursing for nearly 30 years. Jan attended schools in a large city where she took her O’ levels and A’ levels. She then spent time back-packing which she funded through office work. However, Jan decided when she was 23 that she needed a career and saw nursing as a good choice as it provided opportunities for travel. Jan stated that she did not go

31 Available http://www.healthcarecommission.org.uk/nationalfindings/surveys/staffsurveys.cfm Access date 10th October
* Names have been changed
into the profession because ‘she wanted to help people’ and this was the wrong motivation as emotional detachment from patients is needed in order to be able to aid them. She sees the putting on of the uniform as ‘role-playing’. Jan did her nurse training at a nursing school attached to a hospital in a large city. Jan describes a very strict, formal practical training in an era of nursing where sisters ran the wards and junior nurses did as they were told. However, Jan noted that her student intake was specially selected as mature students and so they were keen to question the rationale behind practices. Jan described this training as typical of its time and very different to the academic education nurses experience today. Jan's training was a three year course and she qualified as a Registered Nurse (RN). After a short period working in the large city where she qualified, Jan came to the present hospital as it offered the chance to undertake a specialist training course. Jan worked in various roles and locations in the hospital over the years and she described how gradually general wards have become increasingly specialised and this had influenced her career path. It has also meant that throughout her career, Jan has undertaken extra training courses. Jan's current job involves seeing patients as well as managing other nursing and clerical and administrative staff. Jan is interested in alternative medicine. She has plans to take early retirement.

June* – Mid-career nurse – highly specialised knowledge
June is in her mid 30s and has been nursing for nearly 10 years and comes from a family of nurses. June attended various schools as a child due to her father travelling for work, but her later schooling and college were more settled and she took O' levels and A' levels. June always wanted to be a nurse, but after school she spent various years travelling and doing different jobs including working as a healthcare assistant. However, June decided to undertake her nursing education when she was in her mid 20s and felt confident due to her experience of care work. She found the course stimulating and was pleased to meet many other mature students. June is representative of this generation in that her course was based at a university and she graduated from her 3 year, Project 2000 training, with a Diploma of Higher Education in Adult Nursing and started work immediately in a specialised area. June was promoted in her previous hospital, before coming to work at the case-study hospital. She is pleased to be working in the current hospital where an extensive range of services are offered in her speciality so she can offer more for patients. Her role involves managing other nurses, treating patients and administration. June lives with her husband and children.

May* – Early career nurse – values work-life balance, non-specialised
May is in her mid 20s and is an early-career nurse. Having taken GCSE's and A' levels at a local comprehensive school, followed by a college, May decided to study nursing. This decision was partly based on the fact that she did not want to leave university after 3 years still untrained for any profession. This possibly reflects this younger generation of students' attitudes as they now have to pay for their own fees. (Although in contrast to other students, nurses receive a bursary and those on the Diploma courses do not have to pay their fees.) Having qualified from a university with an Advanced Diploma of Higher Education in Adult Nursing, May worked in the hospital she trained at for a year and a half. During this time May was sent on many study days including IVs and cannulation. May felt well supported during this period, but typically found being newly qualified stressful. May then went travelling for 18 months including to Australia where she enjoyed occasional work as an agency nurse in several hospitals. It was during this time that she met her partner. On returning from travelling, May worked as an agency nurse in a big city for 6 months. May relocated to her current town ago due to her partner's job. She reported being pleased to feel settled after her recent years of moving and she has bought a property near the case-study hospital. May enjoys the social life of hospital working, but she does not enjoy the stress and responsibility. Consequently May described how she has not chosen to progress up the career ladder in comparison to some of her student contemporaries as she values her work-life balance. She is also undecided in which area to specialise.
3  Thematic Analysis

This section aims to look at the major themes that arose from the interviews, the focus group, and observations. The problems associated with using case-studies to make generalisations is a well-covered issue (Bassey, 1999). However, using the quantitative and qualitative data collected here, it is possible to identify themes and make some wider generalisations due to the centralised NHS system in England. Following the agreed Profknow structure the following areas will be addressed: working conditions, professional knowledge, social position, worklife balance, emerging themes (gender) and conclusion. The issues of restructuring and generation are addressed throughout the thematic analysis as well as in the final conclusion.

3.1  Working Conditions

3.1.1  Organisation of Work

At a local level, one of the most immediate working conditions issues currently affecting the organisation of nurses is the fear of redundancy. All the nurses interviewed had permanent contracts but due to the debt of the hospital Trust, redundancies are being made of various grades of staff. Some members of staff have been made to re-apply for their jobs. This is not a totally new phenomena as nurses from the older generation also talked about their wards being closed in the past and fearing redundancy in the cuts under Thatcherism in the 1980s. During observations the cuts were seen to be creating a bad atmosphere and I heard nurses discussing how secure they thought their own personal jobs were depending on whether they were in key services or for example, older nurses noted that they would probably not lose their jobs as it would be expensive to pay them off. N3 mentioned other nurses were worrying how they would pay their mortgages if they lost their jobs. N2 talked about how the current situation was affecting morale in her department.

> There have been a lot of very stressed out people that have not quite been... so you've been able to forgive them because they're all a bit short and curt, because they're stressed out to the hilt and don't know if they're going to lose their job or not. Or where they're going to end up working, how much extra work they're going to take on, which all of them have. [...] I'm now more stressed, I'm having to pass things on to other people that I work with, erm, they're having to pick up bits of my job because I can't do all of everybody else's job, so they're having to do their own job, plus, and that's just going to get worse. (N2, mid-career nurse)

Although management are cutting jobs, nurses complained of poor working conditions and organisation already due to shortages of staff. In the hospital, nursing agencies or bank nurses usually supply staff if there is a shortage. However due to the cuts there had been a freeze on using agency staff as they are expensive. Consequently, nurses reported being especially short staffed. N2 stated that she had told the consultants she worked with about the situation and they were very sympathetic but this just made her want to cry. Meanwhile N6 noted,

> Because half of the problem with nursing is just caused by staffing. Low morale is caused by low staffing. It is horrible going home and thinking and knowing that you have not done your job properly and you have not looked after someone as well as you would have liked to because you haven’t physically hadn’t had the time to do it. (N6, early-career nurse)

During observations, some of the nurses could be seen to be over-stretched due to lack of staff. N3 for example was observed working a double shift. Apart from a designated half hour break and two 15 minute breaks, N3 did not stop, looking after 6 patients, going from patient to patient and task to task, with barely a moment to exchange pleasantries with colleagues. The following excerpt
from my fieldnotes highlights the working conditions of N3. At the same time another lady is wheeled in with her son and greets Nurse 3 enthusiastically. N3 says, "Hi." When she's gone past into another bay N3 says it is impossible to remember all the different patients are because they deal with so many. N3 recognises the patient from a few days ago but cannot remember anything about her now.

3.1.2 Management of Work - Control, Supervision, Autonomy, Decision-making, planning, documentation

Nurses are now educated to be autonomous professionals - free to make their own decisions, rather than being controlled by the doctors. This move has freed nurses in some ways giving them more responsibility for their own work. However in other ways, their autonomy has been reduced due to new methods of monitoring their work. Nurses are now subject to control by their managers, government guidelines - National Frameworks, National Institute for Clinical Excellence (NICE) guidelines, and subject to ward inspections by the Healthcare Commission. N4 expresses the loss of autonomy that older generation nurses can feel by the encroaching powers of hospital managers.

...Years ago...[...] I had to make a decision by midday, we knew how many people were coming in and how many were going home, but we knew we always had to save so many beds for casualty and make a decision by midday. One person, the buck stopped at me. And - didn't have a problem with it. Now, you'd be lucky if you make a decision by 6 or 6.30 at night and it would still be changed and you know, it is just there are so many people trying to make the decision. (N4, experienced nurse)

Complaints about management are historic, for example, N4 described how the ward she worked in had been shut down in the 1980s due to cuts, with members of staff being notified by work of mouth about redundancies rather than being formally notified. Complaints were also made about non-clinical managers running the hospital rather than doctors as it was in the past.

I just think one of the worrying things is they have these managers and they have short-term contracts, and then they only plan, let's say, for two years or something because they don't care what happens, you know, and selling assets off and that, I mean, I think that's a worrying concept that er, it's dealing with just now and not thinking long-term that much and how to bale out the Trust financially.... (N4, experienced nurse)

Working conditions have been affected as nurses have gradually lost control of areas of work that they used to manage. Restructuring in the 1980s meant that over time, hospital portering, cleaning, catering services and building maintenance were tendered to outside contractors who need to make profits. N4 described how before contracting out, each sister controlled the ward so cleaning standards were maintained. When patients left, it was the nurses' job to clean the area thoroughly including the bed, the chair and the locker. Nurse uniforms were also sterilized at the hospital and new ones provided each day by a laundry service. Today, nurses have no power over hospital cleaning contracts. Nurses also wash their own uniforms at home. The rise in hospital superbugs has been blamed on these contracts and has increased pressure on nursing staff. N3 states,

Because you know, the, the wards are shitty, the cleaners don't give a monkey's, and I wouldn't give a monkeys at four pounds money an hour either. You know, I wouldn't care that it wasn't clean. I wouldn't care that, you know, if it was my ward and if it was my job to clean it, then I would, you know, I would care. And I think that that as an example of what's changed is that somehow we've become so elevated in nursing that cleaning the ward isn't for us any more. Which is crazy. (N3, early-career nurse)

Private contractors provide the food for patients and serve it, rather than this being carried out by nurses in the past. Consequently nurses find it difficult to monitor this task. For example, during observations, one patient had a nil by mouth sign about his bed. One of the caterers proceeded to ask this patient what he wanted for a meal and was about to serve it. A nurse intervened and
stopped the patient receiving any food but said to me 'I knew that would happen' indicating this is a common frustration. Older generation, N8 compares this to his early days in nursing.

_A huge change. I mean, certainly when I was training it was like the big thing, you served up the meal. You took them in, you gave them, if you were serving them up you gave it to whoever was helping you and they'd take it to the patient. And once that was all done and put away, the trolley would be put away, you'd go round and clear up, and say 'why didn't, didn't you like that, then? Can I get you something else?'_ (N8, experienced nurse)

Working conditions of one of the observed nurses were seen to be made harder by the poor attitude and lack of respect for patients of the privately contracted hospital porters. For example the nurse's task is to go with patients when they are being transferred to different wards. However one of the nurses had to reprimand a porter as he had not bothered to wait for the patient handover and bed transfer in the new ward and instead had left a trolley dangerously in the middle of a corridor. On another occasion, the porter was complaining and criticizing the observed nurse for having called him early for a patient transfer before all the paperwork was organised.

Another area of tension is the privatisation of car-parking. Car-parking has been contracted out to a private firm so hospital visitors have to pay to park at the hospital. There are not enough spaces and nurses were observed discussing this with patients who were complaining or explaining their lateness. Another example of working conditions being affected by private sector contracts is the provision of hospital televisions and phones. During fieldwork one nurse discussed how representatives from one of the two companies in England who provide patient communications want to sue one of the wards for allowing patients to use electrical equipment brought in from at home. This had upset patients and caused extra stress for staff.

A fairly recent NHS initiative involves contracting out of some small operations to private hospitals where there are very long waiting lists in the public sector. Nurses' opinions on this varied. N2 and N6 felt that this practice did have some benefits. However, N6 noted how only the easy procedures were undertaken in private hospitals with implications for the knowledge nurses could gain working in this context. N2 noted how working in private hospitals was a different ethos as it is 'about money'. The nurses also discussed how the case-study hospital is now facing competition in orthopaedics from a new privately built and run but NHS funded treatment centre. Nurses opinions of this were that it is bizarre, wastes NHS money and cannot produce profits for the private company without long uncompetitive contracts. One nurse stated that this scheme is not 'fair competition' as the only way profit can be made is to 'hand-pick the elective orthopaedic cases and anything that's a bit crumbly or is going to be a bit long, is going to be bounced back to the Trust'.

Working conditions are affected by targets introduced by New Labour into the NHS in a bid to raise standards and make Trusts compete with each other. Experienced N4 explained how she has to meet targets and how these exacerbate stress and relations between staff. In the past referrals were graded depending on clinical need. However, now there are also targets to meet. So for example, in the past referrals in a speciality might have been 52 weeks, but now Labour targets could mean patients must be seen within 13 weeks. N4 complained that this meant some patients got appointments even though they were not urgent while urgent cases were not prioritised. It also means that although the first appointment is quick, subsequent appointments and tests will not be any closer as more money has not been put in the system for this. Targets are seen by many as simply an exercise; however they increase pressure on staff. One of the important New Labour targets that all the hospitals get measured against is that patients should not have to wait more than four hours in Accident and Emergency. N8 describes the additional strain on nurses created by the targets

_N8: I don't believe in targets. I do believe in people being seen, you know, promptly [...]. But I mean that puts a lot of pressure on people to hit the four hour targets, and how can_
you hit a four hour target if you've no beds? And the reason you've no beds is because you've got some old ducks that's been sitting in the bed there for months on end because Social Services can't get their finger out their arse. (N7: Yeah. Yeah.) It's true. (N7: Absolutely.) True. Or you've got some idiot who's just stoned out of his head, or what-have-you and giving the nurses hell on the ward. Or the nurses have just had somebody die, and they're trying to give respect and dignity to that body, and clean the person and let the relatives see them, and they're getting pressure constantly from A&E saying...

N7: We want the bed.
N8: We want the bed, we want the bed, we want the bed, we want the bed, forever on the phone. And the nurses are running back and forth, trying to answer the phone, (N8, experienced nurse and N7 newly qualified nurse)

Hospitals are graded depending on how well they meet their targets. Lists of well-performing and poorly performing hospitals are printed in newspapers and on the internet. The lack of any stars in the case-study hospital can also lead to low morale. As N4 described,

Stars, what do they mean, you know? What do they mean? Is there the quality there? […] it just sort of, it can be very, sort of low morale, which hasn’t helped. […] It really hasn’t helped the hospital really. I just rise above it, you know, I just think there is a star? Me! [laughter] (N4, experienced nurse)

Increases in paperwork are another feature of restructuring affecting nurses’ working conditions and structuring their work. Nurses have been bombarded with guidelines and policies they have to comply with such as Care Frameworks and Care Pathways laid down by NICE (National Institute for Clinical Excellence) and Essence of Care, benchmarks first introduced in 2001 by the Department of Health Modernisation Agency to try to ensure the fundamentals of nursing care are covered. Essence of care benchmarks cover eight areas of care:-continence and bladder and bowel care, personal hygiene, food and nutrition, pressure ulcers, privacy and dignity, record keeping, safety of patients with mental health needs and principles of self care. Paperwork to demonstrate these areas have been addressed needs to be completed. The introduction of Payment by Results also means that records of every procedure or intervention need to be kept by nurses and fed into a central system so costing can be worked out. This means that more focus is placed on administrative work. For example, N1 described to me the system she kept of patient appointments on her computer and how this now had to be sent to administrators. N2 described how complicated the system for reimbursements could get when they treat private patients from other hospitals.

The working conditions are also controlled by self-regulation and fear of litigation. Patients are becoming increasingly ready to resort to litigation if they feel they have been wronged. Nurses’ work has had to be restructured to account for this, again increasing paperwork. For example N4 explains how important she feels knowledge of documentation is. 'You have to be squeaky clean both on paper and on verbal and non-verbal, it's as simple as that. […] The phrase ‘it is my pin-number on the line’ was mentioned by several of the nurses. This repetition can be seen as an important element of nursing knowledge or part of nurse habitus. N3 notes that it was part of the informal knowledge gained during training. It serves to keep reminding nurses of the importance of being vigilant in their practice. I think the idea amongst nurses is as well, in any kind of big mess-up, if any, if the patient dies […] I think the idea that we were, you know the rumour that was passed down through our training as well is, that generally heads roll, because that's what people, that's what family members want, and generally those heads are nurses' and not doctors'. (N3, early-career nurse)


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3.1.3 Social Relations

Working conditions have changed over the generations by the different relations between healthcare workers. The emphasis is now on team-working between the different specialities and there has been a decrease in the hierarchical nature of hospital working.

Working conditions are influenced to a large extent by patients and their relatives. Nurses noted that restructuring, the choice agenda and consumerism has led to higher expectations from more assertive, knowledgeable patients and relatives, determined they will demand a good service in what the media terms 'the postcode lottery'. All generations of nurses complained about the changes they have seen in the public. As was noted in the hospital description at the beginning of this report, nurses experience physical violence from patients and relatives. The following sign was noted down during observations: "Significant violent behaviour in this hospital could mean you get a criminal offence. Any form of violence against staff working in the NHS is unacceptable. Zero tolerance means ridding the NHS of intimidation and violence. Staff working in the NHS do so to care for others. They do not go to work to be intimidated or face violence. Aggressive, violent and threatening behaviour does not go with the job and will not be tolerated any longer. Violence against staff within the NHS and council employees will be passed on to the police locally to handle."

Older generation nurse, N8 noted the changes in relationships with clients.

They're much more demanding than they were. And that's because they've been given the wrong impression of the health service. I think that comes from the very top, it's about these targets and you can have this and you can have that. [...] But there's a small minority and there is an increase in verbal abuse to staff. Yeah, and I've certainly noticed that. And it's not just your usual, 'I don't like you'. It's assault. It really is. (N8, experienced nurse)

Some nurses see the change in patients in a positive light with a new collaborative professional identity being built with better informed patients who are in charge of their own health. During observations, N2 and N9 (mid-career nurses) discussed how patients are getting more assertive and are sometimes seen as 'problematic' but in actual fact they saw it as positive if they had an 'expert patient' who was very involved and knowledgeable about their own condition and care as they could all work together to improve their health. N3 noted that as part of his course he had been instructed that the older generation of patients had a respectful attitude to doctors and medical staff and this had to be taken into account when nursing older people.

[...] it used to be [...]. 'The doctor says this and you follow the doctor's orders and you follow them to the T.' Whereas now people are a lot more assertive about, 'I don't want this, I don't want that, I've read this on the internet, I've read that here.' (N3, early-career nurse)

During fieldwork, it could be seen that nurses in the different generations displayed a slightly different approach in relations with the patients. The older generation nurses were more brusque and business-like when dealing with patients and less approachable, whereas the younger generations spoke to patients in a more collaborative way as equals. The habitus of the younger generation is more steeped in patient advocacy, holistic care and evidence-based nursing so it means their practice is more attuned to mutual negotiation with patients rather than the medical profession holding all the power.

Working conditions are affected by relations between nurses. Nurses have become a less homogeneous group with greater specialisation and new roles such as nurse-practitioners, nurse consultants, modern matrons or nurse prescribers. The older nurses talked about how the hierarchical structure of nursing has been relaxed over the years. N4 recalled how she would never speak to sisters in the past. She compared this to some of the staff today who she feels do not have enough respect. Although N2 is in her mid 30s, she can also remember some of the older nurses and their inflexible ward routines.
It, it's not as regimented as it used to be, and in some ways I think that's a good thing. I, certainly as a student went along to a ward, it was an elderly care ward, er, where the Charge Nurse used to insist on every patient getting out of bed and sitting by their bedside regardless of how they were feeling, [...] Whereas now there is far more holistic understanding, ... (N2, mid-career nurse)

Nurses related their working conditions could also be made harder by the negative attitude of some nurse colleagues and their motivation and practices. One nurse noted the frustration of working with some uncaring colleagues who did not treat patients 'like people' and the disheartening experience of handing a patient over to a disinterested nurse in a different ward and seeing the meticulous care the patient had been receiving was not going to be upheld.

Working conditions are affected by the relationship between doctors and nurses, with doctors having to change their attitude towards more autonomous nurses today. While observing the nurses, different relations between the doctors and nurses were observed. For example, N3 enjoyed bantering with some of the younger doctors on the ward and N2 and a consultant shared a very equal unit progress meeting. N4 was working closely with consultants taking over some of their workload as her advanced skills and knowledge were recognised. On the other hand, an example of the subtle dynamics of power embedded in everyday practices are noted in my fieldnotes when one nurse, after answering the phone, complained about the rudeness of doctors never saying their name when they answer the phone. They just say 'hello', and you always know it's a doctor. Another nurse stated that all the consultants she worked with were 'moody'. The issue of it being in doctors' interests to keep waiting lists long so they can profit by doing private work was also raised. So the doctor nurse relationship is still a source of some frustration across the generations as the following quote also demonstrates.

I mean, you see the junior doctors and the critical care sisters, and you know that the sister, her knowledge or his knowledge just exceeds the junior doctors' just outrageously, and yet they still have to say, you know, 'I think you should prescribe this', there's a certain amount of you know, yeah, which is madness. [...] you know, you're still playing it in this, 'you're the doctor, I'm a nurse', kind of bullshit. (N3, early-career nurse)

Working conditions for nurses are also shaped by working with increasing numbers of health care assistants (HCAs). A commonly expressed view is that by delegating jobs to HCAs, nurses fail to pick up on knowledge of their patients they would have gained through tasks such as bathing. Another issue is how nurses gain knowledge of managing HCAs. In the following quote N6 notes how being in charge of HCAs can cause more workplace stress.

[...] there seems to be an increase in tendency to take on Health Care Assistants [...] which can work on some wards. But I have worked on some wards where there are 14 or 15 patients, 2 staff nurses and 2 care assistants but that means you have 7 or 8 people with drugs to do. They seem to be doing a never-ending drug run. Then you try to help with washing in between and yeah...it is a dangerous way to go really [...] you do have to be careful really because you are responsible for them. So ultimately it will be your fault. You do have to watch your back a bit. It's your registration that is on the line if something goes wrong and that's the bottom line. I know if I make a mistake I can take the blame for that but if you are taking the blame for someone else's mistake then that is frightening. You feel a bit paranoid. (N6, early-career nurse)

Social relations and inter-cultural knowledge are important when working in a multicultural workforce. Since the 1990s there has been an especially big increase in overseas-recruited staff. For example, during fieldwork, staff were seen to be highly multicultural including workers from the Philippines, Australasia, India and Africa. During fieldwork, nurses discussed how working in a multicultural workforce needs negotiation and knowledge of the different occupational culture of nurses from overseas. Gaining knowledge about how to work with other nurses with diverse
professional identities is needed for team working. N5 noted progress had been made over the last 10 years in the hospital.

The doctors weren’t sure that they could trust the overseas nurses to use their judgement to make decisions and start processes rolling and the nurses felt offended, [...] and the nurses felt very, very threatened. They felt belittled and insulted and discriminated, (I: right) so it was all a bit emotional [...] but the mix of not just one cultural group, but several is actually quite good. It works better [...] so not just Filipino nurses, not just British nurses, not just Caribbean nurses, the mix; they seem to work better, to get on... (N5, mid-career nurse)

4.2 Professional Knowledge

A major problematic in this investigation are the multifarious conceptualisations and articulations of nurses' professional knowledge and expertise. This has been an issue in nursing since the 19th century when Florence Nightingale defined nursing knowledge as both an art and a science. She focused on 3 realms – i) the speculative (science), ii) rules and iii) insights gained through experience (Johnson and Ratner, 1997). Despite this, empiricism has reigned in nursing and the scientific paradigm and focus on clinical knowledge is still strong, especially with the rise of evidence-based practice. However, since Carper (1978) famously identified four patterns of knowing - empirical (the science of nursing), ethical, aesthetic (the art of nursing – social interactions and clinical experiences) and personal, nursing scholars have been increasingly interested in non-scientific knowledge. Benner has tried to articulate embedded and intuitive knowledge and the importance of experiential knowledge (Johnson and Ratner, 1997). Other common dichotomies noted by Thorne and Hayes (1997) are speculative versus practical; conscious versus unconscious; discursive versus non-discursive (Carper, 1978) or "know-how" versus "know-that" (Benner, 1984). Others have noted the multiple ways of knowing used in nursing (Giuliano et al., 2005).

However in this report the work of Eraut et al. (2004a) and Belenky (1997) will be used. Eraut has highlighted the importance of tacit knowledge Eraut (2000). In some recent work Eraut al. (2004a) researched early-career nurses, engineers and accountants and found professionals progressing along different learning trajectories in gaining knowledge in different areas - task performance, awareness and understanding, team work, personal development, role performance, academic knowledge and skills, decision-making and problem solving and judgement (see appendix 3). This typology of professional knowledge is useful when trying to interrogate the expertise of nurses in detail.

This data will also be approached from a gender perspective, as the majority of nurses are female. Belenky et al. (1997) note that feminist writers have convincingly argued that there is a masculine bias at the heart of most academic disciplines, methodologies and theories (Belenky et al., 1997:6). They find a historic absence of women as major theorists in social sciences and psychology. Consequently research has traditionally focused on autonomy, independency and abstract critical thought. But research has neglected knowledge of inter-dependence, intimacy, nurturance and contextual thought. In Women’s Ways of Knowing, Belenky et al. (1997) interview 135 women and examine how women conceive of themselves and the world. They outline five stages of knowing. They find there is 1) Silence: one blindly follows authority, sticks with stereotypes, women are treated like children 2) Received Knowledge: one listens to the voices of others, receives and reproduces knowledge from 'experts', 3) Subjective Knowledge: one listens to oneself and severs the sense of obligation to follow others views, truth and knowledge are conceived of as personal, private, and intuited, 4) Procedural Knowledge: one heeds the voice of reason, relies on objective procedures for obtaining and communicating knowledge and 5) Constructed Knowledge: one integrates their own opinions and sense of self with reason and the outside world around them.
views all knowledge as contextual; one values subjective and objective strategies and develops a narrative sense of self, high tolerance for internal contradiction and ambiguity. These approaches to knowledge combined with the Bourdieuan perspective as outlined at the beginning of the report will be returned to while looking at restructuring and its impact on professional knowledge and expertise in the conclusion of this report.

4.2.1 Tasks, requirements, demands

The professional knowledge needed to be a nurse has changed over the three generations of nurses. There are an increasingly widening range of career paths and roles in nursing today and jobs are increasingly demand specialised clinical skills and knowledge. Opinions differ about the extra tasks nurses are expected to do today, although there is growing acceptance that these are part of the job. A commonly discussed dilemma of nursing is that they feel that the knowledge required to do their job has become too technical - taking blood, giving drugs and doing paperwork and there is no longer any time for knowing the patients.

*Sometimes if someone else washes your patient for you, you give them the tablets and sort out a few other bits. You sometimes might hardly see them the whole day, which is a shame really. Some people might like it. Some don’t want to see their patients that much. But I came into nursing because I liked people.* [...]

4.2.2 Knowledge

Since the 1990s the growth of evidence-based practice as part of nursing knowledge and as a basis for best-practice, has been explosive. Current discourses include, evidence-based decision making, evidence-based nursing or evidence-based healthcare. This outlook relies on the scientific paradigm, but it can also be seen as a justification for cost-cutting and the rationing of treatment. It prefers the medical paradigm rather than the more holistic nursing outlook and fails to take into consideration the importance of tacit knowledge. French (2002) argues that ‘evidence-based practice’ is a euphemism for information management, clinical judgement, professional practice development or managed care. He notes that the term adds little more to the existing traditions of quality assurance and research-based practice. Estabrooks et al. (2005) argue that nurses are encouraged to take responsibility, and make decisions backed by evidence-based practice, however in reality much of their practice is actually founded on embedded tacit knowledge. So responsibility should not be forced onto the individual nurse but has to be taken by the collective organisation. N2 gave an example of her reliance on EBP in her work. She stated that she had been pushing for a certain treatment for a patient and had been told by a consultant that she had to find the research evidence to prove it was the best course of action. As N2 said, "your clinical knowledge has to be updated, kept updated, and you have to prove yourself, erm, all the time."

The importance of holistic care in nursing knowledge is also important. Nurses are encouraged to seek knowledge of the whole patient rather than see them as divided between specialisms. However, N9 commented that the holistic approach can be a trap for making nurses work harder and setting them up to fail as it is impossible to meet every patient's needs and be their psychiatrist and friend. Nurses additionally now need to be knowledgeable and confident enough to act as patient advocates - this maybe bring them into opposition with doctors or the NHS system. The difficulty of nurses to explain to outsiders exactly the demarcations of their practice and professional knowledge and their role as holistic carers is highlighted by the motif about caring for patients’ pet which was repeated by 2 of the interviewees.

*And that is the difference between a nurse, you know alright a nurse and a doctor, what is the difference between nursing diagnosis and a physician’s diagnosis?... I mean like doctors now, [...] they would not be interested if the patient is very upset because their dog died, you know. I mean, that is the holistic approach because from a nursing point of view if that patient is depressed or something is not right at home or they are worried about...*
Nurses spoke about the amalgamation of elements that combined to make up their professional knowledge. N4 for example outlined the knowledge that informs her practice as the combination of her clinical knowledge, her people management skills and her Trust knowledge.

*I mean, definitely from my clinical things. Erm, then another thing is how the actual, dare I say, [chuckles] Trust works, this big broad umbrella [...] you have to know about the NHS Plan, the targets, the political agenda, erm, what's happening within the Trust, the financial restraints. You need to have a bit of, obviously definitely people management, because obviously handling staff, erm, yeah, I mean, it's just, and it is my experience, I mean, over the years you just er, pull on all that knowledge and it just comes as second place to me, and whereas if you know, someone was newly-qualified they'd probably be floundering really, I suppose. I mean, I just, I've just been doing it for so many years, I mean, I go from one thing to another....* (N4, experienced nurse)

4.2.2 Learning

Changes in education are an important difference in the habitus of different generations of nurses and are reflected strongly in the interviews. Nurse education was restructured with the introduction of Project 2000 in 1988. The hospital based nursing colleges were amalgamated into the university system over the 1990s and the old ethos that existed in the schools of nursing where the emphasis was on practical skills was dropped in favour of more academic disciplines of psychology and sociology (Bradshaw, 2001). Nurses today graduate with either a Diploma or a Degree in Nursing. The experienced nurses described their rigid old style training in a school of nursing rather than a university, which had included nationally set exams and on the job training and where students had a book that had to be ticked off before they could qualify. Emphasis was placed on the character of the nurse trainee. N4 described strictly assessed procedures such as bed bathing where there was a set way of bathing patients, left arm first, then right etc and any deviation meant exam failure. The significance and elitism surrounding university attendance was alluded to by the older generation of nurses who had not had the opportunity to attend for their initial training. Meanwhile massification of university education had demystified it for the younger generation for whom education was as special or valued particularly. Due to this educational restructuring a theory/practice divide developed between the older generation of practical nurses and the younger academic breed of 'new professionals'. The new breed were criticised in the media and by older nurses as being "too clever to care" and lacking in practical skills and knowledge. However, starting with a pilot scheme in 2000, university training courses have now been reformed with more emphasis again placed on practical skills. Students now go on the wards earlier in the course and for longer periods, they have a "home" hospital and the practice part of the course now has to be at least 50% of the student experience. The generational divide appears to have faded although it was mentioned, for example by N4 and N1. Nevertheless some of the early career nurses interviewed were critical of their training courses which they felt were still too theoretical and lacking in anatomy and physiology. For example one nurse stated modules such as - *The Social Context of Health Care* and *Professional Nursing Practice* were unnecessary as the content was obvious. N3 stated, 'We also did human biology, which was just a joke...[...] I got like 98%, and just through, it was, you know, through nothing they'd taught me'. N3 seemed to be typical in valuing practical learning experiences rather than theoretical approaches.

_The practical understanding is how I work as well. If you show me something on the ward, this is how I think anyway, and this is why I enjoyed placement, if you show me something on the ward and explain to me how that works in relation to a person I can remember, I mean, that goes in a lot quicker. I've got loads of stuff that I just know, like drugs, drugs, how you mix them up, how they go in, you know, how they work, what they do, and that is...*
through repetitive practice and erm, as opposed to just book memorisation. (N3, early-career nurse)

Another change in nurse training is that shortages meant the nursing profession has been opened up with increasingly wider access, for example cadet and apprenticeship schemes for HCAs and APEL (Accrediting Prior Experiential Learning) courses. The calibre of student nurses and the stringency of their courses has come under criticism. Drop out rates on courses are high and universities are penalised for failing students. Interestingly N7 entered university through an APEL course after working as a HCA and unlike the other newly qualified nurses, she found the sociology and psychology and holistic approach a total eye opener and noted that the training had turned her around as a person.

Life-long learning is now seen to be key in nursing knowledge. The hospital Trust 2005 Staff Survey shows that nearly all nurses received some professional training in the last 12 months. Fieldwork and interviews demonstrate that the hospital provides a learning environment with many of the nurses outlining extensive training in their own specialties and undertaking degrees, MAs and modular courses. N1 for example had attended university in the 1980s one day a week for a year to undertake an MA course without loosing pay, something she said would not happen today. Some nurses today feel pressure to update skills especially as some specialist roles are not available to them unless they have a degree. During fieldwork, N2 outlined how she had instigated teaching on her unit to increase the skills and knowledge of younger members of staff. However, when I returned to carry out the second interview these plans had been shelved due to the cut backs causing a lack of staff. One nurse was observed signing up for study days during fieldwork but later stated that it was necessary to push oneself forward for these courses and take responsibility for one's own professional development and that it was sometimes difficult to get on courses.

Nurse registration has been restructured since 2000, with nurses now having to re-register every three years with the Nursing and Midwifery Council (NMC) and demonstrate professional development if requested as part of this. Consequently nurses are very aware of the need to keep up to date and have evidence of this.

I think it's good, actually, you should, you should have to show professional development. [...] you should have to prove if you're called upon, definitely. But, equally I think the registration fees are a bit [laughs] heavy, and a bit, and also you should be given the time to, erm... my director is actually very good at giving you study time, a lot of places aren't, but you should be given that time as part of your workload. (N2, mid-career nurse)

Nurses’ ICT knowledge has increased as it has across society in general. During observations, all the nurses were observed working on computers for tasks such as looking up patient notes, appointments, drug lists or blood and x-ray results. The nurses were also seen to be receiving work-related e-mails. Not all of the computers were able to access non-NHS related sites. Mid-career N5 worked noted how, initially the nurses were saying, ‘Oh we nurses we are here to care, [...] I don’t care about computers - avoid, avoid, avoid’ and now they embrace it - tentatively, but they embrace it. One nurse who was observed confidently using computers confessed that in her previous hospital there had been less ICT and she could not sent an e-mail; however she noted that she had quickly learned.

Personal challenges of life were mentioned by some nurses as important to their professional knowledge and practice. Nurse training emphasises reflection on practice as a way surfacing experiential knowledge (Schon, 1983). One nurse noted how experiencing serious illness herself had made her work 'from a completely different perspective'. Dealing with the emotional labour (Sheward et al., 2005, Smith, 1992) involved in nursing is something that may need to be negotiated as the following quote illustrates.

33 http://www.healthcarecommission.org.uk/nationalfindings/surveys/staffsurveys.cfm
I thought to myself, ‘I can’t do this job if I am going to be like this’. Because no job is worth going home and worrying yourself to death about it. And also my first job I worked with a lot of cancer patients, a lot of young cancer patients and that was very upsetting. [...] But I do find it easier to switch off. Maybe that’s just because I am older now. I think you get a bit more hardened really. But you have to be. I don’t think I’ll go back and do that sort of nursing because I just find it too hard going. (N6, early-career nurse)

Personal development and knowledge acquisition also obviously depends on the stage in the life course. For example one of the older nurses stated she would not be taking any more courses as she did not think it was worth it when she was retiring soon. N1 explains that despite her years of experience, she would no longer feel confident practicing outside her speciality in any capacity today due to the increase in high dependency patients.

 [...] you know that’s being realistic you know, the stuff you have now, the pumps and the monitors and things are new, you know and I wouldn’t know how to use them, um, you know, you could learn how to but, um, no, the skills that you would need today are very different to the skills I needed then [...] it’s the speed things are done now. [...] now if you go onto the wards everybody is really ill, (I: yeah) so it is very, very different. (N1, experienced nurse)

Meanwhile the younger nurses are more likely to be seen as keen to learn. Although N3 (early-career nurse) was aware that this could be taken advantage of on the ward and joked with another colleague when asked to do something, “What do you think I am, young and keen?”

Feedback and support from colleagues functioning in a community of practice is obviously an important area for improving confidence, professional knowledge and allowing professionals to develop as is demonstrated by this diagram by Eraut (2004).

Collegial support is important for gaining knowledge and for lifelong learning, but lack of support is a theme across the generations and the years as was also highlighted in the quantitative data presented at the start of this report.

 [...] it doesn’t matter how much work you do in training people or, encouraging people to look for support, or offer support and supervision, it really doesn’t happen and that is something that has been all the way through. [...] I mean I think now with appraisal and things like that there is more opportunity but it depends how you feel about your manager, whether you’d feel safe to actually say, ‘look I’m not, well I just don’t know how to handle this’, (N4, experienced nurse)

Bullying is a reported problem in the NHS and was reported in the life history interviews. This obviously affects professional experiences, knowledge and learning. One nurse talked to during the fieldwork stated that within the Trust there used to be a huge bullying culture from the top. Another nurse noted the difficulty of managing staff who were aware of their rights and ready to accuse colleagues of discrimination or bullying if pulled up for not doing their jobs correctly. Another nurse, while working in a previous hospital outlined how the destructive experience of
bullying led to her crying and being sick at work and how the harassment had included access to training being denied. During fieldwork, some departments reported better team spirit and support than others. One nurse reported having to go on two separate Christmas events as there was a divide between workers on her ward. Another mentioned feeling unsupported as their mentor had left and had not been replaced. A common attitude was noted that you cannot be too nice in nursing or other people will take advantage of you and so assertiveness is an essential skill.

4.3 The Nursing Profession and its Social Position

4.3.1 Symbolic Capital: respect and prestige

The nurses involved in this study felt that the public do not understand what nurses do and felt that the media representation of nurses was unhelpful. N4 noted, ‘You know, you see how they perceive nurses, that is not seen now as a profession and that is a shame really because nursing is a profession.’ The historic problem is that knowledge that nurses possess is often belittled and undermined as coming naturally to women and this hampers their attempts to gain greater status as a profession. N2 explained when her father went into hospital he gained a greater insight into the knowledge of his wife, who had been a nurse for 30 years.

So he said to her when he came out when he was much better, and it was a real opening for them, actually, real, quite a big, major thing, he said, ‘I'm so sorry, I had no idea how clever you were or how much responsibility you had’. And he really didn't, he just thought she was just, used to go along and wash bottoms and... (I: That's heartbreaking isn't it.) Yeah. And they were both hurt and elated by it at the same time. Yeah. (N2, mid-career nurse)

Nurses felt that respect for them has declined especially due to media reporting of hospitals that perform poorly and receive bad ratings. N3 describes in the quote below approaching patients who come in with a defensive, confrontational attitude.

[...] you've people come in and they say, 'I've read about this place in the [paper]' and I just think, 'You haven't read about me, individually, why don't you trust me for seven and a half hours', and that's what I say, I say, 'Look', I say, 'OK, whatever, you know, fine, you've heard bad things, but I, let's, me and you can start afresh, whatever you find with other nurses, whatever you find with anyone else, that's fine, but don't judge me on it', you know, and that's frustrating. You just think, people come in and they're shitty, before they've even, they're pissed off with you for poor care before they've even met you, and experienced what care you kind of, you know, that you give. (N3, early-career nurse)

4.3.2 Pay

Despite increases in pay under New Labour, nurses reported feeling under valued by their perceived poor pay. N6 for example stated she found the pay disheartening and that the NHS relied on the goodwill of nurses working over their hours. She stated she got the same pay as a postman and she obviously had far greater responsibilities. N3 said the pay was fine for a single person, but if you had to support a family it would be difficult. Meanwhile N4 stated she would have an adequate pension and was looking forward to retiring. A new pay scheme named Agenda for Change has been introduced across all NHS staff (apart from doctors) and the old nursing bands (A to G) have been replaced with new pay scales. Agenda for Change was seen positively by some nurses, for example N4 notes that the new scales are supposed to be reward skills and knowledge and allow fairer career progression. However, other nurses were critical of the paperwork involved and worried about the re-grading of their jobs. Pollock (2005: 251) notes Agenda for Change has prepared the ground for ‘local pay bargaining and widening inequities in pay and terms and conditions’.

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5 Worklife Balance

Worklife balance can be seen as a theme in the nurses’ life stories with the phrase, ‘you work to live, not live to work’ being mentioned by nurses across the generations. Loyalty and devotion to one’s work is seen as being unappreciated but despite this all the nurses professed to working more hours than they were contracted to (collaborating the Trust survey data). The younger generation talk about work life balance but are they putting this into practice in reality? N4 for instance could be seen as a typically older generation nurse and professes to working far too hard. She stated that she worked overtime regularly and always had done. N4 said that her husband came to collect her every day otherwise she would stay on as there was always work to do.

[...] do you live to work or do you work to live? Erm, I suppose I am a bit too conscientious, and I'd be the first to admit that, but why break a habit of a lifetime? [laughs] I've always been like that, it's how I work. (N4, experienced nurse)

In contrast, early-career nurse, N6 stated the most important thing in her life was her family, partner and friends and she wanted to forget about work when she went home not worry about it. Meanwhile N3 also values free time to pursue outside interests over work.

I mean, I worked on, [current ward]'s it is good. I mean, I'm happy with what I can do here. But I worked on units that were great in [town 1], and the nurse in charge, I mean, just lived and breathed the ward, the, you know, working seventy hour weeks, which is fine for them, but it isn't for me. I mean, I don't, I think I'm more, I work to live, I don't live to go to work (N3, early-career nurse)

N3 also noted the difficulties women especially face with work life balance issues.

If you're forty and you've got kids, you don't want to come in and you don't want to run around for eight hours and if you did long days, fourteen hours. I mean you don't, you can't be knackered when you get home, you can't..(N3, early-career nurse)

It has been suggested that in a less regulated job market where there is a culture of performativity, social interaction and collegiality is degraded (Senett, 1998). Evidence from the different generations of nurses on this issue is hard to unpick due to the life course effect – younger people tend to socialise more than older generations. However, experienced N4 was said she did not socialise with her current colleagues at all, although she did say she had nurse friends from years ago that she socialised with. She suggested that work is less enjoyable than 20 or 30 years ago as the increased pressure and throughput of highly dependent patients has meant increased responsibility for staff. "I'm sure they don't have that much fun, I mean, as a newly-qualified nurse I didn't even think about targets [...] you could have a bit of fun." However, the early-career nurses said they did go out on work social events and for drinks with colleagues. N6 noted that one of the good things about being a nurse was that it was a fairly young profession and when you started a new job on a ward, you could immediately have 15 new friends. However this was qualified by the statement - "not all wards are like this".

6 Restructuring and Gender

6.1 ‘Symbolic Violence’ in a Historically Gendered habitus?

Over the three generations of nurses the dynamics of gender relations have changed. Most obviously nurses have become more autonomous. However, Walby (1986, 1990) argues that the move from the 19th and 20th century has been a change from private to public patriarchy as the state has taken over the control of women's labour and terms of employment through occupational
segregation and inferior part-time work (cited in Zulaf, 2001). The individual life stories themselves contain many references to gender – highlighting how nursing is a historically gendered habitus and how life chances/choices are rooted in gender as well as the socio-cultural situation of the family. Narratives highlight how women’s choices in the past were rooted in family, class and gender expectations and this has changed over 3 generations. The older generation of nurses note how there were only two career paths open to them in the past - nursing or teaching. In contrast when there are so many other career choices for women today, nursing has become much less popular.

The biographies also note how traditional notions of women’s caring work are reproduced within families. For example, N2 (mid-career nurse) followed in her mother’s footsteps despite her father’s warnings about the anti-social hours and bad pay. N4’s mother was also trained as a nurse before marriage and her grandmother was a St John’s Ambulance nurse. N1, was inspired to become a nurse dressing up in a cousin’s uniform when she was a child.

Bourdieu (2001) argues that women are complicit in maintaining the male hegemony as they do not question the taken for granted practices and thought categories that subjugate them. To an extent this attitude could be seen as operating in this professional sample, for example the nurses expressed dissatisfaction with pay but did not bring up voluntarily that this might be related to their gender. However, Bourdieu’s stance fails to take into consideration the long history of complex subjugation nurses have faced in challenging the hierarchical status quo in their profession. Interestingly, it was the male nurses who mentioned the gender issue more than the women. For example one nurse noted how in the past women were excluded from going on courses due to gender - “a lot of people were being excluded from that because, they had been married, and they’d had marital commitments and they couldn't do that and, and that was wrong.” Another male nurse noted various issues arising working in an environment as the minority gender. There is discrimination against male nurses from colleagues such as stereotyping attitudes that male nurses cannot clean or multi-task. This was noted in my fieldnotes, for example, a male nurse was observed being jokingly blamed, due to his gender, for leaving a urine bottle where it got knocked over. The rule in some hospitals that male nurses are not allowed to catheterise female patients can also be seen as a lack of trust in male nurses. However the advantages of being a male nurse in a female profession were seen to outweigh the disadvantages. The experience of being male in nursing means preferential treatment in the job market. It also involves helpful dynamics such as patients often assuming male nurses are doctors and being in demand by patients due to being a minority.

7 Conclusions

7.1 Restructuring and Working Conditions

Snapshots from the narratives of nurses have highlighted the working conditions and habitus of different generations of NHS nurses working under restructuring. From one viewpoint, English nurses may be seen to have good working conditions. Apart from recently, they have enjoyed an environment with many job opportunities. They have permanent jobs, a pension scheme and they can take early retirement. They have opportunities for a variety of career pathways, flexible working arrangements and opportunities of continuing professional development. However, despite this, N1 (experienced nurse) stated that morale was currently the lowest that she had even known it the hospital due to the instability created by fear of redundancies and uncertainty about how the NHS was being ‘dismantled’.
7.2 Restructuring and Professional Knowledge

Using Eraut’s (2004) typology, it can be seen that various areas of professional knowledge have all been affected to some extent by restructuring over the 3 generations. The academic work of nurses has been restructured with the move into universities and the increase in more academic epistemologies. Historically, nurses depended on practical knowledge within a working context where power was held by doctors and value was placed on the medical scientific, positivist paradigm. However, the development of nurse education has meant that wider outlooks have been incorporated into nursing knowledge and given more value. Nurses are now encouraged to draw on both practical and more theoretical learning. Life-long learning is now essential to the job. Task performance and role performance are different especially with the specialisation of medicine and nurses now carry out extended technical roles. Nurses are involved in using ICT for accessing patient information and updating their own knowledge. The internet means information circulates more quickly and nurses are required to be flexible. The speed at which nurses have to work has increased as over the years and there has been a steady increase in the throughput rate of patients and consequently their dependency has increased. Nurses have been called upon to increase their collaborative team work and negotiate with an increasing number of other allied healthcare professionals and outside agencies. They also have the job of managing the increasing numbers of health care workers. These roles call for development in the awareness and understanding and personal development categories. Increases in litigation and the development of nurses as autonomous practitioners mean that judgement and decision-making knowledge and the documentation of practices has increased. So Eraut’s typology is useful in illuminating different areas of nursing knowledge that have changed.

Using Belenky’s et al’s (1997) typology is also interesting when viewing the data however. Firstly the book underlines the importance of the role of gender in the construction and control of knowledge. Secondly the nursing profession's knowledge can be viewed as located within the typology. So the nursing profession has moved from being a receptacle for received knowledge and procedural knowledge in the past when nurses relied heavily on the 'given' knowledge of doctors and the medical paradigm to being an autonomous profession acting as patient advocates on the basis of their own professional constructed knowledge. Nurses today are encouraged to practice based on their own constructed knowledge from education and training combined with practical knowledge and experience of their patients’ holistic needs. However, the importance placed on the evidence-based practice paradigm and best-practice could be said to be forcing nurses back into the procedural knowledge category.

7.3 Restructuring and social position

The life history interviews elicit the changes that have occurred in nurses’ social position over the last 35 years. Firstly the nurse narratives highlight societal restructuring and how patients and relatives have changed. Nurses now have to deal with a more demanding public with greater awareness of their rights and less respect for professionals, meaning work places become more fraught and stressful. Media representations of nurses now include the discourse of nurses who are ‘too posh to wash and too clever to care,’ and have lost control and influence on their wards leaving them dirty and harbouring the super-bug MRSA. Nurses have to deal with the vicious circle where bad media about the NHS means the public already have a poor impression of services before even having accessed them. Nurses are freer from the old fashioned paternalism and power that doctors used to exert over them and work in a less hierarchical organisation. However, at the same time, nurse autonomy has decreased with the huge increase in managers urging greater efficiency with targets to meet and greater regulation of the profession (eg. the need to re-register every 3 years with the Nursing and Midwifery Council (NMC) demonstrating evidence of learning). Specialisation and extended roles are seen by some as positive while others see the government getting mini-doctors on
the cheap and fragmenting nurse unity. Difficulty in recruitment of nurses for the last 10 years until recently demonstrates that the public accept nursing is a stressful profession. Nurses noted they felt the profession had lost prestige over the years and was not valued despite the increases in material rewards under New Labour. A favourable economy in the last 10 years in England has also meant more job opportunities especially for women. However, the nurses noted that there were intrinsic benefits of working in a caring profession and they enjoyed working with people and valued the different work ethic of the public sector.

7.4 Restructuring and Work life balance

The nurses narratives tell of frustration by new initiatives they do not feel benefit patients, staff shortages, the level of care they can give, the lack of support, media attacks and the vicious circle this creates with patients becoming more demanding and more critical. The nurses find it hard to find a good work life balance. N4 for example is looking forward to retirement. N2 fears redundancy.

 [...] yeah, I mean I actually love my job and what I do. If things change too much or this, I don't know, [...] if my job were to be on the line here, then that's probably what I'd do, is actually sell my house here, move up to nearer my sister and do that, just get out of nursing altogether until it settles down a bit, if ever. (N2, mid-career nurse)

N3 also discussed the stresses of nursing and contemplates future career choices.

 [...] I just think that you burn out at some point. And everyone, everyone does. I mean, everyone burns out, or, or it becomes your complete and utter life. And the system is such that I'm frustrated by it already. And I mean, and I'm never going to change the system so... [...] I mean, I love looking after people, and I love people and meeting new people, but [...] I'm not just going to settle into a life of kind of monotonous nursing, and half-heartedly running a ward... [...] half-hearted nursing is worse than no nursing at all, I think. And I think, you know, I think that I would get half-hearted if I stayed in it forever. (N3, early-career nurse)

7.5 Restructuring and professional Strategies - (non) Resistance?

Today professionals in different fields are vilified in the press with incompetent members regularly attacked in the media. But at the same time, professionals appear to be in greater demand and more relied upon than ever and they need to be in possession of increasing amounts of knowledge and expertise. Davies (1995) describes how the ‘old profession’ of nurses had tried to gain status following the traditional model of elitism, paternalism, authoritarianism and exclusive knowledge. Changes in society mean this model is no longer a basis for professions due to greater public scrutiny, increased regulation and high profile media scandals about negligence and criminality. Consequently the ‘progressive nurse’ professional now has to gain legitimacy by partnership, collegiality, collaboration, shared knowledge, reflective practice, evidence-based practice and lifelong learning.

One professional strategy is to oppose the NHS funding cuts, redundancies and further restructuring. The Royal College of Nurses (RCN) has joined NHS Together, an "unprecedented alliance" of unions including the British Medial Association (BMA) and the Royal College of Midwives to fight against the current rapid changes in the NHS. However, the nurses interviewed felt that restructuring of the NHS would continue as neither the Conservative or Labour parties want to stop the marketisation process. Nurses stated that the NHS could be broken up and replaced by an insurance system. Nurses across the generations appeared to be resigned to this and unwilling to fight it. During the observation period, a demonstration was called in the hospital by the group Keep
our NHS Public.\textsuperscript{34} However it was not a huge success, demonstrating the growth of individualism in England and the failure of collective action to ignite the imagination of NHS workers.

\begin{quote}
N8: I think there was only about fifteen people there, I heard.
I: Oh, really.
N8: Yeah. Let's just get on with it. We're here to look after patients, and we've got to do what's right for them. As long as they don't suffer, I don't mind people protesting, but...
N7: [...] I said 'Well, you're all fighting that you don't want any more redundancy and 'scuse me I've just been taken on full time permanently.' I said 'I'd be a bit of a hypocrite to come down to your rally, I feel'. Erm, and when I thought about it afterwards I thought, 'Oh, that's a bit pious, really wasn't it, you know.' I don't care about anyone else now, it sounds like, you know, I've got my job, so, you know, bless them all, but...
\end{quote}

(N8, experienced nurse, N7, early-career nurse)

N2 expressed her feelings about NHS restructuring.

\begin{quote}
I: And what about the future of the NHS?
N2: Er, it's crashing. It's going to crash, to me it's going to crash fairly soon [...] it'll probably be over the next ten years. I can't, it can't continue, I, no matter what government you have, I don't think that'll change.
I: You don't think they'll be prepared to defend it?
N2: No, it's gonna be, no I don't think any of them will, they won't put the money in to support it.
I: Like, I think they had a demonstration or something here, didn't they, and hardly anyone turned up.
N2: [...] Erm, also like myself, I was actually going to go, but I was just too busy. I was on the ward. You know, who can actually get off and go? They say, 'Go in your break time' but, you know my break time that day was sort of three o'clock, so that, that, and I'm sure that was the same for a lot of people. (N2, mid-career nurse)
\end{quote}

Since this fieldwork was carried out, the Trust has announced more restructuring including ward and unit closures across the Trust hospitals in a bid to save extra money. The prospect of this has fired up staff and patients to demonstrate in local town centres.

7.6 Restructuring and Generations

The idea of different generations who have been imprinted with a specific historical identity according to when they were born is not new (Abrams, 1982, Edmunds and Turner, 2005, Mannheim, 1952). Edmunds and Turner (2005) combine Mannheim (1952) and Bourdieu’s (1990, 1993) work to argue that generations are engaged in a fight over resources. They describe how trauma combined with opportunity and leadership can create “activist” generations that manage to monopolise resources for themselves. Later ‘passive’ generations may be less successful in maintaining a favourable situation for themselves. They also discuss the growth of new global generations – marked by shared global real time experiences - notably September 11\textsuperscript{th}. Using this theory, the older generation of nurses – trained during the 1960s and 1970s would be seen as having managed to appropriate economic and cultural capital for themselves setting the scene for decades with their popular culture and generous social provision and working conditions. It can be seen there is some truth in this proposition. Many of this generation of nurses in England have secured themselves pensions, early retirement and enjoyed a generous NHS. Meanwhile, the younger generation finds these social goods are being attacked, they have less stable work conditions combined with intensified labour regimes and media reports of collapsing pension schemes are frequent. However, part of the younger generational attitude involves not being prepared to fight to preserve these social goods. Alternatively as N1 stated, the public may just not have grasped the

\textsuperscript{34} http://www.keepournhspublic.com/
seriousness of the situation due to being distracted by the war in Iraq and it being a Labour government that is carrying out the restructuring. Alternatively, the feeling of powerlessness to stop changes in the NHS can be seen as part of the decline of social capital (Putnam, 2000) in England.

The nursing interviews can be seen to show an increase in individualism in society (Giddens, 1991, Beck and Beck-Gernsheim, 2002) for example the decrease in union activity. One older generation nurse discussed belonging to a nursing union. Another experienced nurse told me the only time she had involved herself with the RCN was when she had recently written a letter about the proposition that the retirement age for nurses should be raised. Younger generation nurses simply did not raise the issue of unions.

A major difference between the generations is the knowledge they bring from their nurse training but in practice nurses share a common working context and do not speak of a wide generational divide. The theory/practice divide and debate about nurses not having time to spend with patients affects nurses across the generations. Tensions between the generations created by their different initial nurse education appear to be fading. Older generation, N4 for instance did express some disapproval the younger generation's sloppy attitude to dress codes. But apart from this, the older generation appeared to have adapted their attitudes with the times. This also applied to worklife balance, where across the generations, nurses talked about 'working to live, not living to work', but in practice were observed working very hard and putting in extra hours. Differences over knowledge of IT are important, but older nurses, were observed as competent computer and internet users.

7.7 Restructuring and Periodisation

The nurses' biographies underline how government restructuring has hugely changed the working environment. Since the 1980s the introduction of New Public Management, contracting out and devolving responsibility for the long term sick created tensions in nurses work as they have to work with new agencies. Nurses' workload has increased as patient throughput in hospitals has steadily increased. The introduction of public star ratings and targets has increased pressures hugely. Increased privatisation and Payment by Results has also created more work for nurses and destabilised and eroded the ethos of the NHS. The 'golden age' of welfare provision with the privileging of public sector professionals is over – will a 'silver age' (Taylor-Gooby, 2004) continue or are we about to witness the selling off of the family silver in England with implications for the working lives of nurses?

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Appendix 3

A Progression Typology (Eraut, 2004)

**Task Performance**
- Speed and fluency
- Complexity of tasks and problems
- Range of skills required
- Communication with a wide range of people
- Collaborative work

**Awareness and Understanding**
- Other people: colleagues, customers, managers, etc.
- Contexts and situations
- One’s own organization
- Problems and risks
- Priorities and strategic issues
- Value issues

**Personal Development**
- Self evaluation
- Self management
- Handling emotions
- Building and sustaining relationships
- Disposition to attend to other perspectives
- Disposition to consult and work with others
- Disposition to learn and improve one’s practice
- Accessing relevant knowledge and expertise
- Ability to learn from experience

**Teamwork**
- Collaborative work
- Facilitating social relations
- Joint planning and problem solving
- Ability to engage in and promote mutual learning

**Role Performance**
- Prioritisation
- Range of responsibility
- Supporting other people’s learning
- Leadership
- Accountability
- Supervisory role
- Delegation
- Handling ethical issues
- Coping with unexpected problems
- Crisis management
- Keeping up-to-date

**Academic Knowledge and Skills**
- Use of evidence and argument
- Accessing formal knowledge
- Research-based practice
- Theoretical thinking

Knowing what you might need to know
Using knowledge resources (human, paper-based, electronic)
Learning how to use relevant theory (in a range of practical situations)
Decision Making & Problem Solving
When to seek expert help
Dealing with complexity
Group decision making
Problem analysis
Generating, formulating and evaluating options
Managing the process within an appropriate timescale
Decision making under pressurised conditions

Judgement
Quality of performance, output and outcomes
Priorities
Value issues
Levels of risk
CHAPTER 3

Irish nurses’ work and life under restructuring: Professional experiences, knowledge and expertise in changing contexts

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1 Introduction

The overarching ambition of the Profknow project is to understand knowledge at work among nurses and teachers as professional actors, situated between the state on one side and the citizens on the other side. This report is related to workpackage 5 of the project and concerns life histories of Irish nurses. The title of the workpackage is “European Nurses’ work and life under restructuring: Professional experiences, knowledge and expertise in changing contexts”. It aims “to get a deep understanding of nurses’ personal experiences of work life changes and of professional expertise in the present as well as over time” and “to present ethnographic descriptions and analyses of nurses’ work and life”, in an Irish context.

This report examines how restructuring in healthcare in Ireland has changed nurses, their working lives, and their professional knowledge by documenting the identities of three generations of professionals. Life-history interviews with nurses were conducted focusing on thoughts, feelings and judgements about changes that have occurred in healthcare during their career as a nurse. The individual biographies illuminate different outlooks and personal approaches of nurses but vividly highlight their shared working environment and demonstrate how restructuring has altered the profession and what life is like for these nurses in Ireland.

This text was created with the help of recorded and transcribed stories about the lives of nurses. The stories are told by three nurses, but have also been supported with notes from shadowing these three nurses.

With regard to our conception of professional knowledge, as practitioners, as well as researchers and academics, we are aware that much knowledge is tacit and remains unarticulated. From a more intellectual perspective, we readily recognise that concepts of knowledge are contested and problematic, particularly when considering the epistemic through a postmodern lens. The tacit unarticulated can be readily captured when we consider, for example, recognition of a person’s face among a thousand though usually we remain inarticulate about how this knowing works either practically, theoretically or conceptually. We take some comfort from Schon’s (1983) notion that competent practitioners usually know more than they can say. They exhibit a kind of knowing in practice, much of which is tacit.

According to Schon (1983) knowing/knowledge has the following properties.

• There are actions, recognitions and judgements that we know how to carry out spontaneously; we do not think about them prior to or during their performance.
• We are often unaware of having learned to do these things; we simply find ourselves doing them.
• In some cases, we were once aware of the understandings which were subsequently internalised in our feeling for the stuff of action. In other cases we may never have been aware of them. In both cases, however we are usually unable to describe the knowing which our action reveals.
When intuitive, spontaneous performance yields nothing more than the results expected for it, then we tend not to think about it. But as Schon (1983) states

> when intuitive performance leads to surprises, pleasing, promising or unwanted we may respond by reflecting in action. Reflection tends to focus interactively on the outcomes of action, the action itself, and the intuitive knowing implicit in the action. (p.56)

For example, when a nurse’s method of communication with a patient leads to an unexpected outcome, s/he may reflect on the phenomena before her/him and on the prior understandings which have been implicit in her/his behaviour. S/he may then carry out an experiment that serves to generate both a new understanding of the phenomena and a change in the situation.

While much of knowledge therefore may be regarded as tacit, this is not the whole story. There is espoused knowledge, while there is also a knowing in the doing, a knowing in action. Rather than differentiate sharply between espoused knowledge and practical knowledge, or knowing in action, we prefer the Aristotelian notion of phronesis as it captures the wisdom of practice rather than a more reductionist notion of skill whereby the latter becomes separated from understanding and judgement. We regard phronesis as encompassing the theoretical and the practical and holding them in productive tension. This is the theoretical turn that we bring to data analysis.

The carrying out of the Irish case studies followed the objectives set out by the Technical Annex, the guidelines provided by the Finnish partners and the agreements reached at project meetings. By examining narratives of the lives of three generations of nurses, changes in the work-place and professional identities can be investigated. The term restructuring will be used to refer to 1) societal changes such as a change in population demographics 2) national government inspired changes affecting Health especially since the 1990s and 3) changes occurring from within the nursing profession.

The hospital where fieldwork was conducted was chosen because it was thought that the process of securing ethical approval would be less bureaucratic than other hospitals. Following a submission to the Hospital Ethics (Medical Research) Committee in October 2005 we were told that our study did not require their approval. The Hospital Committee stated that it would be considerably more appropriate if our protocol were submitted to the Research Ethics Committee of St Patrick’s College. We were also advised to seek permission from the Director of Nursing of the Hospital to carry out our study. A member of the ethics committee informed us that the Nursing Research Access Committee may or may not wish to review the study. The Research Ethics Committee in St Patrick’s college reviewed and approved the study in November 2005. Subsequently we submitted our proposal to the Hospital Nursing Research Access Committee. Due to a long term illness of a member of the Hospital committee the proposal was not reviewed until March 2006. Permission was refused at this time owing to concerns about the ethical implications for patients and other members of the health care team. After measures to ensure confidentiality and anonymity were made more explicit, final approval was granted in April 2006.

Notices about the project were put up around the hospital and an advertisement was placed in the hospital newsletter. Cognisant of the fact that this method was not a particularly expedient way of recruiting participants, a meeting was arranged with a divisional nurse manager and a member of the school of nursing. The aims and objectives of the project were explained and they agreed to approach suitable candidates corresponding to the requirements set out by us.

Actual fieldwork started in late April 2006 and finished in July 2006. The first participant completed one interview and then secured a new position in the hospital so was unavailable to take part in the rest of the study. A replacement was quickly found. The first round of interviews
was semi-structured following the thematic guidelines distributed in the Consortium by the Finnish colleagues. Our clear emphasis during fieldwork, analysis and report was on the working conditions, social relations at work and knowledge/professionalization. Maeve Dupont conducted all interviews and ethnographic observations. Interviews were later transcribed and observations were returned to the nurses for their feedback. The first and second interviews combined extend between 51-62 pages for each participant when transcribed. Subsequently a draft of this report was given to the nurses so as to ensure that it constitutes an accurate representation of their thoughts, judgements and experiences. This was part of a process of triangulation and verification of our interpretation of data with nurses. Thus we attempted to increase the authenticity and trustworthiness of the accounts (see Lincoln and Guba, 1985). It was also intended to carry out focus groups and thematic interviews with additional participants so as to further 'test' our findings. However, given the considerable wait (3/4 months) to secure ethical approval we feared that to do so would significantly delay our report and ultimately our European partners in their process of comparative analysis. Hence, the focus groups did not take place. However, we are confident that with regard to both teachers and nurses that our account has been 'validated' by the participants themselves, thus lending significant credibility and dependability to the accounts in the cases.

2 National context

The Irish Health Service

Broadly speaking, there are three different types of hospital in Ireland but there is very little difference in practice between the first two types:

- Health Service Executive hospitals, owned and funded by the Health Service Executive
- Voluntary public hospitals, most of whose income comes directly from the government. Voluntary public hospitals are sometimes owned by private bodies, i.e., religious orders. Other voluntary public hospitals are incorporated by charter or statute and are run by boards often appointed by the Minister for Health and Children
- Private hospitals, which receive no state funding.

Public health services are provided in what can broadly be termed the public hospitals - Health Service Executive hospitals and public voluntary hospitals. Most of these hospitals also provide private health care but they must clearly distinguish between public and private beds.

There are a small number of purely private hospitals that operate independently of state health services in Ireland. If patients opt for private care in a private hospital, they must pay the full cost of treatment and maintenance.

Private and semi-private hospital care in Ireland is also provided in public and voluntary hospitals. If patients opt for private care in a public or voluntary hospital, they must pay for their maintenance at a rate set from time to time, in addition to public hospital in-patient charges.

According to the report of the Commission on Financial Management and Control Systems in the Health Service (The Brennan report, GoI, 2003) the Irish health service employs almost 100,000 people and spends almost €9 billion annually. Between 1997 and 2002 spending has gone up by 125% and employment has risen by over 25,000. However the same report (GoI, 2003) found that existing resources are insufficient to meet demand. Furthermore it is anticipated that demographic changes will increase pressure on the health system. The report states that

To continue to increase the resources at the rates achieved in recent years is unsustainable; hence much greater effectiveness and efficiency will be required. (Brennan report, GoI, 2003, p. 6)
The report heard evidence that despite the substantial increase in health spending

- 3,000 additional acute hospital beds and 1,000 additional medical Consultants are needed to satisfy current demand.
- Some of the most expensive acute hospital beds in the health service are used inappropriately.
- Some of the time of Consultants is wasted because they have to cancel admissions, surgery or treatments when their beds are reassigned to patients admitted through Accident and Emergency departments.
- The underutilisation or underprovision of walk-in (ambulatory) day surgery was seriously compromising the throughput of patients and productivity.

This and other reports have been influential in driving the reform of Irish health services. In recent years, national health policy in Ireland has undergone dramatic change and an extensive health service reform programme is underway. It is hoped that the reforms will: improve the nation’s health care system, reconfigure existing services and processes of care and introduce new ones, and ensure quality and value for money. The reform programme is directed by the national health care strategy - *Quality and Fairness: a Health System for You* (DoHC, 2001). The strategy has four principles: Quality and fairness, People centeredness, Accountability, and Equity. These principles have, in turn, determined four national goals for implementing the strategy: Better health for everyone, Fair access, Responsive and appropriate care delivery, and High performance (DoHC 2001). The key bodies in the reformed health system are the Health Service Executive, the Health Information and Quality Authority and the restructured Department of Health and Children.

The Health Service Executive (HSE) was established on a statutory basis under the Health Act 2004. On January 1, 2005 the HSE took over responsibility for management and delivery of health and personal social services from the Eastern Regional Health Authority (ERHA), the health boards and a number of other agencies.

The Health Information and Quality Authority (HIQA) has been established on an interim basis and the necessary legislative proposals will be submitted to Government in the near future. Its responsibilities will include promoting and implementing quality assurance programmes; overseeing health technology assessments; developing a strong health information evidence base for decision-making; and assessing whether health and personal social services are being managed and delivered to ensure the best possible outcomes within available resources.

The Department of Health and Children (DoHC) has divested itself of involvement in the operational delivery of health and personal social services. Its current focus is instead, on providing the overall organisational, legislative, policy, financial and accountability framework for the health sector. A core responsibility of the Department is to hold the HSE to account in relation to its financial and service performance, as well as its effective implementation of Government policies.

Six frameworks structure the planned reform of the Irish health service. Each framework has been addressed in a dedicated report commissioned by the Government. These include: Primary Care: A New Direction (DoHC, 2001a); Report of the Taskforce on Medical Staffing (The Hanly Report, DoHC, 2003); Action Plan for People Management (DoHC, 2002); Report of the Commission on Financial Management and Control Systems in the Health Service (The Brennan Report, GoI, 2003); Audit of Structures and Functions in the Health System (Prospectus Report DoHC, 2003a); and National Health Information Strategy (DoHC, 2004)
2.1 Local context

The Hospital is located within one of the networks of the Health Services Executive (formerly the Eastern Regional Health Authority). The Hospital provides acute care services across more than fifty medical specialties. The Hospital offers both in-patient, day patient, out-patient and casualty services to the population which it serves. The Hospital partakes actively in the city’s Accident and Emergency services and in addition has Regional and National speciality commitments for patients suffering from certain diseases and illnesses.

These commitments are decided upon by the Department of Health in consultation with the Health Advisory Body of Comhairle na nOspideal which determines the numbers and types of consultant appointments and oversees the rationalisation of medical services. The Department of Health co-ordinates centrally these arrangements to ensure that a comprehensive, integrated range of nationally available services are provided without duplication.

The Hospital currently has a bed complement of over 600 beds. It provides a 24 hour continuous emergency call service for its own catchment area of approximately 250,000. An average 60 patients per day are admitted for trauma or elective treatment making it one of the busiest general hospitals in the country.

The hospital is the principal undergraduate and post-graduate medical training and research centre attached to a college of medicine and houses its own undergraduate and post graduate nurse training school. It shares its campus with the College and has very strong academic links with it as most of the consultants on the staff hold undergraduate or post-graduate lectureships or professional appointments in addition to their clinical caseload.

The hospital is managed by a Board of Management nominated by the Minister for Health & Children comprising of representatives from the Department of Health, Eastern Health Board, College of Medicine, local political representatives and representatives from local voluntary bodies. The Board has 15 members and are accountable by law to the Department of Health & Children for the provision of an acute general hospital care service centred around the hospital. The Board’s role is to determine hospital policy and priorities in line with the Government’s National Policy on Healthcare. The day to day managerial and operational responsibilities of the hospital are entrusted to the Chief Executive who is appointed by the Board and is directly accountable to them. The hospital has a staff of over 2000 people covering approximately 250 disciplines and an annual financial budget allocated by the Department of Health and Children to enable the hospital to function.

Since the hospitals funding is received via the Department of Health & Children from the Exchequer its main priority is the treatment of public patients who by law once eligible are entitled to out-patient and in-patient care. The hospital does, however have a number of beds specifically designated for the treatment of private or semi-private patients who are insured by the Voluntary Health Insurance Board and BUPA.

The hospital, as a major teaching centre, must ensure that it has the variety and mix of patients and clinical material necessary for academic and service needs. Therefore it draws its patients from a wide range of areas. The patient mix and caseload vary from day to day and are dependent on admissions via the Accident & Emergency Services or on patients seeking elective (non emergency) treatment.

There are two main sources of admissions to the hospital, emergency cases transferred by ambulance following accidents or elective patients referred by General Practitioners/other
hospital doctors for specialised treatment. The hospital has a bed occupancy level of almost 100% daily so the demand for services in certain cases can far outweigh the capacity to supply.

There are a number of major external factors which will impact on the hospital: New partners and new players; Population health approach; Value for money and procurement; Hospital based funding-casemix; Quality, Patient expectations; Technology and Procedural shifts; and Changing demographics.

The hospital participates in the National Casemix Programme. Casemix is the comparison of activity and costs between hospitals by analysing each hospital’s ‘mix’ of patients (their ‘casemix’) into discrete ‘Diagnoses Related Groups’ (or DRGs) which are clinically meaningful and consume similar levels of resources. The programme aims to fund hospitals for the patients they actually treat, at a cost per case which is determined by their own peers. Casemix analysis was used to make small adjustments to a percentage of the in-patient budgets; the remaining percentage was based on the hospital’s historical allocation. The Department of Health and Children announced their intention to increase the impact of Casemix on hospital budgets from 20% in 2005 to 50% by 2008.

The hospital’s bed capacity is insufficient at present to service the needs of its catchment population and tertiary referrals. Current figures show a bed occupancy rate of over 100%, where best practice for an acute hospital of its size and profile recommends a bed occupancy rate of 85%. Excessive occupancy levels create inefficiencies and in addition, there is significant evidence, across City Hospitals that the lack of bed capacity contributes to problems in the area of infection control. The demographic trends nationally also point to the need for additional capacity requirements.

The hospital works within a number of operational constraints. Examples of these restrictions include fixed global revenue budgets, scarcity of public capital funding, annual budgetary arrangements, skills shortages, Whole Time Equivalent ceilings and the impending demands of the European Working Time Directive. Given these and other restraints the hospital faces an ongoing challenge to grow and develop services within these strict limitations.

3 Each collaborator’s life course in a nutshell

3.1 Nora- 3 years experience

Social background and Educational background (primary and secondary)
Nora grew up in Dublin. When she was in school she describes herself as being a mediocre student and said she wouldn’t have had enough points to do nursing. She commented how her mother was told once that I would probably get a job in a corner shop.

Choice of a profession, professional education, qualifications obtained
At the time she was leaving school there wasn’t the opportunities there are today. She felt that there wasn’t a huge variety of options available to her. She mentioned teaching, the police force, secretarial work, business and nursing. She liked the secretarial work and pursued that. She did a secretarial course and then secured a job working for an airline. She moved up within the company and became a customer supervisor. It was a very responsible job with good perks. She was there for eleven years and felt that she was in a rut. There was an offer of a redundancy package and she took it. She had thoughts of doing nursing when she was in school but wouldn’t have had sufficient points to gain entry to a nursing course. She applied for nursing as a mature student and was accepted following an interview and aptitude test.
She completed a three year diploma course in nursing. She got the highest marks in the year and was awarded student of the year in her final year. She attributes her success to a system she had for answering questions. Most of her training was in the school of nursing within the hospital. She thinks the experience made it easier to adapt to working in the hospital because she was in there every day. She is glad her training is over but she enjoyed it and "got stuck in".

She is continuing her education by applying to do a higher diploma in her area of specialty. She wants to learn more. She has also done some study days where she has earned certificates. There is no obligation to do these courses except for Cardio Pulmonary Resuscitation (CPR) and manual handling. They have to keep updated in these areas.

**Professional career and current job**
She did a placement during her training on a surgical ward and the ward sister said that she would give her a job if she applied. Nora is a staff nurse working in a surgical ward and has been working on the same ward for the last two and a half years.

At this point in her career she feels that she would like to expand her knowledge because she wants to know more about various medical conditions. It is also a way of advancing her career. She comments that further qualifications are necessary if you want to progress.

> the way it is in nursing now is that everybody has degrees, there are a lot of people with masters, there’s a lot of people with higher diplomas. Everybody has something...management courses. And ok you can be a nurse but you certainly won’t progress with not even a degree I suppose now.

She commenced a diploma course in her area of specialty in September, 2006.

**Family relations, hobbies, friends and networks**
Nora lives with her husband and her two children. She lives a convenient distance from the hospital. She has very good family support and gets great help with childcare which allows her to be flexible if she is needed at work. Her mother also works in the hospital as a care attendant.

### 3.2 Ellen- eleven years experience

**Social background (childhood family)**
Ellen grew up in Dublin. She was the second youngest of a family of eight. Her parents operated a business from home and she was exposed to a good work ethos and a drive to do well.

**Educational background (primary and secondary)**
Ellen attended local primary and secondary schools. Her favourite subject was biology and she described herself as a diligent student.

**Choice of a profession, professional education, qualifications obtained**
Ellen was always interested in ill health and the body. After school she did brief work experience in a hospital. In addition, her father and grandmother’s ill health exposed her to the hospital environment. She enjoyed the hustle and bustle of the health system and her sibling and first cousin shared numerous anecdotal stories about their experiences as nurses which she found intriguing.

She started her nurse training in the early 1990’s. It was a certificate course of three years duration and at the end of it she gained a Registered General Nurse (RGN) qualification. At that
time there were two intakes of students per year. In 1991 additional block (lecture) time was added to the curriculum.

She enjoyed her nurse training. She felt that the busy clinical ward placements prepared her well to adjust from the student nurse to the staff nurse role.

Since her basic qualification she has gone on to further study. Her qualifications include: a certificate in infection control, higher diplomas in critical care and subspecialty. She has had to travel to the UK for distance learning courses in her disease specific area. She is in the process of completing a Masters in the same disease.

**Professional career and current job**
Ellen has been working predominantly in the hospital in which she trained. Following a one year temporary contract in Intensive Care she was made permanent. After returning to work from maternity leave she needed to work more regular hours and so discontinued shift work to work on a medical ward. That role has since evolved into a Clinical Nurse Specialist (CNS) role which is a Clinical Nurse Manager 2 (CNM2) grade.

Ellen currently works predominantly off the ward in a specialist role. She operates a telephone triage service for patients with a particular condition. She also forms part of the multi-disciplinary team in an outpatients clinic for people with this condition. She has never been unemployed.

**Family relations, hobbies, friends and networks**
She lives with her husband and two children. She recently returned to work full time and her husband juggles a number of projects. They find this works well with childcare. She takes time for interests and hobbies.

### 3.3 Aideen- eighteen years of experience

**Social background and Educational background (primary and secondary)**
Aideen grew up in Dublin. She thoroughly enjoyed primary school and was very upset when she left. Secondary school was equally enjoyable and she made some really good friends. She said that she had a drive to do well, studied very hard and describes herself as a total and utter perfectionist. She was the class captain nearly every year and then was appointed school head girl in her final year.

**Choice of a profession, professional education, qualifications obtained**
Upon completion of secondary school Aideen studied for a Bachelor of Science degree. One evening during second year on her way home from college she was passing by a hospital The lights were on and she could see the nursing staff and thought and she recounts how something just clicked with her. She didn’t know anything about nursing. The idea of being in a caring profession and working with people appealed to her.

She trained to be a nurse in a children’s hospital. She gained a qualification of registered sick children’s nurse. It was a three year certificate course. They were primarily based in the hospital and had block lectures. There was a twelve week preliminary assessment where they had exams every week. If they didn’t pass they were let go.

She describes her training as very strict. It was run by the nuns and student nurses lived in the convent during their schooling. They had to be in at ten o’clock at night. At that time students
most of their time on the wards. The director of nursing would do rounds every day and they had to know their patients inside out \textit{“and every single thing to do with them.”}

Following her qualification in 1989 she applied to do a one year postgraduate course in general nursing. It was a very common career path at that time and gave Sick Children nurses more options of where they could work. She graduated with first class honours in 1990.

About three years after gaining the general qualification she did a course in her area of specialty. She has done a diploma in Management in a college of medicine that was a year’s duration. In addition she did a one year diploma course in Communications in the same institution. She has also gained a diploma in Teaching and Assessing. The latter course lasted for six months. She did a two year leadership programme that was \textit{unbelievably difficult to get onto.}

\textit{it was absolutely excellent. It wasn’t academic as such. It was much more practical, for example how to work and how to be a leader}

She was funded by the hospital to do the programme. She also has a degree in nursing. She did it by distance learning in three years.

\textit{Professional career and current job}

Following Aideen’s postgraduate qualification in general nursing she secured a position as a junior staff nurse on a 35 bed surgical ward. She then moved to another surgical ward as a middle senior staff nurse. Subsequently she worked in an Intensive Care Unit (ICU). It was at this point she decided to do a higher diploma in the area of the specialty. It was a six-month certificate course. As part of the course requirements she moved around a number of wards within the specialty. She returned to work in the ICU and about a year later the junior ward sister’s post became vacant. She applied for the position. According to Aideen, the management knew her and her track record and felt she could do the job so she got the post. Six months later the senior ward sister was promoted so Aideen remained in the acting post for about a year. In 1999, a divisional nurse manager went on maternity leave so Aideen applied for her job and got it. After maternity leave the former divisional nurse manager wanted to job share but was not permitted in a divisional nurse manager position. Hence Aideen applied for and successfully secured the permanent post.

Aideen currently works as a divisional nurse manager. She has responsibility for a particular division within the hospital.

\textit{Family relations, hobbies, friends and network}

Aideen lives with her husband and her two young children. She gets great family support. Her own mother looks after her children while she is at work and her husband loves to cook so he takes care of meals.

\textbf{4 Thematic Analysis}

The nurses’ experiences, thoughts, perceptions and judgements with regard to various aspects of their working lives and the Irish Health system in general are presented below. This information is supplemented with observation data and the evidence is organised into themes and sub themes. Following each theme the comments are put into context by referring to relevant literature and restructuring processes in the Irish context. The impact of restructuring on their professional life and professional knowledge is discussed as appropriate.
4.1 Working conditions

4.1.1 Working hours

Nora is currently working reduced hours. She takes twelve hours parental leave per week so she only works two 13 hour shifts. However, during the weeks prior to observation the ward was short staffed so she was working three shifts per week.

Nurses on Nora’s ward generally work thirty-nine hours a week and this is divided into three 13 hour shifts. Three such shifts amounts to 36 hours. Hence, every few weeks, nurses work four days to make up the 39 hours. There are two shifts on Nora’s ward: the day shift and the night shift. Each shift lasts thirteen hours with one hour for breaks. Previously, there was a two hour overlap where twice the amount of nurses were on duty. This system changed because it was felt that half an hour was sufficient time for nurses to handover patients to staff coming on duty.

Ellen is paid for 39 hours a week. She is very busy and feels that she utilises every minute as best she can. She said that it is very difficult to convey the idea of clocking in and out in the health service.

_Clinical needs take priority. Even though you are officially off duty, completion of duties is required especially in roles that are 9-5, with no other nurse taking over duties outside of those hours_ (Ellen)

Aideen starts work at 7.50 in the morning and she finishes at around 6.00 in the evening. Her contract does not specify rigid hours of attendance as the duties and responsibilities sometimes require attendance outside normal office hours. For example, she may have to attend a meeting at 7.30pm. She is meant to work from 8.30 until 4.15 but feels that she could never be organised enough to leave at that time. She states that most of the divisional nurse managers work more than their contracted hours. Indeed Aideen was observed to work longer than her contracted hours.

According to Profknow survey data\(^\text{35}\), approximately 22% of nurses normally work over 41 hours per week. This includes paid or unpaid overtime. When asked to state their basic or contracted hours each week only 2% of those surveyed indicated that their contracted hours are greater than 41. These findings suggest that a considerable proportion of nurses work overtime. Perhaps they are motivated to increase their earnings by working additional hours.

Restructuring and working hours

The reduction in Nora’s working hours has been made possible by The Parental Leave (Amendment) Act 2006. This Act allows parents in Ireland to take parental leave from employment in respect of certain children\(^\text{36}\). Since 18 May 2006, leave can be taken in respect of a child up to eight years of age. Parental leave is available for each child and amounts to a total of 14 weeks per child. Where an employee has more than one child, parental leave is limited to 14 weeks in a 12-month period. The 14 weeks per child may be taken in one continuous period or in separate blocks of a minimum of six weeks. If the employer agrees, leave can be separated into periods of days or even hours (as in Nora’s case). However, during observation there was talk that the option of taking parental leave in periods of days and hours would no longer be

\(^{35}\) In autumn 2005, the Profknow survey was launched to a total of 8,800 teachers and nurses in Ireland, Finland, Spain and Sweden. It dealt with questions of work-organisation; authority and power; professional practical knowledge and expertise.

\(^{36}\) Employees are not entitled to pay from their employer while they are on parental leave nor are they entitled to any social welfare payment equivalent to Maternity Benefit or Adoptive Benefit.
available to new applicants. Perhaps the Hospital felt that such practice exacerbated staffing problems.

Jobsharing/ flexible working is an option available to Hospital staff. Flexible hours and flexible working arrangements (like jobsharing) are generally at the discretion of individual employers and are not governed by specific legislation. It appears that the Hospital has been influenced by the ‘Nursing and Midwifery Recruitment and Retention Initiative’ that was launched by the Minister for Health and Children in 2000. The initiative includes a range of measures key amongst which are more flexible working arrangements for nurses and midwives enabling them to work on a permanent part-time basis. The initiative is designed to attract qualified nurses and midwives currently not working back into the public health service, retain nurses and midwives in the public health service and address the need for more trained nurses in specialist areas.

Aideen’s working hours may be understood in the context of the demands of recent Health reforms and the problem of staff shortages. This will be discussed in the section entitled professional knowledge and skills.

4.1.2 Staff shortage and limited resources

Nurses of all three generations talk about staff shortages, limited resources and intense workload and how that impacts on their work.

As a recently qualified nurse Nora works on a surgical ward. She comments how a lot of people have got promotions and they haven’t been replaced. Hence they are short staffed by four or five people. If a patient dies on a ward she feels they should take time out or go for a break but often there isn’t the availability to do that because it is too busy and they have to get on. Reduced staff numbers make Nora feel that despite prioritising her work and doing what she has to do she cannot give what she should be giving. She can only do a certain amount. Lack of staff means her workload is intensified and because of time constraints she may neglect to do things like oral hygiene

*it’s not that I don’t want to do it or I don’t aim to do it. It’s just that I haven’t got the time often and you are rushing a lot.* (Nora)

Similarly, Ellen feels there is a conflict between her duty of care as a nurse and resource constraints. She finds it very difficult to refuse to support and advise people outside the catchment area if they phone her service. So when she advises, word spreads, and then she is in a situation where she needs extra resources. Ellen comments that there is a two tier health service, with both private and public patients feeding into one public service. A service plan is developed requesting additional resources through the identification and priority of needs. However there is a ceiling on nursing posts so she feels it doesn’t matter what service plan she produces because there is no resources filtering down to her.

Aideen comments how recently there has been a huge amount of administrative work in the hospital. For example initiatives such as Accreditation and Hygiene require staff to spend considerable time documenting evidence that standards are being met. Aideen thinks it is a problem that nurses have responsibility for implementing changes associated with these initiatives yet their resources have never been increased. There is no staff to assist with the extra work. Similarly, if a new consultant comes on board she feels that the allied health care should come with them and often that is not the case. As a result the nurses’ workload is increased because there is a higher turnover of patients but they get no resources.

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37 Accreditation is a quality initiative that involves evaluating the service and seeing what improvements can be made.
The nurses' remarks are supported by the Profknow survey data. 80% of respondents strongly agreed that the work climate has become more demanding since they first started working as nurses. In addition, a majority of nurses\textsuperscript{38} cited lack of economic resources and time as serious obstacles to the realisation of ideas in work.

Although a considerable number of international nurses were recruited (in order to cope with the shortage of nurses) it appears that their introduction has not been without its problems. For instance, they only get six weeks to acclimatise to the Irish system. This is possibly inadequate given that they come from different cultures and training systems. Aideen comments how nurses from certain cultures had less responsibility in their home countries.

\begin{quote}
the overseas nurses that have worked in the Phillipines and India (where) doctors did a lot more. Nurses would never have told relatives that a patient was dying. This is part and parcel of work here... they would never have spoken to families ... about the patient's condition (Aideen)
\end{quote}

It follows therefore that such responsibilities are left to nurse colleagues who have trained in Ireland.

While the introduction of international nurses has not really impacted on Ellen (because she is not based at ward level) Nora comments that international nurses are like new nurses, even though they may have eight or ten years experience. She feels that it takes them a while to get used to the Irish system and way of doing things and that they need direction.

\begin{quote}
Some of them are excellent [... they] are taking charge of the ward but they would be there ... four and five years at this point. Some of them definitely wouldn't be up to that (Nora)
\end{quote}

Hence, it is possible that (in some instances) the introduction of international nurses has inadvertently intensified the workload of some nurses trained in Ireland.

\textit{Restructuring and nursing shortages}

The shortage of nursing staff on the wards may be attributable to a number of structural changes in the Irish health system and the nursing profession.

Firstly the format of nurse education has changed. A new undergraduate four year honours degree programme has been introduced as the pathway for entry to nursing in Ireland. The programme is fully integrated within the third-level education sector. The latter point is significant because student nurses are no longer part of the workforce. Previously a student nurse was a salaried service provider and so occupied a dual role as learner and employee (An Bord Altranais 1994). Moreover the need to provide service meant that there were two student intakes for training per annum. The degree programme has just one intake of students per year. In addition there were no nurse graduates in Ireland in 2005 because the last cohort of nurses from the previous three year programme qualified in 2004. The first group of nurses participating in the degree programme qualified in June 2006. Hence, the reduced intake and the absence of student nurses on the ward created a demand for more qualified nurses.

Although the Department of Health recruited more nurses following the introduction of the degree programme there were difficulties filling vacancies. There were a number of factors that contributed to this problem. For instance a substantial proportion of nurses continue to seek

\textsuperscript{38} 53.5% of those surveyed strongly agreed that lack of economic resources was a serious obstacle to the realisation of their ideas in work. Similarly, 66.6% strongly agreed that lack of time was also a serious obstacle.
career and travel opportunities abroad. According to the Nursing and Midwifery Resource (DoHC, 2002a) the statistics on the number of verifications of qualifications issued gives an indication of intent of a nurse or midwife to travel. In 2000 and 2001, despite the considerable shortage of nurses and midwives in Ireland a significant number of verifications (1,017 and 1,294 respectively) were requested. A submission from the INO (INO, 2006) provides support for the practice that nurses seek better career opportunities and remuneration abroad. They report that almost 12,000 Irish trained nurses have left this country since 1998; this represents an average of over 1,500 per year which equals the number of nurses educated in Ireland each year.

Turnover also has an impact on staffing levels. According to the National Study of Turnover in Nursing and Midwifery (DoHC July, 2002b) the nursing profession in Ireland is experiencing a major challenge relating to shortages of registered nurses and midwives. The same study considers the rate of turnover in nursing and midwifery a significant problem across services in the Irish health care system. Results of the turnover study show that the two major reasons for leaving a current position were reported to be to pursue other employment in nursing (35%), and to travel abroad (21%). A further 12 per cent left to pursue studies in nursing. A variety of other reasons were reported including, to study outside nursing (14%), to pursue employment outside of nursing (4%), and being unhappy/discontented (5%).

Consequently, a number of recruitment and retention initiatives have been implemented by the Department of Health and Children including, the funding of part-time nursing degrees and specialist nursing courses. Moreover, many nurses have been recruited from overseas. According to a study by Buchan and Sochalski (2004) in the year 2001 about two-thirds of new entrants to the Irish nursing register were from other European Union and international sources. Nurses have been recruited from countries such as India, Philippines, South Africa and Nigeria. The Irish Nurses Organisation (INO) expressed concern about the current policy of widespread recruiting from these countries. They state that this policy

*cannot deliver the stable workforce required to expand Irish health services to meet current inadequacies and future demand.* (INO, 2006, p. 4)

When recruiting nurses for a ward position skill mix is an important consideration. Skill mix is the balance between trained and untrained, qualified and unqualified and supervisory and operative staff within a service area (Needham 1996). For example Nora commented that despite the availability of newly qualified graduates they cannot fill all the vacancies on her ward. This is because there would be too many inexperienced nurses working on the ward at the one time which would have implications for patient care and newly qualified nurses’ access to a preceptor. Similarly, the introduction of international nurses with little experience of the Irish health system has implications for skill mix.

The ceiling on the recruitment of whole time equivalent staff (including nurses) has an obvious impact on nursing staff shortages. The government introduced a head count ceiling in an effort to curtail excessive hiring of staff. In his Budget speech (delivered on 4th December 2002) the Minister for Finance announced that numbers employed across all sectors of the public service are to be capped at their present authorized levels with immediate effect. The announcement was made as part of wider efforts to move Ireland’s expenditure, pay and cost levels onto a lower growth trajectory given the changed economic and financial circumstances.39 According to the Brennan Report

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39 There was a downturn in the Irish Economy prior to the Brennan report. See Budget 2002: Macroeconomic Context and Fiscal Stance as accessed at http://www.esri.ie/UserFiles/publications/20060831091230/Budget02chp_Duffy_Macroeconomic%20context.pdf
there remains, at least in the short to medium term, a place for an employee numbers ceiling, consistent with the overall budgetary allocation, as an additional tool in budgetary management. (GoI, 2003, p.95)

The shortage of staff impacts on the nurses’ professional lives in the sense that workload is intensified and they are under increasing pressure. At times they feel that they cannot deliver the care they would like because there simply isn’t the time. Workload is of concern within the nursing and midwifery workforce, and has been cited as a reason for leaving the professions. The DATH’s (2000) report (as cited in DoHC, 2005) on nurse recruitment and retention ranked workload fourth out of nineteen categories for most important factors that lead nurses to consider leaving an organisation.

Restructuring and lack of resources

There are a number of possible reasons for the lack of funding for resources within the hospitals. Such factors include: the method of allocating funds, changing demographics; expensive technological advances; and a lack of accountability in the health system for service planning, budgeting and expenditure control. Each factor will be discussed in turn to demonstrate the possible effects on the availability of resources within the hospital.

The main source of hospital income is the allocation it receives from the Health Services Executive. Funds are allocated annually and according to an incrementally based estimates process. As a consequence hospital allocations are largely a reflection of their historical funding positions. However, there have been significant demographic and social changes over the years (e.g. changes in the size and age profile of the population within the region) that have implications for health service delivery and needs but are not reflected in the Hospital budget. Funding is not determined in a manner that captures these changes in society. Hence, the hospital struggles to meet service needs within its budget.

Another possible contributory factor to the lack of resources is the system of allocating funds annually. Such a system is not conducive to longer-term service planning, although there is a multi-annual planning framework in place for capital expenditure. It is possible that funding sought on the basis of the expenditure to be incurred in the relevant year only does not adequately capture the full cost implications of many developments. Consequently, the hospital may struggle to fund some developments.

The changing demographics of Irish society have put additional pressure on limited resources. The Irish population has grown considerably in the past ten years. The catchment area for the Hospital in particular has experienced considerable growth due to the recent housing development that has occurred to support the rapid expansion of greater Dublin. The population boom is largely due to a favourable economic climate. According to NCCA (2005) during the late 1990’s and early 2000’s, significant labour shortages developed which had a negative impact on economic growth. The number of workers from EU countries was not sufficient to meet the economy’s labour needs. As a result several thousand work permits were issued to Non-EU citizens to fill specified jobs. In addition there was a large increase in the number of immigrants seeking asylum.

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40 Report of the Working Group to examine the development of appropriate systems to determine nursing and midwifery staffing levels (DoHC, 2005)
41 A percentage of the Hospital budget is also determined by the Casemix programme.
42 In 2004, 34,054 work permits were issued to Non-EU citizens (see NCCA, 2005).
43 Between the years 1991-2004, the number of people seeking asylum rose from 31 to 4,766 (see NCCA, 2005).
Resources have been further strained by the change in patient mix. Although the age profile of the hospital’s catchment area reflects a young population, the census figures for the catchment area show an overall decline in the proportion of people aged 0-14 and an increase of 10% in the population aged 65 years or over. In one of the Hospital’s community services areas, the population over 65 years grew by 26.3%. This is significant when one considers that currently an estimated 30%-40% of total healthcare spending is on those aged 65 and over, a group which comprises only 11% of the population. Treating older patients in hospital is far more complex and costly than treating younger patients. Hence the change in patient mix puts increasing pressure on already strained hospital resources.

Adverse health indicators such as the growth in obesity and alcohol consumption constitute factors generating increasing demands on Irish health services (Annual report DoHC, 2006). Obesity is directly associated with a number of serious diseases including diabetes, heart disease, many forms of cancer and high blood pressure. In Ireland, 47% of people report being overweight or obese (SLÁN, 2003) and it is estimated that obesity accounts for up to 6% of Ireland’s total health care costs. According to the Strategic Task Force on Alcohol: Interim Report (DoHC 2002c), a pilot study of alcohol related attendance in the emergency room showed that alcohol was a factor for one in four (25%) of those in attendance at the hospital Accident and Emergency Department and 13% were clinically intoxicated.

Technological advances (that necessitate the purchase of expensive equipment) also place demands on limited financial resources. Aideen referred to a procedure that enables patients to avoid the need for open-heart surgery. The equipment necessary to perform such a procedure is very costly and the Hospital budget does not reflect that expense. However, the Department of Health and Children announced their intention to increase the impact of Casemix on hospital budgets from 20% in 2005 to 50% by 2008. This will allow hospitals to receive money for the patients they actually treat, at a cost per case which is determined by their own peers.

The Brennan report (GoI, 2003) found a lack of clear accountability throughout the health system for service planning, budgeting and expenditure control. The absence of planning and accountability may mean that service providers are less likely to use resources efficiently. Clinical consultants are considered to be the key decision makers affecting expenditure in hospitals yet they are not required to account for the cost of resources consumed as a direct consequence of their clinical decisions. For example, they may choose a more costly procedure (such as drug eluding stents rather than cardiac surgery) in the interest of optimal patient outcome. Even though resource management is already part of the consultants’ common contract, the Brennan report (GoI, 2003) asserted that resource management responsibilities are not being systematically and uniformly discharged because of the absence of appropriate mechanisms for planning outputs and budgets and monitoring expenditure. According to the same report (GoI, 2003) consultants’ common contracts as they currently stand contain inherent weaknesses that impede the full application of general principles of financial accountability by clinicians. For example, existing arrangements allow consultants to pursue both public and private practices which may restrict the time available to pursue resource management issues.

Under the European Working Time Directive (EWTD) the average working hours of Non Consultant Hospital Doctors must fall to no more than 48 hours per week by August 2009. The impending demand to reduce doctors’ working hours will necessitate the employment of more staff. Increasing staff numbers will put additional demands on already constrained financial resources.

4.1.3 Management

General opinion
During her training Nora came across some nurses who were mean and rude. They would have had an attitude where student nurses should do all the mundane tasks ‘I have done it so you can do it type thing’. Fortunately Nora thinks that the ward sisters on her current ward are very flexible and that is one of the reasons she is still working there. She said that even though they are flexible they like the ward to run smoothly and the ward sister would call people in if they weren’t pulling their weight. If Nora gets called into work and she accommodates them they give her a day off if she has to go somewhere

they would make it their business to … help me out because I helped them out (Nora)

Nora didn’t like how on another ward the supervisors were very rigid about breaks. She doesn’t think that’s the right way to treat people who are in a stressful job for thirteen hours a day. According to Nora treating staff well is particularly important when you want the best out of them.

Ellen echoes Nora’s sentiments about being treated well. She feels that nurses

They really need to know from hierarchy that roles are valued and from the most senior nurse to the most junior nurse…to feel valued maintains motivation and standards alike (Ellen)

Ellen feels that nurses lack strong leadership within the hierarchy of nursing. According to Ellen, encouragement to develop and innovate services exists from medical peers but rarely from nursing management.

Aideen thinks there is a very clear structure in nursing. There is a definite pathway for people to know which way to go and who to go to if there are any issues with patients or nursing. In the past it has been criticised for being hierarchical

if there is a good working relationship with all of those people it works really really well. (Aideen)

Restructuring and management

Nora and Aideen’s comments regarding the control of nurses’ tasks and management hierarchies were also referred to in the report of the Commission on Nursing (GoI, 1998). During the consultative process of the Commission on Nursing (GoI, 1998) a range of issues were identified. One such issue was the perception that nursing and midwifery management was preoccupied with hierarchies and the detailed control of nurses and midwives rather than the management of the nursing and midwifery function.

The Commission (GoI, 1998) also identified a need to examine the recruitment, selection and training of nurse/midwife managers in order to ensure that the profession had an effective cohort of leaders capable of responding to changing service needs. There is evidence that the hospital actively attempts to recruit effective leaders. According to the minimum qualifications (necessary to be considered for appointment to a nursing management position in the hospital) candidates require a recognised nursing management diploma or degree and evidence of recent or ongoing post-registration studies. Furthermore, evidence of leading and motivating staff is considered essential. Perhaps Ellen’s comments about the lack of strong leaders are aimed at managers that were appointed prior to the stipulation of such minimum qualifications. It is also possible that some members of management have been overwhelmed by the pace and demands of Health reforms. This may have impacted on their ability to motivate staff effectively.
**Problems with management**

Management is criticised for unrealistic expectations. Ellen feels that Nursing management would say that it’s up to her to make protected time to do research. But she doesn’t consider that practical with her caseload. Furthermore, Ellen is frustrated that management want services developed but there are no resources or finances to develop services.

> the management of an organisation should be developing services alongside clinicians and finding the resources in order to do that (Ellen)

She is also bothered by the lack of consistency and transparency with which projects are funded.

> Money is being found for some projects and other projects are being declined and there is no consistency of why some are declined and some are accepted… I don’t think there is transparency enough about the money in this organization (Ellen)

Nora has concerns about too much flexibility in the management of the ward sometimes. There are too many visitors at beds early in the day and that shouldn’t be allowed because of patients’ privacy and their care. She also recounts how a patient was allowed to bring in a television to a high dependency bed which she felt was inappropriate.

Nora thinks there are too many bed moves on the ward. It intensifies her workload. She has to write progress evaluations for each patient and at the end of the day she could be writing for ten rather than six because there are so many people passing through or coming and going. Bed moves are necessary when patients return from theatre. Post-operative patients need to be in a high dependency bed which sometimes results in another patient being moved to a lower dependency bed to facilitate this.

Aideen thinks that changes in the health service have impacted on her as a manager because there is a lot more bureaucracy and red tape. She is required to attend several meetings in order to discuss new developments and strategies. This, in turn, leads to increased tasks and responsibilities.

**Restructuring and management problems**

Ellen’s wish that the management of an organisation develop services alongside clinicians is also expressed in the Brennan report (GoI, 2003). The report advocates the establishment of a system wide mechanism to engage clinical consultants in the service planning process, in the preparation of associated budgets or in the evaluation of results against budget. According to the report (GoI, 2003), such a system would create opportunities for improving value for money within the health service without compromising clinical independence.

Ellen’s concern about the lack of transparency about money in the organization is also articulated in the Brennan report (GoI, 2003). The report states that the full costs of treating private patients in public hospitals should be transparent and publicly available. A comprehensive analysis of the amount of public resources consumed by private patients within the public hospital sector is also recommended.

Ellen’s comment about the lack of time to do research is interesting in the light of recent policy documents espousing the importance of research. In their report, the Commission on Nursing (GOI, 1998) attached particular importance to the development of nursing and midwifery research at every level. The Commission asserted that research should form an integral part of all
aspects of nursing and midwifery if nursing and midwifery practice is to be evidence based. Accordingly, the Minister for Health and Children provided a dedicated budget to the Health Research Board for nursing and midwifery research. In addition, in 2002, a Research Development Officer was jointly appointed by the National Council and the Health Research Board. The Research Strategy for Nursing and Midwifery was launched by the Minister for Health and Children in January 2003. It is the Research committee’s responsibility to agree a project plan for implementation with the joint appointed Research and Development Officer of the Health Research Board and the National Council for the Professional Development of Nursing and Midwifery.

In a recent study, Glacken & Chaney (2004) report that studies have consistently demonstrated that nurses are increasingly recognizing the role research has to play in their daily practice. Despite this recognition they assert that the actual application of research findings in the practice setting is still poor. In order to address this issue, they investigated perceived barriers and facilitators to implementing research findings in the Irish practice setting. They found that the top barrier was a perception of insufficient authority to instigate change in the practice setting. The perceived key facilitators to implementing research findings included protected time for retrieval and evaluation of research findings, instrumental support from management, informed supportive personnel in the practice settings and accessible educational opportunities to augment critical reading skills.

The Irish government is committed to provide the people of Ireland with an evidence-based health service. From a nursing perspective the findings of this study indicate that a number of strategies have to be introduced or enhanced in the practice settings before this commitment can be realized.

4.1.4 Monitors and control/supervision

Nora’s work can be monitored and controlled by the care plans and progress evaluations she writes. The ward sister would also observe her subtly at work. She has yearly evaluations with one of the ward sisters. They discuss how she is getting on, what progress she is going to make and if she is going to do courses. It’s not very detailed but rather more general. The ward sister complimented Nora on how well she was settling in after maternity leave.

Ellen has never had a performance review in any of her nursing roles. She thinks they are only used for people they have a problem with. She would like more monitoring

\[ and I would like actually more performance review... with an appropriate person who understands the role...it wouldn't matter to me what division they were in...somebody who understands the role. \] (Ellen)

Clinical Nurse Specialists are new roles and currently come under the remit of unit nurse managers.

\[ I would foresee the roles in the future reporting to practice development units, and the NCNM as these roles are innovative in practice and require considerable steering. \] (Ellen)

Ellen’s experiences may be somewhat similar to that of other clinical nurse specialists. According to a report by the National Council (2004) it was the exception rather than the rule that clinical nurse specialists and clinical midwife specialists received formal feedback on their performance from their line managers. Of respondents to their questionnaire, 16% stated that they did not receive feedback at all, 11% stated they had a formal performance review and 52%
stated they received informal feedback (see National Council, 2004). In addition, according to the Profknow survey results 53% of nurses (surveyed) indicated that their supervisors did not regularly talk to them about their competence development.

Aideen’s performance as a divisional nurse manager is monitored by the director of nursing. Aideen would represent the director at different meetings and reports back to her once a week. Aideen also produces reports and the director of nursing would indicate if they weren’t up to standard. In addition, Aideen feels that the performance of a manager can be monitored by staff turnover in his/her division. For example if a lot of staff were leaving, questions would be asked as to why the sudden outflux of people. Similarly, if beds weren’t being managed the staff would be very quick to complain.

4.1.5 Documentation and Accountability

All the nurses talk about the importance of documentation and how that impacts on their practice. Their experiences resonate with Profknow survey respondents. 91% of the latter strongly agreed that the demand of written documentation is greater nowadays. Furthermore 80% stated that the demands of documenting work very much/rather much influences their everyday work.

Nora mentioned being legally accountable. She described how they have to use a black pen when writing their notes.

*I think it’s for photocopying purposes. You can’t see another pen on the photocopier…legal things I suppose if you had to go court as well to read the notes.* (Nora)

When recording drugs they (nurses) are not allowed to go over the line in the box on the chart because then it is not a legal prescription. They have to ask the doctor to prescribe the drug again. Nora referred to a situation where a junior doctor was nervous about prescribing the drug again without talking to the consultant and he wanted her to write over the line.

*But I said technically speaking well legally we are not allowed do that.* (Nora)

Ellen described how services need to be audited and how nurses need time to document. There is currently no protected time outside of clinical caseload in order to audit.

Aideen commented on the increasingly litigious society and how it has impacted on nursing practice. She recalls how early on in her nursing career if someone fell out of the bed they were dusted off, helped back in and asked if they wanted a cup of tea. Now there’s a whole procedure to be followed.

*Documentation must be filled out, insurance people informed, risk management informed, families informed. It’s all what should be happening but it’s a time-consuming lengthy process.* (Aideen)

In the past there was no formal procedure for dealing with accidents.

According to Aideen, documentation is

*more time consuming but at the end of the day it’s what’s right and these systems should be in place and people should feel one hundred per cent confident and there should be a tracking mechanism if anything ever did happen.* (Aideen)
She thinks that accountability helps raise standards. Following an issue about hygiene in the hospital there was a number of meetings and the standard has improved dramatically.

*I just think that if people are doing what they are meant to be doing and accountable for what they are meant to be doing the system then tightens up.* (Aideen)

However, Aideen did express concern that there were no resources or supports put in place to ensure that changes were implemented. For instance, staff was required to document evidence that standards were being met. Team meetings were held in order to discuss evidence for standards for accreditation and hygiene. There were 17 standards for accreditation and each standard was further subdivided into parts. Hence the process was lengthy and time consuming. In addition quality improvement plans had to be written. However, the staff did not get protected time in order to perform these tasks.

The impact of the Scope of Nursing and Midwifery Practice Framework (ABA, 2000) is referred to by Aideen. The framework aims to assist nurses and midwives in making decisions about the scope of their clinical practice. ^44^ Aideen comments how people quote it like the bible saying ‘that’s beyond my scope of practice’. She feels that in the past nurses would have muddled through if they were unfamiliar with a patient

*they would have rung the doctor or checked with another nurse to see … what else they were meant to be looking out for.* (Aideen)

Now she thinks that nurses are more wary of being sued

*and if they are working outside their scope of practice would they be supported then by the profession of nursing?* (Aideen)

Similarly 54% of Profknow survey nurses stated that the risk of being sued very much/rather much influenced their everyday work.

Restructuring and accountability

In an increasingly litigious society, accountability is an area that has gained importance and (judging by the nurses’ comments) this is also apparent in the Irish Nursing Context. Writing care plans and progress evaluations is one means by which nurses demonstrate accountability. Similarly the development of hospital policies and procedures for dealing with incidents such as patients falling out of bed is evidence of the change in society’s attitude towards litigation.

Mindful of the fact that nurses are accountable for the decisions that they make, An Bord Altranais (ABA) introduced the Scope of Nursing and Midwifery Practice Framework (ABA, 2000). The purpose of the framework is to assist nurses in making decisions about their clinical practice. According to ABA (2000) in the course of his/her professional practice, a nurse or a midwife must be prepared to make explicit the rationale for decisions they make and to justify such decisions in the context of legislation, professional standards and guidelines, evidence based practice and professional and ethical conduct. ABA (2000) states that nurses and midwives are accountable both legally and professionally for their practice. They are accountable to the patient/client, the public, their regulatory body, their employer and any relevant

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^44^ The term scope of practice refers to the range of roles, functions, responsibilities and activities, which a registered nurse or a registered midwife is educated, competent, and has the authority to perform.
supervisory authority. It is also noted that accountability applies to both actions and omissions (ABA, 2005).

Aideen’s comments about hygiene may be understood in the context of the recent controversy following the first-ever National Acute Hospitals Hygiene Audit. It was undertaken on behalf of the National Hospitals Office of the HSE. The results revealed that 91% of hospitals fell below acceptable hygiene standards (see Desford Consultancy Ltd, 2005). A number of practical recommendations on how to achieve top class hygiene standards were made. Following publication of the audit the Minister for Health and Children emphasised the need for accountability

In hospital cleanliness as in other vital areas of health services, we need the highest standards to be monitored and enforced consistently at national level, while managed locally with clear lines of accountability. (As accessed at http://www.dohc.ie/press/releases/2005/20051103a.html)

Despite the Minister’s confidence that the HSE will have sufficient resources to make the required investments, in equipment and training, Aideen claimed that nursing did not receive additional resources or support to ensure that changes associated with improving Hygiene standards were implemented. However, according to the results of the second National Hygiene Audit (Desford Consultancy Ltd, 2006) the hospital managed to significantly improve hygiene standards.

Financial accountability

Ellen talks about how the whole health service has revolutionised. She also mentions the increasing accountability agenda.

things… have to be cost effective, they have to be deliverable (Ellen)

Aideen said that there are a number of formal monitors and controls in her job. From a budgetary point of view the financial controller monitors her work. She has to send down a locum budget every week to show what agency nurses they have brought in and what staff they have. Every ha’penny that they spend is monitored. According to Aideen, even if they have twelve vacant staff posts and they use only ten there would still be complaints saying could they not have used nine or eight.

Restructuring and financial accountability

It is unsurprising that Aideen has to account for ‘every ha’penny’ spent on staffing. According to the Brennan report (GoI, 2003) pay is the single biggest expense in the health service. It accounts for over two-thirds of total non-capital health expenditure. In absolute terms, pay costs have risen by a cumulative €2.1 billion or 69% over the four-year period, 1999 to 2002. Moreover, numbers employed in the health service increased by 37% (from 68,000 to 93,000) between 1997 and 2001. In addition, for a number of groups in the health sector, gross pay rates (i.e. with overtime, call-out payments, etc. included) are significantly higher than basic pay. Hence, it was recommended that the Department of Health and Children, in consultation with the Department of Finance, should obtain numbers and associated costs of employment to inform the appropriate authorised limit (Brenann Report, GoI,2003).

Ellen’s comments about services being cost effective may also be understood in light of the recommendations of the Brennan Report (GoI, 2003).
4.1.6 Decision making and Autonomy

According to the nurses, most decisions are made in collaboration with others rather than independently. However, they find ways around the limitations on their ability to make autonomous decisions.

Nora says that she can make independent decisions about basic patient care but not anything beyond that. She can make decisions about a patient’s pain control when they need it and what they need but all the medication has to be prescribed. Hence, she advises the doctor that a patient needs a four hourly controlled drug.

However if a patient was seizing she wouldn’t wait for a doctor to walk up the ward she would make the phone call and the two would verify it over the phone

*technically oxygen is a drug and it has to be prescribed as well but we’d never wait for a doctor because you couldn’t you are leaving somebody’s life at risk.* (Nora)

She is happy with her current level of decision making and autonomy. For example, if she had the authority to decide to increase a patient’s fluids, the action could push the patient’s blood pressure up too high and put them in a dangerous situation.

*I am not prepared to make the decision that will jeopardise her and put her at risk so no I am happy enough to leave it with whoever wants to make it.* (Nora)

Nora’s comment suggests that she is nervous of the increased accountability associated with the authority to prescribe. Her reluctance to take on this role may be due to a fear of possible legal consequences, such as litigation. She is also unwilling to take on prescribing rights without appropriate renumeration, a development now to be introduced in Autumn 2007.

Nora also makes decisions about the appropriate person to ask certain questions. She would not ask the intern about complicated cases.

Ellen is unsatisfied with her current level of autonomy but she thinks that she will gain more autonomy in the future when the role is developed into an Advanced Nurse Practitioner (which is a more autonomous role).

Currently in her role as a clinical nurse specialist there are a number of decisions that Ellen can make independently. For example, she can decide when to deliver talks to student nurses at undergraduate and postgraduate level. On the telephone she can decide to advise patients to go to their GP, go to casualty, or wait for her return call. She can also decide whether cases are urgent. She can decide to bring forward patient appointments although she tries to avoid doing that. She can decide if there is a need to admit a patient. Often such decisions are made in collaboration with doctors. She can make suggestions to the medical team about patient medications.

With regard to the management of the disorder she deals with there is not a great deal of decisions she can make because it is to do with prescribing and ordering investigations. She is only allowed to dispense medication. A doctor has to approve and sign off medication (including over the counter medication). Hence in consultation with patients problems are identified and treatment options discussed. The case is then discussed with the team and changes made.

Ellen summarises the decisions that she can’t make independently as follows: prescribing, referring, ordering of scans, ordering of investigations, ordering of blood tests. She is constrained by a number of policies which she finds frustrating.
An investigation may be a psychology referral, a psychiatry referral but they all have different policies and procedures about who they accept referrals from and nursing would not be one of them. So even though I would see the need I would often have to go through a registrar or an SHO (Senior House Officer/doctor) to get that letter written. So I would do it but in an indirect way. I wouldn’t have the autonomy to write that referral so that’s a little bit frustrating. (Ellen)

She would like to have the authority to prescribe existing (rather than new) medication. However, she is unwilling to take on such a responsibility on her current salary. She would also like to have the autonomy to titrate medication and refer patients to have scans or other investigations where appropriate through protocols and policies.

Aideen feels quite empowered in terms of the decisions that she can make which are mainly about nursing, nursing personnel and nursing issues. If she wanted to give someone an annual leave day or if she wanted to arrange a study day she can go ahead and do that. She would just inform rather than ask the director of nursing.

She makes decisions about care of the patient in consultation with the ward sisters. For example if they wanted a mattress for a patient or families to stay overnight it would be discussed with the ward sisters. Similarly she attends multi-disciplinary meetings with representatives from the different departments and at the end of the day they all reach an agreement as to what decision is made to move issues forward. Aideen is involved in the decision making process about the medical care of a patient. She can initiate a meeting to discuss a patient and their future care but ultimately she has no discharging and admissions rights.

One of Aideen’s responsibilities is to interview candidates for new or promotional positions in her division. She does not interview alone. There is a panel of interviewers. Hence decision making with regard to recruitment and promotion is a collaborative process.

Both senior nurses insist that they cannot make any decisions about the distribution of funds. Ellen insists that as a nurse she is not involved in decision making about whether or not additional resources are needed.

No you are not involved in that process at all. You deliver the information you deliver the service plan you deliver the annual report you have meetings, letters more meetings, letters but you don’t hold the purse strings you have no decision making really. (Ellen)

Ellen’s comments are echoed by Profknow survey respondents. 80% of those surveyed indicated that they do not participate in general policy decisions about the distribution of funds within the overall budget of the place in which they work. Similarly, 80% stated that they are not involved in decisions to increase or decrease the total number of people employed in the place where they work.

Aideen finds decisions relating to purchasing equipment frustrating because there is a lot of red tape. She cannot just sanction a two thousand euro piece of equipment. She can put forward a case as to why they need it and then the financial controller, a member of the senior executive, nursing and allied health care professionals meet and each item for purchase is discussed. In addition Aideen can’t make the decision to employ or redeploy more nurses. There is a ceiling rule that they can only have x amount of staff working in the hospital but she knows they could really do with more nurses in ICU etc and she could justify employing each additional nurse. They have the lowest number of ICU staff in the Eastern region. She finds that very frustrating but she can appreciate the bigger picture that if everyone at her level were recruiting there’d be
no end to it and there has to be some rules in place. She can move nurses from one ward to another if they were really stuck but it might not be a popular decision. She manages up to 220 staff and she has to stick to HR policies

but within that I would have a huge amount of flexibility and decision making and authority (Aideen)

Restructuring and decision making

Data from interviews and observations indicate how most of the nurses’ decisions are made collaboratively with other health care professionals rather than independently. This concurs with the team approach to care espoused in several policy documents. (See Primary Care: A New Direction (DoHC, 2001a); Quality and Fairness: A Health System for You (DoHC, 2001); National Health Information Strategy (DoHC, 2004); The report of the Commission on Nursing (Gol, 1998); Report of the National Task Force on Medical Staffing (DoHC, 2003).

Nora’s and Ellen’s comments about the decisions they can and cannot make suggest that they have been influenced to a degree by The Scope of Nursing and Midwifery Practice Framework (ABA, 2000a). The purpose of this Framework is to provide nurses and midwives with professional guidance and support on matters relating to clinical practice. It introduces a decision-making framework to assist nurses and midwives in making decisions about the scope of their clinical practice.45 Nora and Ellen demonstrated an awareness of the roles, functions, responsibilities and activities, which they are educated, competent, and have the authority to perform. Indeed Ellen mentioned that she constantly asks herself “is this my role, is this my job?”

Nora and Ellen’s comments indicate that they do not prescribe drugs prior to obtaining sanction from a doctor. These findings contrast with research by the National Council for the Professional Development of Nursing and Midwifery (National Council, 2005). In their Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products, nurses participating in the study said that in many instances they prescribed a number of medications in advance for each patient. Thus, they made prescribing decisions (arguably in the interests of timely delivery of quality patient care) but required sanction by the medical practitioner to write the actual prescription.

However, Nora said that in an emergency they would give patients oxygen (which is a drug) following a doctor’s decision over the telephone. Acceptance of verbal and telephone instructions (specifically in emergency situations) constitute a “grey” area for nurses. Some nurses in the National Council (2005) study indicated that whatever model of prescribing was introduced it would be an improvement on the present practice of using one’s scope of practice to guide decisions in medication management – which was a cause of some confusion. Many felt that authority for nurses to prescribe was one way of alleviating uncertainty for nurses in these situations. One participant noted that legal clarification would also acknowledge nurses’ own present expanded practices (see National Council, 2005).

Nurse participants in the National Council (2005) study stated reasons for introducing nurse prescribing. One such reason was to alleviate the problem of time wasting and the adverse effects on patients. The experience of the participants resonates somewhat with that of Nora and Ellen. The nurses in the National Council (2005) study described how they had had to wait for doctors to come to their practice setting to write prescriptions for their patients and who were delayed for various reasons. These situations were seen to result in less than optimal patient/client care, frustration for nurses and an under-use of their expertise.

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45 The term scope of practice refers to the range of roles, functions, responsibilities and activities, which a registered nurse or a registered midwife is educated, competent, and has the authority to perform.
Although Nora is satisfied with her current level of decision making authority, Ellen in her capacity as a clinical nurse specialist is frustrated with her lack of prescribing autonomy. Ellen’s sentiment is similar to that expressed by nurses working in other countries that did not have prescriptive authority (Jones, 1999; Ogilivie, 1999). However, despite her frustration, Ellen is unwilling to take on prescribing responsibilities until there is further structured education, changes in law, discussion on liabilities and remuneration for role expansion. She believes that historically nurses have taken on too many roles from junior doctors and that writing prescriptions is another role that is waiting. This view is also shared by participants in the National Council (2005) study. The nurses involved in the research stated that although they were interested in expanding their roles they were concerned about taking on doctors’ responsibilities for convenience sake and not on their own terms. Specifically, nurses said that expansion of the nurse role should be considered for the right reasons, i.e. to improve patient care and not as a solution to medical manpower issues.

Current Irish medicinal products legislation gives prescriptive authority only to doctors and dentists and not to nurses and midwives. A review and subsequent enactment of all relevant primary and secondary legislation is required to extend this authority to nurses and midwives. A report by the National Council (2005) recommends that an explicit legislative basis be provided for the supply and administration of medicinal products using medication protocols by nurses and midwives in hospital and community settings. In addition it recommends that prescriptive authority should be extended to nurses and midwives, subject to regulations under the relevant legislation by the Minister for Health and Children and regulation by An Bord Altranais. Furthermore, according to the same report, nurses and midwives should be enabled to supply and administer over-the-counter medications to patients and clients in accordance with their competence and within their scope of practice and supported by medication protocols where appropriate. An Bord Altranais and the National Council for the Professional Development of Nursing and Midwifery have established a project implementation team to work in consultation with key stakeholders to facilitate the implementation of these recommendations and actions. Subsequently, an implementation group has been established by the Minister to oversee the rollout of nurse prescribing on a national basis in Autumn 2007.

The importance of documentation and accountability is apparent in Nora and Ellen’s comments about doctor’s verifying their actions and signing prescriptions. Increasing accountability and fear of litigation may explain Nora’s reluctance to take on additional prescribing responsibilities. Moreover, she is unwilling to take on such responsibility without appropriate remuneration. The nurses’ lack of decision making capacity with regard to resources (financial and human) is a source of frustration. Although nurses give their input sometimes there are no resources available. It appears that in theory they contribute to the financial and resource allocation decision making process but in practice they don’t hold the purse strings and that situation does not look like it is about to change. Moreover, there are many people competing for resources.

4.1.7 Social relations and co-operation with medical colleagues

The more senior nurses have contradictory views about their working relationship with doctors. Perhaps the difference in their perceptions is related to their positions and career stages. Ellen needs to work very closely with consultants in her service. They operate clinics together and she discusses cases and the management of patients’ conditions on a daily basis. Aideen, on the other hand, doesn’t get to see consultants frequently because they are in surgery for most of the day. In addition she is in a managerial role which necessitates a different type of interaction than Ellen.

46 This authority is contained in the Medicinal Products (Prescription and Control of Supply) Regulations 2003.
According to Ellen in the past nurses were very deferential to consultants and would have followed their requests unquestioningly. Now she says that professionals refer to each other using first names. She feels that now the workplace is more friendly.

Ellen notes that health care professionals have adopted a team approach

\[\text{there is no ... I am better than you or you are better than me. We are all working as a team...there is more of a team approach to care. (Ellen)}\]

The team approach is evident at research conferences. Ellen considers that nurses and doctors are amalgamating their information, pooling their resources and trying to strive towards better plans within the service of what they both need rather than individual needs. Resources are privately obtained to assist in attendance at national and international conferences and Non Consultant Hospital Doctors have an annual study budget to attend such events. According to Ellen, nurses must apply through nursing management to avail of finances which are minimal.

Observation suggested that the doctors have respect and faith in Ellen’s considerable expertise.

While Aideen gets on with the consultants who work in her specialty she feels that relationships could be improved. She thinks there isn’t as much of a team spirit as there could be. She feels some of the consultants are a bit ‘God’ like and want to be referred to as professor yet they call her by her first name. Ellen and Nora expressed similar views about particular consultants (with whom they don’t work closely) being unapproachable. Aideen feels that they would all benefit from coming together to see how they could improve the service for patients as opposed to looking at what the individual professions can get for themselves.

With regard to Accreditation she has to appeal to the better nature of the consultants to be involved in it because they don’t have to be because they are not employed by the hospital.

\[\text{that’s a pity because if you want to move things forward as a whole team you know you need them on board for things like that. (Aideen)}\]

Moreover Aideen feels that medical staff may perceive her as trying to be obstructive and negative when she voices real concerns on behalf of the staff. She insists that you can’t just say yes to their demands because a lot of the time it doesn’t have a huge impact on them but it would have a huge impact on the profession of nursing.

Aideen talked about organising a function for a consultant that was retiring. It wasn’t really their responsibility as nurses but it was very much appreciated. She said that she likes to chip away in order to improve team spirit and relations.

Nora commented that junior doctors have a respectful relationship with the experienced nurses on her ward. The new doctors tend to act on the nurses’ advice because there are a lot of nurses with great experience in the specialty.

Restructuring and relationship with medical colleagues

Restructuring in terms of the introduction of a clinical nurse specialist post\(^{47}\) in the area of specialty has certainly facilitated increased co-operation and collaboration between Ellen and doctors working within the specialty. A close working relationship with medical colleagues is

\(^{47}\) Clinical nurse specialist positions were created following the recommendations of the Commission on Nursing (GoI, 1998).
essential for Ellen to carry out her tasks effectively. Such tasks will be discussed in further detail in the section entitled *professional knowledge, skills and expertise*.

A close working relationship with medical colleagues may be perceived as a desirable development. However, in a study by the National Council (2004) there was some critical discussion about reporting relationships and control and management issues. Some directors of nursing were concerned about the lack of control over clinical nurse specialists. This happened apparently when clinical nurse specialists allied themselves to the medical staff and were perceived to have a medical-orientated post. It appears that in some instances enhancing relationships with medical colleagues has a detrimental effect on relationships with nurse colleagues.

There has been a proliferation of policies recently and associated initiatives espousing a team approach for the effective delivery of quality health care. (See Primary Care: A New Direction (DoHC, 2001); Quality and Fairness: A Health System for You (DoHC, 2001); National Health Information Strategy (DoHC, 2004); The report of the Commission on Nursing (GoI, 1998); Report of the National Task Force on Medical Staffing (DoHC, 2003). The effects of such developments may be contributory factors to Ellen and Nora’s perceptions of co-operation and collaboration.

On the other hand Aideen’s comments in relation to the consultants may be understood in the context of the latters’ contracts. The clinical consultant can make clinical decisions independently and free from the direct control or supervision of the hospital management, medical administrators or other consultant colleagues. Hence, they aren’t obliged to be involved in initiatives such as Accreditation. It is a time consuming process and as Aideen suggests the support of consultants is vital in order to make service improvements.

### 4.1.8 Social relations and co-operation with nursing colleagues

Nurse colleagues for the most part are described as being supportive and a good source of knowledge.

Nora comments that there are always very senior people from whom she can seek support and advice. When a nurse starts on the ward they have a preceptor for six weeks but it is not always possible to be on duty at the same time as the preceptor.

As a student nurse Ellen felt that she had so many good role models. She had immense respect for staff nurses and she would have been quite conservative in her interactions with senior staff nurses and sisters. Ellen values the support and understanding of her colleagues and would consider herself at a serious loss without them. She would also like to think that they value her too. She states that she has learned an awful lot from her nurse colleagues throughout her nursing career; different skills from different people.

The aforementioned perceptions are supported by survey findings. 84% of Profknow survey respondents felt that it is quite true or very true that they are well recognised for their professional expertise among their colleagues.

According to Ellen nurses do look out for each other more. She feels that now a senior sister would come to the assistance of a staff nurse if a medical team member was being difficult and that would have been unheard of in the past.

Aideen acts as a support to the ward sisters. They would go to her with concerns about vacant posts and skill mix and issues surrounding international nurses. She has got feedback from her
colleagues that she is very diplomatic. She gets on well with her nursing colleagues. There would be ups and downs with staff working in different departments like A and E. They could be really busy and could get a bit fed up with her department not taking a patient.

There are times when other nurses don’t “pull their weight” and that puts a huge amount of pressure on Nora. Sometimes she would raise the issue, while other times she would say there is no point. She recounts an incident where the night staff hadn’t prepared a patient for theatre and when she arrived on the ward they were calling her for theatre ten minutes later. She thinks it’s not fair on the patient and it’s not fair on her to be put under that pressure. She also talks about a nurse failing to document a patient’s fluids which meant that she was left to think for everybody.

4.1.9 Social relations and co-operation with care attendants

Nora says that some of the care attendants are really brilliant and they just get stuck in. There are some that she has to chase and that adds to her workload

‘cause you have to ask them to do something without them taking the initiative to do it themselves. And I find that you are taking up more time telling people what to do and then chasing them to do things… and you shouldn’t have to do that I don’t think. (Nora)

She thinks maybe she should delegate more to another care attendant or nurse but

Then they are often not too happy to be doing your work for you because they have their own work to do. (Nora)

Social life

Both Ellen and Nora insist that they like to keep work and leisure separate. Nora gets on with most of her work colleagues yet she doesn’t socialise with them. Ellen describes her relationship with her work colleagues as amicable. Although she likes to keep work and leisure separate she would always attend any function if asked.

Restructuring and relationships with nurses and other care staff

When nursing moved to an all graduate profession in 2002 the students were no longer on the ward because they were in college. Hence, they were replaced with health care assistants and more cleaners were employed. The introduction of care attendants/health care assistants to Irish hospitals is evidence of the evolving role of the nurse. Tasks that were once the responsibility of nurses have now been transferred to care attendants. For example, making beds is now a care attendant’s task. However, Nora’s comments suggest that nurses still help out in this area

I mean technically making beds is not a nursing duty either that’s supposed to be for the care attendants to do but we do that (Nora)

4.1.10 Relationship with patients

Nora said that you have to know what approach to take with patients. She thinks coming in with a loud voice helps when dealing with an aggressive patient.

it’s kind of like a distraction for them or you know if… they are starting to hit somebody here and you come in and say hello or in a loud voice it’s like they are pulled from the situation. (Nora)
Nora trusts the patient’s description of their pain. As part of her training she was told that pain is what the patient tells you it is. So she believes what the patient tells her and gives them the drugs accordingly.

When Ellen was training she was motivated to acquire as many skills as possible because she hated having to ask others to do tasks for her. She felt that if she could deliver everything for the patient it would be more efficient and the continuity of care would be better. Furthermore she felt

\[
\text{it is nice for a patient to have the same person doing everything rather than five different people coming to do different things (Ellen)}
\]

Ellen considers being caring and patient-centred among the qualities necessary to be a good nurse. It is important for her to be delivering nursing care

\[
I \text{ think if you lose your clinical focus, ultimately you stop nursing and personally for me there would be little job satisfaction (Ellen)}
\]

Aideen said that she treats people how she would like to be treated herself, with ultimate respect. She approaches patients with an awareness that they are at their most vulnerable. She values being courteous, caring, sensitive, and empathetic. During her training they were told to treat patients as they would their relatives.

The patient centred approach to care is also evident from Profknow survey findings. 74% stated that the opinions of patients very much/rather much influenced their everyday work.

Communication skills and interactions with patients will be discussed in greater detail in the section entitled professional knowledge, skills and expertise.

Restructuring and relationships with patients

There are some who argue that the academisation of nursing impacts on the time or attention devoted to the caring aspect of nursing. Restructuring measures relevant to patient-nurse relationships will be discussed in the professional ideals and motivation section.

4.2 Professional skills, knowledge and expertise

The nurses are at different stages in their career and have differing roles and responsibilities. Hence, there is variation among their tasks, requirements and demands.

4.2.1 Tasks, requirements, demands

Nora

Nora’s tasks include giving direct and indirect care. Direct care comprises the assessment, planning, delivery and evaluation of care to patients/clients and their families. Nora is also required to give indirect care. Such care relates to activities that influence others in their provision of direct care. For example, she contacted a doctor following concerns about a patient’s status. His Glasgow Coma Scale (GCS) score was dropping. The patient was subsequently referred for surgery.

Correspondingly, Nora is required to act as an effective member of the health care team and participate in the multi-disciplinary approach to care of patients/clients. During observation she
co-operated with health care assistants, doctors, physiotherapists, speech and language therapists and pharmacists.

She also acts as a patient/client advocate. For example, when handing over a patient to a surgical nurse she communicated the patient’s needs and helped the patient to answer questions.

Nora is required to practice in accordance with legislation affecting nursing practice and within the limits of her own competence. For example, as previously discussed, she is legally prohibited from prescribing medication.

**Ellen**

Ellen’s tasks, requirements and demands are outlined in the job description of clinical nurse specialists. Since Ellen also works in the clinical area she is required to provide direct and indirect care. For instance, when a patient calls her service (or comes to the outpatient clinic) she assesses, plans, delivers and evaluates their care. Often the consultation will result in the provision of indirect care. For example, a patient may be referred to their GP for a blood test to check their levels of medication.

Ellen is required to act as a patient/client advocate. Her role involves communication, negotiation and representation of the patient/clients values and decisions in collaboration with other health care workers and community resource providers. She recounted an incident when a learning disabled patient was approached to participate in a medical research study. Ellen felt that the experience would be frightening and unsettling for the patient so she contacted the researcher on behalf of the patient.

Ellen has a remit for education and training which consists of structured and impromptu educational opportunities to facilitate staff development and patient/client education. During observation, Ellen frequently availed of opportunities to educate patients and their families about the condition and the various treatment approaches. She also explained a particular treatment to a general nurse.

In tandem with her line manager, she is responsible for her continuing professional development, including participation in formal and informal educational activities, thereby ensuring sustained clinical credibility among nursing, medical and paramedical colleagues. Ellen has taken responsibility for her professional development through her Masters study.

Audit of current nursing practice and evaluation of improvements in the quality of patient/client care are essential requirements of her role. For example, Ellen takes note of patients with the condition who present at A and E. She notes the date, reason for attendance and the outcome of their visit. She then follows up with a phone call to monitor their progress. She is anxious to make sure they are not missed especially those who are newly diagnosed. Part of the rationale for her telephone triage service is to reduce the number of unnecessary presentations at A and E. The phone service also alleviates numbers in the clinic. Patients don’t need to bring their appointments forward because they can call the helpline to have their concerns answered.

Ellen must keep up to date with relevant current research to ensure evidence-based practice and research utilisation. She must contribute to nursing research which is relevant to her particular area of practice. Any outcomes of audit and/or research contribute to her service plan. For example, she is involved in research regarding lengthy waits in her area of specialty. Apparently the waiting time for investigations (for patients with this condition) is two and a half to three years. This information is particularly salient when one considers that surgical treatment is particularly effective for a high percentage of patients with this condition.

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Inter- and intra-disciplinary consultations, across sites and services are recognised as key functions of her role as clinical nurse/midwife specialist. She is required to work closely with medical and para-medical colleagues and may make alterations in prescribed clinical options along agreed protocol driven guidelines. Ellen was observed to work closely with consultants in her area of specialty. She also had reason to consult with medical and nursing colleagues in other areas of specialty.

Aideen
Aideen in her position as divisional nurse manager no longer provides direct care. Her responsibilities are associated with the following areas: bed management, staffing and manpower planning, professional practice, personnel management, support services, staff development, budgeting, standards of care and work, and self development. Details of some tasks inherent in these responsibilities are presented below.

Aideen takes up policy and procedure issues relating to bed management with the patient services manager, director of nursing and individual consultants as appropriate when problems arise. In consultation with the patient services manager, she develops and implements discharge planning protocols and works with community services to ensure efficient outcome.

Aideen is required to develop a staffing plan based on patient census, case complexity and staff experience. She agrees a total complement of staff for each ward or department and deals with requests for additional staff or changes in staff mix. She has to ensure that resources are deployed effectively and efficiently between wards and departments to cope with fluctuating workload and case complexity. As a consequence of limited resources and staffing shortages, manpower planning was observed to be a very demanding and time-consuming part of her job. In order to staff wards she often has to negotiate with other nurse managers the deployment or transfer of staff from and to wards as required. Additionally she decides when to utilize agency or locum staff.

With regard to professional practice Aideen is required to lead in the formation of new and specific divisional policies, procedures, protocols and manage their implementation. She holds regular meetings with sisters, staff nurses and nursing staff as appropriate.

Aideen has a number of responsibilities associated with personnel management. For instance, she has a key role in the selection of nursing staff for the division. During fieldwork she was observed to interview a candidate for a permanent position in her division. She also works in consultation with the Centre of Education staff to organize and develop programmes of induction and training for new staff. Aideen deals with staff grievances, handles disciplinary matters and negotiates conditions of employment appropriate to the work. A major part of her role is improving and maintaining morale amongst staff. She aims to do this through effective leadership, consultation and communication.

Liaising with support services is an important aspect of Aideen’s job. She initiates and conducts discussions with heads of departments providing services to the wards/departments (e.g technical services officer, cleaning officer) to formulate workable proposals for improving services policies and procedures. During observation there was a meeting with the waste manager about improving hygiene standards at ward and corridor level.

In order to facilitate staff development, Aideen leads in the setting up of in-service training programmes for staff, including courses on specific topics. For example, during observation she met with a nurse to discuss priority learning needs for nurses in the division. The needs were identified by the staff. In addition the practice support nurse was asked her opinion regarding
needs she had observed when visiting the wards. This discussion informed the appropriate planning of professional development events.

Aideen also has budgeting responsibilities. These include preparing estimates of resource requirements each year and negotiating these with the director of nursing. She is also required to establish and agree stock limits for each ward or department in consultation with each sister and medical consultant. She tracks budgetary spending on staffing and supplies so as to create and maintain an up to date picture of expenditure for discussion with director of nursing, medical staff, finance manager and others as necessary. Aideen controls expenditure within budget by monthly review and agrees to implement corrective measures as necessary. For instance if the hospital has overspent they may try to reduce the number of agency staff for certain grades of staff. Aideen also advises the director of nursing regarding the developments and changes that impact on the work of nurses in the unit in order that adequate resources staff and other are negotiated.

To ensure high standards of care and work, she collaborates with the infection control sister in the auditing of infection control standards and in the changing of practices as necessary. She identifies specific areas in which improvements can be made in effectiveness of care and works to achieve these improved standards.

Self-development is important in Aideen’s role. She discusses her present performance and future needs with the Director of Nursing. She is also required to read current literature and nursing research. During observation Aideen was observed to read the Lourdes Hospital Inquiry49 (GoI, 2006) in order to see what could be learned from it.

4.2.2 Professional Knowledge and skills

In order to carry out their tasks and fulfill their responsibilities the nurses require a great deal of knowledge and skill. Conducting observations were important opportunities to document their knowledge at work and to gain insight into and understanding of their workplace knowledge and its practice. The subsequent interviews provided an invaluable opportunity to enable them to varying degrees reflect on their expertise, thus articulating taken for granted aspects of their embedded knowledge.

As mentioned previously, the nurses are at different stages in their careers and have differing roles and responsibilities. Hence, there is variation among their considerations regarding the most essential skills and knowledge required for their work.

Nora’s professional Knowledge and skills
For Nora, the staff nurse, the basic nursing skills are the most essential. These skills are associated with a model of nursing (Activities of Living) developed by Roper Logan and Tierney (1980). ‘Activities of Living’ is a way to describe the functional status of a person. According to the model there are 12 activities of living namely: Maintaining a Safe Environment, Communication, Breathing, Eating and Drinking, Elimination, Washing and Dressing, Thermoregulation, Mobilisation, Work and Play, Expressing Sexuality, Sleeping, Death and Dying. Following assessment of a patient’s activities of living needs, Nora plans how to attend to each need. For example, if a patient is assessed as immobile, Nora plans how to prevent the complications of bed rest. She then delivers the appropriate care and evaluates the patient’s progress.

49. The Inquiry found that a consultant doctor engaged in poor and even bad practice by carrying out unnecessary hysterectomies on a number of women. See Lourdes Hospital Inquiry- An Inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda. (GoI, 2006).
In order to identify and meet the nursing care needs of the patient, Nora needs skills in the area of assessment, planning, delivery, and evaluation of care. These skills are informed by professional knowledge. There is knowing in her action. For example, when attending to a patient’s thermoregulation needs, Nora needs to assess the patient’s temperature. This involves knowing how to correctly take a patient’s temperature. In the event of an abnormal recording being taken she needs to know what (plan or) actions are required. This requires the ability both to recall (knowledge about) normal and abnormal limits and the actions to take/ care to deliver.

Further examples of knowledge informing Nora’s nursing skills (knowing in action) were evident during observation. Nora attended to patients’ mobilisation needs by walking them up and down the ward. She also gave them TED socks to wear to enhance their circulation. Her actions are informed by the knowledge/evidence that prolonged periods of immobilisation can lead to the development of deep vein thrombosis. She attended to another patient’s drinking needs by preparing thickened fluids for him to drink. This action was informed by the knowledge that the patient’s condition made him susceptible to aspirating liquids. Thus thickening the fluid served as a preventative measure. These examples illustrate how Nora needs a good knowledge of her area of specialty (particularly about post-operative care for specific conditions) in order to do her job effectively.

Nora was also observed to have knowledge about various diagnostic investigations. She shared this espoused knowledge when explaining to a patient what to expect, why the investigation was necessary, and how the results would inform their treatment. Similarly, she demonstrated knowledge of a range of treatments for a number of conditions. This knowledge was also used to educate and reassure patients.

Nora demonstrated knowledge of injury and how it alters normal function and the activities of living. This informed her practice in terms of the frequency with which she monitored the progress of particular patients. In addition, she shared this knowledge with relatives of patients in order to enhance their understanding of the condition. When one patient failed to make any progress, she reflected on the outcome of her assessment in order to generate a new understanding of his condition. The reflection was a collaborative process. She discussed the patient with senior nurses and medical colleagues.

Knowledge of communicable diseases informed Nora’s practice when attending to a patient who tested positive for MRSA. She wore a protective gown and gloves when attending to his elimination and mobilisation needs.

An awareness of her scope of practice is also part of Nora’s professional knowledge. She refused to continue to administer a drug that wasn’t prescribed (despite the entreaty of a junior doctor) because she knew she didn’t have the authority to do so.

She is involved in writing a policy about a particular assessment procedure used on the ward. In order to do this effectively she requires the skills of analysis, critical thinking, problem-solving and reflective practice.

Nora’s interactions with patients revealed her interpersonal skills. She had the skills to establish and maintain caring therapeutic interpersonal relationships with individuals and their families and friends. This was evidenced in the way she ensured clients received and understood relevant information concerning health care. She assisted clients to communicate needs and to make

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50 Methicillin-resistant Staphylococcus aureus (MRSA) is a specific strain of the Staphylococcus aureus bacterium that has developed antibiotic resistance to all penicillins, including methicillin and other narrow-spectrum β-lactamase-resistant penicillin antibiotics
informed decisions. She approached patients gently and adopted a kind and caring tone. She also seemed confident in her approach. Similarly her interactions with other members of the health care team showed interpersonal skills.

Knowledge of confidentiality issues was demonstrated by Nora. This was observed when recording information about a patient on the consultant’s board. Only the bed number was referred to rather than the patient.

The nursing care plans provide Nora with an opportunity to explicate and document her professional knowledge. Such knowledge is also apparent when she hands patients over to nurses who work the next shift. During the handover Nora dictates information such as details about the patient’s surgery, comments on medication, date and reason for admission to hospital, complaints and results of investigations. When listening to another nurse’s handover at the beginning of the shift she has the skills to select the most salient aspects of the patients’ conditions. The knowledge derived from such an exercise is used to inform her nursing practice.

The development of personal coping mechanisms seems to be an important professional skill. Nora is particularly sympathetic towards patients with children because she has children herself. She feels that there has to be a balance

you have to have that balance you know between leaving it in work and having some feelings of empathy towards people ...you know you can’t be that hard that you couldn’t feel that a nineteen year old lying in a bed after a road traffic accident isn’t sad (Nora)

According to Nora, nurses sometimes operate according to routine and ritual. For example, she commented that they often give the drugs and then do the observations but perhaps it should be the other way round. She cites a situation where knowledge derived from individualised, holistic, patient-centred assessment should inform practice.

if somebody is sick and ... you come in and the night staff tell you he is x, you come in and you find y. it’s not always the same ... And with ... people with certain injuries ...they drop their ...status very quickly like within a matter of minutes so they could be completely changed from the time I leave the room til the time I hit the ward ... and they could have dropped their GCS and they could be completely different by the time you look at them in the bed.(Nora)

Restructuring and Nora’s professional knowledge and skills
Nora’s professional knowledge and skills can be related to the nursing literature and developments and changes in Irish health care.

Nora’s expertise in nursing resonates with the work of Roper Logan and Tierney and their model of nursing care. The Roper, Logan and Tierney model of nursing (originally published in 1980, and subsequently revised in 1985, and 1996) is a model of nursing care based upon activities of daily living and is named after the authors. The model and its application is taught in schools of nursing throughout Ireland and is particularly well used by nurses in medical and surgical settings.

Nora’s professional knowledge and skills are associated with giving direct care: assessing, planning, delivering and evaluating care. As previously mentioned, she is required to keep accurate clear and current patient records within a legal and ethical framework. The Nursing Care Plan provides such a framework. Nora records the results of a patient’s assessment. She also documents how she plans to deliver care and systematically evaluates such care and correspondingly the particular patient’s progress. Care plans were first introduced in the hospital
in the early 90’s. They aim to ensure that patients receive high quality care that is evidence based. They continue to be a necessity in an increasingly litigious society where the public demands greater accountability. The plans also serve to protect nurses from allegations such as neglect or inappropriate care.

Her professional knowledge and skills have undoubtedly been shaped by her education and training in college and in the hospital.

Nora’s claim that nurses tend to practice according to routine and ritual suggests that some nursing practices may have been initially informed by an evidence base but soon become part of the routine. Her ongoing study may provide an opportunity for greater reflection.

Ellen’s professional knowledge and skills

For Ellen the most important work related skills are listening, counselling and communicating. The most frequently used skill in her current position is counselling. Like Nora she asserts the importance of having a sound clinical knowledge in order to practice safely and effectively. This view is also highlighted in requirements and Standards for Nurse Registration Education Programmes (ABA, 2005). Ellen feels that the listening, communicating, and counselling skills go hand in hand with the clinical knowledge. For instance, specially focused knowledge about the condition is necessary to advise patients regarding its management.

one can’t counsel a patient’s anxieties if they don’t have the correct clinical knowledge.

(Ellen)

Ellen acknowledges the limits of her competence and emphasises that she only counsels patients about how to manage their condition. If she feels that they would benefit from the services of a psychologist or a psychiatrist she would point them in that direction.

Like Nora, Ellen gives direct and indirect patient care. She needs to identify and meet the nursing care needs of patients. Hence, she requires knowledge and skills in the areas of assessment, planning, delivery and evaluation of care.

As previously mentioned, listening skills and clinical knowledge are necessary requirements when assessing a patient’s needs. When a patient calls Ellen’s service she knows the appropriate questions to ask in order to elicit information that is necessary to plan the patient’s care. There is knowing in her act of questioning patients about their medication, symptoms (their onset and duration) and lifestyle. This practice is informed by Ellen’s extensive knowledge about the condition and factors that may exacerbate it.

In addition, Ellen refers to the importance of looking at the whole picture when considering how to manage the condition. This means taking into account the personal circumstances and family dynamics of each individual case. Such knowledge gained from her holistic individualised and patient centred approach to assessment is used to inform the delivery of care.

So really looking at each individual case individually with the patient and the family and their circumstances and their age and the dynamics, whether they have their own family or whether they are still in their own family support you have to take it all into consideration and with the condition like the one that I deal with you need the whole picture.(Ellen)

Following Ellen’s assessment she plans the actions that are required and delivers the appropriate care. Frequently, Ellen’s assessment leads to the provision of indirect care. For instance, she may
recommend that a patient has an investigation such as a blood test. Such a recommendation is informed by the knowledge that high levels of medication can lead to particular adverse side effects. The result of such a test is then used to plan appropriate care. In addition, to facilitate the timely delivery of appropriate care, Ellen often discusses cases with a member of the multi-disciplinary team such as a consultant in the specialty. The consultant may recommend alterations to the patient’s medication dosage. Ellen then calls the patient to advise them of changes.

Ellen’s delivery of care may also include educating patients and their relatives about how to manage their condition. In such situations, she explicated her espoused knowledge about lifestyle factors and their impact on the condition.

There are a number of nursing skills that Ellen has acquired throughout her career. She demonstrates a kind of dual knowledge base ("expert" clinical and intra and inter personal) each distinct but complimentary. She mentions skills of organisation such as tidying as she goes, organising and planning time and prioritising tasks. She also mentions having the confidence to talk to the public. These skills are still relevant in her current position, particularly the skills of organising and time management.

Since moving into her role as a nurse specialist Ellen has expanded her professional knowledge and skills beyond the domains of direct and indirect patient care. For instance, she has learned how things work around the hospital and service planning and auditing skills.

please know how to get a computer, how to get office space, how you know how to plan your service, how to look for extra hours, how to audit your service, how to prove what you are doing is meeting the requirements of all the health service reports that they are doing (Ellen)

The knowledge gained from auditing her service contributes to her service plan. She collates evidence of patients’ care needs.

showing that … people want to stay out of A and E departments, want to be seen at the outpatients less, want access to information, want access to education, you know want a different type of a service. (Ellen)

The outcomes of Ellen’s audit appear to foster reflection regarding good practice. Her knowledge of patients’ care needs informs her practice in the sense that she counsels and empowers patients with information so they can look after themselves.

Ellen also has pedagogic skills. She educates both at undergraduate and postgraduate level. Knowledge and experience of the specialty informs her education programmes.

The commitment to continuous professional development makes demands on Ellen’s time management skills. She has to find the time to read about current research and policies.

and you are constantly educating yourself and keeping up to date with evidence based within the illness as well and guidelines and benchmarking and all of that.(Ellen)

She thinks that the move towards evidence based practice is a good development.

We do things differently, things have to be evidence based they have to be well researched. (Ellen)
The development of personal coping mechanisms seems to be an important professional skill for Ellen. In order to cope effectively with her demanding workload, she has learned to allocate people extra time so she can still leave work on time.

*I am much better at looking after myself within my role and realising that if I don’t do that I am no good to anybody within it you know* (Ellen)

Interestingly, following the birth of Ellen’s first child she knew she had to move on from working in intensive care. It seems that her personal coping mechanism was to move out of that environment.

*because when I became a mother I felt I could identify with everybody. Personally I found it more difficult when I had family myself. I didn’t feel I could remove myself as well as I used to, and that’s when I knew I needed to transfer to a nursing role with less fatalities.* (Ellen)

Her coping strategy appears to have been to protect the personal by finding a possibly less demanding professional context in which to work.

**Restructuring and Ellen’s professional knowledge and skills**

As part of the reform of nursing due to external and internal influences there has been a significant increase in specialisation. The Report of the Commission on Nursing (GoI, 1998) was highly influential on the development of nursing and midwifery specialties in Ireland. Following the Commission’s recommendations a National Council for the Professional Development of Nursing and Midwifery (the National Council) was established in November 1999. The purpose of the National Council is to give guidance and direction in relation to the development of specialist nursing and midwifery posts and post-registration educational programmes offered to nurses and midwives. Since its establishment the National Council has approved a large number of clinical nurse/midwife specialist positions.\(^{51}\)

According to Ellen The Commission on Nursing has had a major and positive impact on her career as a nurse. It allowed her to pursue a clinical career pathway rather than necessitate a move to management.

*I do think the Commission on Nursing did change a lot in the way nurses shaped their career and in their career pathways…it’s been the most important document over the last thirty or forty years ....it gave me a new career completely because I am a specialist nurse that is my main job. I absolutely don’t know whether I’d be still nursing if I was still on the ward. There was only one career pathway once senior at ward level the next step was into management and I never went nursing to manage people I went to nurse.* (Ellen)

The introduction of specialisms and a clinical career pathway has impacted on Ellen’s professional knowledge and skills. In order to create a clinical nurse specialist position Ellen had to develop specialised knowledge about a particular disease and its symptoms and management.

Ellen’s skills in planning and auditing a service have also been shaped by the creation of clinical nurse specialist positions. According to the National Council (2004) audit of current nursing practice and evaluation of improvements in the quality of patient/client care are essential requirements of the clinical nurse specialist role. However, there was no targeted training to support the development of Ellen’s auditing skills. Hence, she sought assistance and advice from

\(^{51}\) See The Third Annual Progress Report of the Monitoring Committee of the Implementation of Recommendations of the Commission on Nursing (Government of Ireland, 2002)
the multi-disciplinary team. The outcomes of Ellen’s audit demonstrate that her knowledge and skills are very much in demand by patients suffering from this disease. The demand is apparent from the high volume of calls received by her service.

The creation of Clinical Nurse Specialist positions may also have encouraged the development of Ellen’s research skills. According to The National Council (2004), specialist nurses need research skills because they must contribute to nursing research which is relevant to their particular area of practice. Ellen has also enhanced her research skills through further study and through cooperation with colleagues. The availability of post-graduate programmes for nurses has facilitated this process. However it is noteworthy that there is a lack of postgraduate courses dealing with the condition in Ireland.

Ellen’s service planning skills appear to have been influenced by the new emphasis on health promotion and prevention of illness. This approach is advocated in Primary care A New direction. The Health Strategy (GoI, 2000). Ellen offers a preventative role through educating patients in how to manage their condition and thereby reducing presentations at casualty.

The Scope of Nursing and Midwifery practice Framework (ABA, 2000) considers the principles that should underpin decisions about the scope of nursing and midwifery practice. Ellen’s comment about referring patients to other services when appropriate demonstrates that she has an awareness of her scope of practice.

Ellen’s comments about looking at the whole picture when considering how to manage a patient’s condition suggest that she adopts the recommended holistic, patient centred approach to care. Such an approach is advocated in the literature. (See Requirements and Standards for Nurse Registration Education Programmes (ABA, 2005), The Nursing and Midwifery Resource (DoHC, 2002a), An Evaluation of the Effectiveness of the Role of the Clinical Nurse/Midwife Specialist (National Council, 2004).

_Aideen’s professional knowledge and skills_

In her managerial position, Aideen considers communication the most essential skill. She needs the communication skills necessary for negotiation, influencing people and reassuring. These skills may be informed by knowledge in relation to effective management and leadership. Aideen also needs effective communication skills for writing reports.

When negotiating about taking staff from wards to cope with shortages in other wards she tries to reassure staff because it is so busy and makes sure that they feel supported. She also has to make sure that they have the available resources to do their work. She says that you have to be diplomatic with staff and you can’t go in like a bull in a china shop and say “I’m just taking somebody.” As a manager she doesn’t say things like “it doesn’t look busy to me” because she is aware that she might not appreciate every little nuance as she is just passing through the ward.

There is definite evidence of “knowing” in Aideen’s actions. Her interpersonal skills and sensitivity to the needs of others may have come about as a consequence of reflecting in action. For instance, Aideen may have observed that when nurses are given an opportunity to voice their concerns and engage in a collaborative decision making/problem solving process with regard to staffing, they feel more reassured and confident in their practice.

Despite the fact that Aideen is no longer involved in direct patient care, she still needs clinical knowledge to do her job effectively. Her knowledge of the area of specialty is particularly important. For example, from her nursing experience she is aware of the kinds of conditions the patients have and the resources that are necessary to care for them. Such knowledge is particularly relevant when developing a staffing plan based on patient census, case complexity.
and staff experience. She thinks that this knowledge also allows her to empathise with staff. Furthermore, knowledge of the area of specialty helps her to plan professional development provision.

The ability to think laterally and problem solving skills are also important in Aideen’s job. Aideen also referred to the importance of organisation and planning skills such as prioritising. Knowledge with regard to what is practical and realistic is also relevant to her tasks.

*I mean sometimes people can become quite tunnel visioned and you want to kind of try to get them to see the bigger picture because this is only one small part of the whole workings of the hospital and so you know in the ICU they are thinking of ICU but I am thinking of all of the wards, the ICU, the medical staff, the anaesthetic staff, the patients, the hospital as an organisation, because I am in management you know we have a role in management so we are trying to think laterally and then also have some vision you know, some problem solving skills as well. (Aideen)*

Problem solving skills are particularly important when it comes to finding money to recruit additional nursing staff. For instance, with the ceiling on whole time equivalent staff it is difficult to fund new positions. Moreover, there are a lot of other disciplines competing for resources for additional doctors, physiotherapists etc.

*you can get some posts funded privately so that’s where I am talking about the lateral thinking (Aideen)*

Resourcefulness is another skill that is demanded of managers. They are encouraged to save money because the hospital resources are stretched.

Knowledge of the hospital is also necessary for Aideen. For example, she knows how the organisation works and whom she needs to contact.

Aideen referred to the move towards evidence based practice in recent years. She thinks that the emphasis on practising according to research evidence is for the benefit of the patient. She recalls how nurses used to operate according to routine and ritual. For example, they used to check the children’s heads for lice and give them suppositories to make them go to the toilet before an operation.

Aideen also demonstrated considerable knowledge and skills in the area of interviewing. She explicated her knowledge when helping a candidate prepare for an interview. Her knowledge includes knowing appropriate and relevant questions to ask in order to elicit important information. In addition, she knew the strategies and skills necessary to communicate effectively. For example, she asked the candidate to qualify a response such as ‘I’m a good communicator’ with examples such as “I take my time with people and I am unhurried, I use language they can understand”.

Restructuring and Aideen’s professional knowledge and skills
Operational constraints such as nurse shortages and the ceiling on the recruitment of whole time equivalent staff means that Aideen requires considerable leadership and management knowledge and skills. Her skills of negotiation and reassuring are much in demand when the wards are understaffed. Similarly, her knowledge about effective leadership and management is essential in order to carry out her manpower planning tasks successfully.

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52 The factors contributing to the nursing shortages and the ceiling embargo have already been discussed in the section entitled working conditions.
Working in an environment where provision and development of services must be placed within determined expenditure limits has prompted Aideen to develop skills in budgeting and creative ways of accessing resources. The reasons for financial accountability particularly in the area of staffing have already been discussed in the section entitled financial accountability.

Aideen's tasks and responsibilities are outlined in her job description. This practice is recommended in the Report of the Commission on Nursing (GoI, 1998). According to the Commission, when appointing nurses to management posts they need to be furnished with realistic, explicit and detailed job descriptions.

Appropriate responsibilities are also outlined in the Commission report (GoI, 1998) and they resonate with Aideen’s tasks as a nurse manager. For instance, in line with the recommendation of the report, Aideen is required to ensure that appropriate in-service education programmes and on-going learning needs are met for all assigned staff. Another recommendation refers to the need for nurse managers to ensure that modern standards of clinical nursing are in operation. The Hospital and Aideen’s participation in accreditation facilitates the monitoring of clinical standards.

4.2.3 Learning (formal and informal, practice and experience)

The nurses consider that their skills and knowledge have been developed through both formal education and practical on site experience. All nurses show considerable initiative and dynamism in terms of pursuing continuous professional development opportunities. Each nurse has gained (or is in the process of studying for) postgraduate qualifications. Colleagues too are cited as an important source of learning.

Nora learned about different conditions during her training but certain conditions in her area of specialty she learned about when she got on the ward. She learned from her preceptor and her senior colleagues who would explain about the various illnesses and their treatment. She commented that there are folders and books of information on the ward but the difficulty is finding the time to read them whilst working full time.

She feels that she got her basic knowledge through the training and the specific knowledge on the ward.

you enhance your basic knowledge when you are training and your care. I think so anyway. Unless sometimes you are so pressed for time it’s difficult. (Nora)

Contrary to aspirations for evidence based practice, Nora claims that often nurses work according to routine and ritual.

I suppose really we are very set in our ways and we do things as a matter of course but then there’s so much to do that you have to do it at some point. (Nora)

She said that they often give the drugs and then do the observations but perhaps it should be the other way round because patients in her area of specialty can change their status within a matter of minutes.

At this point in Nora’s career she feels that she would like to expand her knowledge because she wants to know more about the conditions in order to improve her practice. She thinks she needs more knowledge so as to be able to speak to relatives with more confidence because she gets asked some very detailed questions. Expanding her knowledge and skills is also a way of
advancing her career. She comments that further qualifications are necessary if you want to progress.

*the way it is in nursing now is that everybody has degrees there are a lot of people with masters, there’s a lot of people with higher diplomas. Everybody has something. Management courses. And ok you can be a nurse but you certainly wont progress with not even a degree I suppose now. (Nora)*

She commenced a higher diploma in her area of specialty in September 2006.

Ellen says that she has learned through the courses she has done and particularly from peer support (from consultants, psychiatrists and psychologists working in the specialty and registrars, medical fellows the wide multi disciplinary team). She states that she learned an awful lot from her nurse colleagues throughout her nursing career; she learned different skills from different people.

*I might have learned an awful lot about how to cope with a distressed family for one. I may have found out an awful lot about how to actually manage other nurses from another. Another would have taught me you know well we can’t admit two because we have to get two discharged and management skills. I learned something from each and every one of them. (Ellen)*

She cites the method of ‘see one, do one, teach one’ as her preferred method of learning/skill acquisition. However, she acknowledges the role of formal education also. She believes her knowledge has expanded from the academic training and assignments and research she has carried out.

*But I do need that piece of paper for the extra information around that subject that goes into it in more detail, more academic as well which helps me understand ‘see one, do one, teach one’ as well. So I like a combination of both and I think I’ve received my skills through a combination of both methods. (Ellen)*

Ellen has gained a number of qualifications since her initial nurse training. She did a certificate in infection control. Her senior sister advised her to do something like that because she’d get permanency a lot quicker if she had an extra qualification. She has a higher diploma in her area of specialty. She then studied for a diploma in a particular disease and is in the process of completing a Masters in the same disease. She has had to go to England for all her education about this particular disease. They have all been through distance learning or e-linked with colleges.

Although Ellen has no formal education in counselling at post-graduate diploma degree or higher level she has acquired her skills through experience observing psychologists and psychiatrists who would be expert in counselling. She has also attended in-service training within the hospital.

While Ellen thinks that continuous professional development is very beneficial, she regrets that the system doesn’t allow employees to take full advantage of in-service programmes.

*your clinical case load really comes first you have to prioritise your clinical case load. It’s a luxury to attend all those things you know (Ellen)*

Ellen comments on taking responsibility for her continuous professional development.
you are constantly educating yourself and keeping up to date with evidence based within the illness as well and guidelines and benchmarking and all of that. (Ellen)

From work experience she has learned to allocate people time and a little bit extra so she can still get out on time.

I am much better at looking after myself within my role and realising that if I don’t do that I am no good to anybody within it you know (Ellen)

From life experience she has learned coping skills

I definitely think perspectives in your own personal life help you deal with things better you know. (Ellen)

About three years after gaining her general qualification, Aideen did a course in her area of specialty. She has also completed a diploma in Management in a college of medicine that was a year long in duration. In addition she participated in a diploma course in Communications in the same institution. She has also gained a diploma in Teaching and Assessing. The latter course was six months duration. Aideen was funded by the hospital to study for a two year leadership programme. It was particularly difficult to get accepted onto the course.

it was absolutely excellent. It wasn’t academic as such. It was much more … practical, how to work and how to be a leader and it was all practical … case studies (Aideen)

She also has a degree in nursing. She did it by distance learning in three years.

Aideen’s numerous qualifications suggest that she values formal learning opportunities to enhance her skills and knowledge. She states that she developed her knowledge in relation to management and leadership through academic study and practical experience. According to Aideen, she learned about communication skills in college and that some of it was putting names on things that she was already doing naturally. She thinks that leadership/communication and management skills are inherent but you can learn practical techniques which enhance skills and experience. She summarises her sources of learning as follows: courses, colleagues (doctors and other professionals) and experience.

Restructuring and learning (formal and informal) practice and experience

The nurses’ pursuit of post-graduate education has been facilitated by reforms following the recommendations of the Commission on Nursing (GoI, 1998). There has been a proliferation of postgraduate programmes in recent years. Furthermore, there is some funding to support continuing education. The consultative process of the Commission identified a demand and need for postgraduate education programmes for nurses and midwives. Hence, The National Council for the Professional Development of Nursing and Midwifery (The National Council) was established in 1999. It recognises the importance of continuing education for nurses and midwives in the provision of quality care and has responsibility for overseeing postgraduate education programmes for these professionals. The National Council also has funding to support additional developments in continuing education which is channelled through the recently established Nursing and Midwifery Planning and Development Units. These units provide education and training and are also involved in research projects.

According to the ProfKnow survey 39% of nurses have additional education at university level that is relevant for their work. The most frequent length of study was more than one year. A majority of surveyed nurses also indicated that they participated in continuous professional
development events, 77% of Profknow survey respondents had participated in courses or conference organised by their employer during the last year. 64% attended courses between 3-9 days of duration. A further 14% participated in courses for more than 10 days in total. These findings highlight nurses’ commitment to lifelong learning.

The Nurses’ comments suggest that availing of formal learning opportunities is one means by which they can further their career, job diversification and promotion prospects. This is particularly significant since the progression of specialisation and the development of a clinical career pathway for nurses and midwives (following the recommendations of the Commission on Nursing, GoI, 1998). Nurses and midwives no longer need to become managers in order to be promoted. There are now clinical nurse/midwife specialist positions. In order to gain the necessary qualifications to practice as a specialist nurse, postgraduate diploma courses are available in areas such as gerontology, coronary care, intensive care, peri-operative care, paediatric nursing, and accident and emergency nursing (to name but a few) in 3rd level institutions in the Republic of Ireland. However given that Ellen has had to go to the UK in order to pursue studies in her area of specialty, there is scope for developing the range of postgraduate courses available in Ireland.

Profknow survey data confirms the importance of colleagues in terms of supporting learning. Colleagues were cited more frequently than journals, newspapers and the Internet. 53% of respondents said that at least once a week they consulted colleagues to gain knowledge. Moreover, most nurses agreed that there was more team work nowadays.

The interviewed nurses’ comments about learning from their colleagues suggest that they value a team approach to care. Such an approach is espoused in several policy documents. For example, An Bord Altranais (ABA, 2002) talk of the need for a nurse to act as an effective member of a health care team and participate in the multidisciplinary team approach to the care of patients/clients. Indeed evidence from observations demonstrates that the nurses work in teams. Ellen frequently consults with doctors when discussing appropriate patient care. Aideen visits the wards to link with the ward sisters. They discuss staffing issues, resource concerns and problems with patients or relatives. She spends considerable time planning meetings and exchanging ideas. Nora was frequently observed to work closely with other professionals. For example she co-operated with health care assistants and physiotherapists when attending to patients’ mobilization and hygiene needs.

Nora showed an awareness of the need to keep up to date with evidence when she said she needed a good knowledge of her area of specialty. However, she felt that time pressures and staff shortages impinged on time available to read the various folders of information on the ward. Ellen talked about needing sound clinical knowledge to do her job effectively and taking the initiative to educate herself. Their comments are unsurprising given the current climate within the health service. Numerous policy documents espouse the importance of knowledge informing practice. For example, ABA (2005) state that nurses need to demonstrate a knowledge base and a level of competence in clinical practice skills essential for safe practice, which are grounded in recent evidence based nursing research, where available. The Commission on Nursing (GoI, 1998) asserted that research should form an integral part of all aspects of nursing and midwifery if nursing and midwifery practice is to be evidence based. Similarly, one of the key aims for the National Health Strategy (DoHC, 2001) is to ensure the delivery of high quality services that are based on evidence-supported best practice. The Interim Health Information and Quality Authority (HIQA) has been established under primary legislation to advance this aim. For
healthcare workers, the HIQA’s role is to ensure that: they apply best knowledge, they deliver best care, best value for money is obtained, and they are supported in achieving these objectives. Perhaps the emphasis on evidence based practice has prompted 40% of Profknow survey respondents to consult scientific journals or books relevant to nursing at least once a month.

The Hospital funded Aideen to participate in a leadership programme. Such practice is consistent with the recommendations of the Report of the Commission on Nursing (GoI, 1998). According to the Commission (GoI, 1998) nursing and midwifery managers should have management training before taking up a post and be required and supported in continuing to develop management skills. The Commission also recommended that, where appropriate, nursing and midwifery management development programmes should be run in conjunction with management programmes for other professional groups and general managers. Indeed Aideen’s course colleagues in the leadership programme came from a variety of disciplines and backgrounds.

4.3 Professional status and position

4.3.1 Symbolic aspects: respect and prestige

Nora thinks that there are some who perceive nursing as a lower rated job and think that all they do is wash people. She feels that until someone is placed in the situation where they have a sick relative they don’t appreciate the nurses’ knowledge. Where previously Nora felt that nursing (in comparison to other occupations) was a relatively low status job, she feels that perceptions are changing.

*I think it used to be kind of maybe not low rated but it wouldn’t certainly have been perceived in the eyes of other professions like physiotherapy or speech and language therapy.* (Nora)

She thinks that nurses are making more decisions than they ever have before and with the introduction of the degree and masters and higher diplomas, perceptions are changing.

Aideen echoes Nora’s thoughts about the previously relatively low status of nursing. She thinks that certain tasks and responsibilities may have diminished nurses’ efforts to be taken seriously as a profession.

*if you are a profession and you know you want to be taken seriously as a profession you can’t be cleaning the sluice and that’s … what we were doing … there’s cleaners to do that now* (Aideen)

Although the nurses sense a possible improvement in status, the Profknow survey indicates that 83% of nurses agreed somewhat or agreed strongly that their professional expertise is more questioned by patients nowadays. This may be because the public in general is more educated. Patients may conduct their own research (possibly via the Internet) in order to gain an understanding of their condition and this may lead them to compare their “knowledge” with that of the nurse. However, 95% of the survey respondents claimed that it was quite true or very true that their patients trusted them.

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Ellen expresses concern about nurses getting caught up in titles and roles.

*I think because we now have a specialist role and a nurse manager role, staff nurses may feel that their roles are less important. But if one is confident and enjoys one’s practice you won’t care how others perceive your role* (Ellen)

As a consequence she thinks it’s only a matter of time before they start making more titles, grades and uniforms out of the different type of staff nurse. She predicts this will be a “big mess”. Ellen feels that when the degree and the master nurse graduate they won’t be happy just to be called a staff nurse and the salary won’t be good enough for them. She hopes there is more change to come.

**Position in health care team**

Nora and Aideen frequently stressed the integral and momentous role of nurses. Nora talked about how other members of the health care team such as doctors, physiotherapists and speech and language therapists come for a short time but nurses have the biggest role in contributing to the patient’s care. Similarly, while Aideen acknowledges that the other disciplines are key and essential, she thinks that nurses have a very strong role by virtue of the fact that they are on the wards 24/7.

*If you are not doing it yourself you are arranging for somebody else to do it Everything is down to nursing. The nurse has to make sure that the cleaners are doing their job ... pharmacy you have to make sure that the pharmacy is up. You have to make sure that the doctor sees the patients. You have to make sure the tests are ordered. You know every single thing comes back to nursing* (Aideen)

Aideen wonders if there is a little bit of resentment from other disciplines that may feel nursing does not acknowledge their importance. She thinks as a divisional nurse manager that she can’t do her job without other team members. In some ways she sees herself as more of a manager than a nurse

*but I would see it as being a nurse manager ...You are managing nursing but being cognisant that nursing is one part of a whole field of disciplines that one can’t manage without the other.* (Aideen)

Ellen thinks that staff nurses and Non Consultant Hospital Doctors (NCHDs) are the unsung heroes of the health service. *They do ferocious work.* Interestingly she feels that her job is no more or less important than other members of the health care team. She sees herself as equal to her colleagues. She comments that *none of us would be here without the patient.*

Aideen thinks there is a stereotype of the nurse as a victim. She doesn’t want to be like that.

**Restructuring and professional status**

Nora’s sense that some members of the public have a perception of nursing as a lower rated job may be understood in the context of the history of the role of the nurse. Aideen referred to nurses having to clean out the contents of the sluice room when she was a student. Now there are machines to serve that purpose. Previously nurses had responsibility for housekeeping activities such as cleaning and tidying which are now the responsibility of cleaners. Similarly, health care assistants have taken over tasks such as washing patients and making beds. According to Robins
it may be construed that, nurses over the years have increased the amount of time they spend on patient-related activities and less on non-nursing activities. Perhaps transferring tasks (such as cleaning and making beds) to support staff has enhanced nurses’ sense of professional status.

The idea that an increased awareness of the work of nurses leads to an appreciation of nurses’ knowledge and skills, is somewhat supported by a survey by the Central Statistic Office (CSO, 1998). According to the results of the survey, forty-two percent of the population aged eighteen years or over had some contact with nursing services in the previous two years. Over ninety percent of respondents gave an overall rating of good or excellent to the nursing service they received. These findings were similar to those of a survey undertaken by the Irish College of General Practitioners, when ninety-three percent of patients questioned held nurses in high regard (see O’Regan, 1998).

Nora’s comment (about the changing public perception of nurses) suggests that the esteem in which nurses are held is related to their education and training. She implies that gaining qualifications such as degrees, diplomas and masters enhances the status of nurses. Moreover, the award of a degree places nurses on a par with other paramedical staff such as physiotherapists and speech and language therapists. Similar sentiments are expressed by An Bord Altranais (2000). They claim that the improvements in education and in the quality and broadening skills of nursing in general have not only enhanced the status of nurses within the caring professions but have also increased their self esteem.

Interestingly, Ellen suggests that the creation of new roles has made nurses more aware of (and in some cases dissatisfied with) their status and position. Her observations lend further credence to the idea that increased educational qualifications are associated with higher status. She thinks that those with degree and masters qualifications will want to be recognized in terms of titles and pay. A pre-Budget submission from the Irish Nurses Organisation (INO) provides evidence of nurses’ dissatisfaction with their pay. This is discussed below.

4.3.2 Material aspects: earnings

Each nurse expressed dissatisfaction with their salary. Nora thinks that nurses are not paid well enough and that nurses are always going to be at a disadvantage. However she says that nurses can make good money if they work a lot of hours and nights and overtime.

the basic pay is not enough money for what you have to do. If you are working a Monday to Friday job you wouldn’t be making much money. The only thing that brings it up is the shift allowance. (Nora)

Ellen is very very unsatisfied with her salary. She thinks the salary is not appropriate for her level of responsibility. Similarly, Aideen notes that administrative staff have less responsibility and accountability yet they enjoy a better salary.

In a big hospital like this ... in some ways ... nothing can happen without us. Every meeting has to have a divisional nurse manager because everything involves nursing no matter what decision you make nursing is going to be impacted by that decision so nursing has to be there so you have a huge remit and responsibility and yet you have

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54 Nursing and Midwifery in Ireland in the Twentieth Century Fifty Years of An Bord Altranais (The Nursing Board) 1950 - 2000
55 The Quarterly National Household Survey. It included questions designed to measure the public’s level of contact with, and their assessment of, nursing services. A total of 33,500 households were included in the September to November 1997 quarterly survey
other people with half that responsibility and remit and they are on a higher pay scale because they are on a clerical pay scale and that is very frustrating. (Aileen)

Ellen thinks that additional responsibilities should be reflected in the salary. She is unwilling to take on a responsibility such as writing prescriptions on her current salary.

Restructuring and nurses’ earnings

Under the national agreement, Sustaining Progress Social Partnership Agreement 2003-2005 (GoI, 2003a) nurses have received substantial pay increases (over 13%) in addition to the benchmarking increases of between 8% and 16%. In return for these pay increases, nurses (and the other parties to the agreement) committed to co-operation with flexibility and modernisation. The key modernisation achievements include: maintenance of industrial peace and the initiation of a major skills mix initiative (the establishment of the grade of Health Care Assistant) on a service-wide basis.

Despite securing a pay rise in recent years, the nurses’ remain dissatisfied with their salary. This may be explained by a number of factors. According to a pre-budget 2007 submission56 from the Irish Nurses Organisation (INO), nurses as degree level graduate professionals are not treated equitably and in the manner in which other health professionals are recognised. For example, there is currently a pay anomaly which sees registered nurses paid less than social care workers who hold no qualification. In addition, the same report states that nurse/midwifery pay rates are at a lower level than all other graduate health professionals. Furthermore, it appears that nurses work more hours for less money. Currently, nurses work a standard 39 hour week while all other health professional staff work a 35 hour week.

The high living costs in Dublin may also contribute to some nurses’ dissatisfaction with their salary. The INO have called for the introduction of a Dublin Weighting Allowance in recognition of the additional costs arising from working/living in the capital city. Apparently, the shortage of nursing/midwifery staff is most acute in Dublin and this may be attributable to the cost of living to some extent.

4.4 Work-life balance

Nora finds that she spends a lot of time at home.

since I reduced down my hours with the parental leave I find it much easier. No it’s fine for me because ... I have great family support so it’s not really an issue for me. (Nora)

Ellen works to live rather than lives to work. She thinks the nursing profession and other professions outside nursing are wide open to exploitation.

You could certainly get swallowed up here and you could certainly put in a 60, 70, 80 hour week without getting paid for it and nobody would thank you for it or even wonder why you are here you know you can get totally caught up in the whole thing if you allow yourself to…no different to other jobs outside nursing (Ellen)

She found that for the first few years of her job she was bringing work home. It was felt that it was unnecessary. Experience has taught her to manage her time more effectively.

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56 as accessed at http://www.ino.ie/DesktopModules/articles/Documents/PreBudget%20Submission%20for%202007.pdf
Aideen feels that she doesn’t give her personal life as much time as she should. She says that from Monday to Friday it’s work work...

but then Saturdays and Sundays I would make a big effort to kind of go out and do things with the kids so housework comes very far down the line… there’s things like you say … I’d love to be doing a bit more in the garden or …I’d like to paint that room .... I certainly wouldn’t get any marks for homemaker of the year (Aideen)

She notes that her work commitments allow her less time to attend to various tasks.

You know the work life balance isn’t good and I am always last to send in the birthday card … they (her child’s class) are leaving school at the end of this week and I have no present for the teacher… I never go to the supermarket (Aideen)

It appears that part of the reason that Aideen’s balance is in favour of work is because she wants to give 200% to her job and is motivated to progress in her career. She feels that there is a perception (although no one says it out loud) that a woman with a family wouldn’t want increased responsibility or promotion.

people are saying have you not got enough to do minding two kids …where are you going to find the time for that … if you didn’t you know kind of put yourself forward … people would kind of assume you are not interested or would overlook you … because they think ah you have got two kids or … you are not interested. So in a way you do kind of have to keep yourself out there and … go, look, just because I have got a family, it doesn’t mean I can’t still give two hundred per cent to this job. (Aideen)

She would like to do a masters but it is just a case of finding the right time.

Restructuring and work life balance

Ellen’s comments about the work life balance and bringing work home may be understood in the context of her position. The role of clinical nurse specialist is relatively new and as Aideen says

their workload is huge. In a lot of cases there is only one person doing the job so if they go on holidays there is no cover you know and they themselves find that really really stressful if they have to go away for the day you know the service doesn’t continue and they have to pick it all up when they come back and they would find that very very frustrating and … at times overwhelming. (Aideen)

Furthermore, with the ceiling on recruitment they can’t get money to appoint another nurse specialist.

Nora is satisfied with her work life balance because she has been able to reduce her working hours according to The Parental Leave (Amendment) Act 2006.

Aideen’s long working hours may be attributable to the considerable demands inherent in her position. Such demands were referred to in the section entitled tasks and responsibilities. Moreover, the shortage of nurses and lack of resources makes her work more challenging and time consuming.

Aideen and Ellen’s comments resonate somewhat with survey findings. 69% of survey respondents said that they need to do more than is required by their contract in order to do their job effectively.
4.5 Professional ideals, values and motivation

Nora thinks that you have to want to do nursing because you wouldn’t last in it otherwise. She values being diligent, conscientious, and responsible. She comments how a nurse’s actions impact on others.

*You would have to give notice if you were ringing in sick it’s not like normal jobs because if you ring in sick at short notice they are stuck and people are stuck and patients are stuck and that’s the type of job it is* (Nora)

This attitude impacts on her practice in a number of ways. For instance, if another nurse isn’t pulling her weight, she will take on that nurse’s responsibilities

*you can’t just say well I’m not doing it because she’s not doing it because it effects somebody else.* (Nora)

Similarly she doesn’t leave a patient when she is in the process of doing something for them even when it is time for her break.

*you just can’t get up I mean that’s all part of nursing kind of ethics and your professional obligations to people* (Nora)

According to Nora the basic nursing care is the core of nursing and that should always be the case.

*Everything else can change around it the policies and the research and everything but you have to be able to provide the basic nursing care and if you can do that then you are a good nurse.* (Nora)

She is motivated to work for the patient’s benefit by delivering basic nursing care. She feels it is important

*that they are washed properly, they look well, that they are comfortable, that they have no pressure sores, that you turn them on time, that you provide the equipment to prevent pressure areas, that you prevent them from having complications of bed rest, clots and chest infections…* (Nora)

Sometimes Nora takes on others’ responsibilities for the benefit of the patient. For instance, she helps the care attendants make beds.

*you have to do that or it wouldn’t be done … but there are some people who feel that that’s not a nursing duty at all* (Nora)

Ellen reports that her professional ideals have remained constant through her career. She values

*fair access health service for all public people and that has never changed. With good high standards in nursing and medical care* (Ellen)

She describes a good nurse as
one who is knowledgeable, accountable, autonomous, responsible, a good observer, communicator, caring, patient focused, holistic.. (Ellen)

The opportunity to deliver nursing care motivates Ellen. She is aware that there are a variety of jobs in the health service that require a nursing background but they don’t appeal to her because

if you are not delivering nursing care … I don’t like it. (Ellen)

Ellen values feedback and would like a performance review to improve herself or to “pat herself on the back”

I am always open to constructive criticism I think it is healthy and I prefer to have it than not to have it. (Ellen)

At the start of each year Ellen breaks up the year into quarters and independently sets targets within those four quarters.

I would motivate myself within each three months to meet that target. That doesn’t always happen but it’s the way I keep myself focused and keep myself motivated. (Ellen)

Colleagues are also referred to as motivators. In addition, Ellen acknowledges her sister (who has worked as a nurse all over the world) as a great motivator.

Aideen in her position as a nurse manager values minding her “own patch” rather than getting caught up in Hospital politics. She thinks that focusing on what people in other departments are doing makes her less effective.

She treats staff like they are her peers. She values making sure that they are progressing and developing in their careers. She would like to think that she is supportive of them.

I mean always trying to … be the manager that people are always saying they want, the manager who gives feedback, the manager who thanks people, the manager who is supportive, the manager who treats you like a human being, the manager who says did you have a good holiday, are you better…so I suppose I would try to be that manager. (Aideen)

She thinks it is important to be proactive.

sometimes you can kind of sit and say well nobody told me about that or they didn’t come and talk to us about that and it was very much like ok well maybe they didn’t but that doesn’t mean you cant go and talk to them. (Aideen)

During Aideen’s pre-service nurse education the students were told to treat patients as they would their relatives. Aideen feels that patients should be approached with an awareness that they are at their most vulnerable. She values being courteous, caring, sensitive, empathetic.

Aideen doesn’t see her role as a nurse manager as ‘just a job’.

it’s not just a job to me and nursing was not just a job. You know I mean you don’t have to make a cup of tea for relatives after they have come from Donegal you could send them to the canteen but if I had a minute to spare I would have made them the cup of tea. (Aideen)
Aideen thinks that going that extra inch is an important quality in a nurse.

"staying that hour and not asking for the hour back...and if I see people doing that I will try to give them the hour back" (Aideen)

Sometimes people ask her if she would apply for a general managers post or an administrative post.

"I am terribly loyal to nursing and ... on the one hand yes for an ambitious personal career development point of view I think yeah I should really try to move into that and then I think oh no ... I feel I have to stay loyal to nursing and I have to keep ... you know bringing nursing along ... so not really no because I am too loyal to nursing" (Aideen)

Restructuring and professional ideals, values and motivation

It has been suggested that increasing the academic aspect of nursing would have a negative effect on traditional caring and interpersonal skills. However, this study found no evidence to support such a notion. While the nurses recognise the importance of clinical knowledge, their comments indicate that the caring patient-focused dimension is paramount in both their practice and motivation.

Data from interviews and observations demonstrates that the nurses are proactive and take initiative. This contrasts with research by Treacy (1988) who found that the former apprentice system of training produced nurses that were unquestioning and submissive.

Ellen’s comments about valuing fair access to health services may be understood in the context of the report Quality and Fairness (DoHC, 2001). According to the report while individuals may be eligible for health services in Ireland, this does not mean that they will receive the services when they need them or within a reasonable timeframe. The situation is most evident in the hospital system where public patients may have to wait considerably longer than private patients for certain elective (non-emergency) treatment. Similarly, inequity arises where some community-based services are available to public patients in one part of the country but less available in another.

The National Treatment Purchase Fund (NTPF) is a recent initiative to reduce long-term waiting lists. Currently, if a public patient is over 3 months on a public hospital in-patient waiting list for an operation they can contact the NTPF to discuss options for treatment in a private hospital. The NTPF sources treatment for qualifying patients in hospitals in Ireland, Northern Ireland and England. Patients who opt for treatment with the NTPF have their treatment paid for by the NTPF.

It is likely that Aideen’s perceptions of an ideal manager have been influenced by her management training and education. Her style of management contrasts with that reported in the Report of the Commission on Nursing (GoI, 1998). The report found that nursing and midwifery management was preoccupied with hierarchies and the detailed control of nurses and midwives rather than the management of the nursing and midwifery function.

5 Conclusion

Our research set out to examine how restructuring in healthcare in Ireland has affected nurses their working lives and their professional knowledge. Interviews and ethnographic descriptions have provided some insight into the lives of nurses in an Irish context. The following section discusses the professional strategies employed by nurses (to cope with the pace and extent of
reforms). Subsequently, generational differences are explored and some concluding comments are offered.

5.1 Restructuring and Professional strategies

The nurses have employed a number of professional strategies in order to cope with the pace and extent of reforms. Such approaches to change are discussed below.

Availing of professional learning opportunities is one professional strategy the nurses have used to secure permanent positions and gain promotions in both clinical and management areas. This has further impacted in terms of increased salary and responsibility. However as Ellen and Nora pointed out, it is through overtime and working anti-social hours (nights and weekends) that nurses are able to augment their earnings. Despite Ellen’s extensive experience and qualifications her salary has not appreciably increased as a result of her specialist position. Hence, further education (to secure promotion) is not necessarily the means by which income is increased.

Although promotion and specialization didn’t impact greatly on Ellen’s net salary, there were other benefits. Becoming highly specialised in one area has allowed Ellen to create working conditions that are more compatible with family life. She works regular office hours. Similarly, since being promoted to management, Aideen no longer works weekends or nights.

By expanding and deepening her knowledge of a specialist area Ellen could further her professional development with the Advanced Nurse Practitioner Role. Similarly, by developing her management skills Aideen has enhanced her employment prospects, and in a sense her “marketability”. Her management skills are transferable. Hence, if she wished she is suitably qualified to work in a management position outside of healthcare.

Despite the recent emphasis on developing nursing research, it appears that it is difficult to procure funding from Nursing for this purpose. In order to cope with this limitation, Ellen has collaborated with medical colleagues and availed of medical funds.

The ceiling on recruitment of whole time equivalent staff and limited resources has impacted on each nurse. Their workload is intense and demanding as a consequence of the lack of manpower. In order to cope Aideen has had to find creative ways of solving staffing difficulties (such as moving staff between wards and seeking private funding). As a result, she frequently works over her contracted hours in order to attend to tasks and responsibilities associated with personnel management and manpower planning. Ellen and Nora respond to demands by prioritising their clinical tasks and trying to manage their time effectively. In addition, Nora avails of parental leave in order to maintain a satisfactory work life balance.

An overwhelming workload can lead to poor morale. Aideen tries to boost morale by reassuring staff and engaging in collaborative problem solving to improve conditions.

Nora feels that there are some nurses who don’t like change and therefore resist new developments. She tries not to let that defensive attitude affect her. She reasons that this phenomenon can be found in any job.

_I think it is important not to get involved in it ‘cause you are enhancing it if you do get involved in it. I think if you are more positive about it it’s easier._ (Nora)
Clinical caseload seems to take priority during regular working hours. As a consequence, the nurses sometimes have less time to read up on the evidence base or attend continuous professional development events. It seems that availing of formal learning opportunities (Diploma and Masters courses) seems to be a strategy used by nurses to read up on the evidence base (and expand their professional knowledge) related to their area of specialty.

Documenting practice is a professional strategy employed by the nurses in order to demonstrate accountability. They record (and justify) their decisions in the context of legislation, professional standards and guidelines, evidence-based practice and professional and ethical conduct. While documenting is considered an important and necessary activity, Ellen expressed a preference for administrative support to assist with this time-consuming responsibility.

The nurses have resisted taking on tasks that are the responsibility of medical colleagues. They do not wish to acquire additional responsibilities (without appropriate renumeration) in order to solve medical manpower issues.

The recruitment of nurses from international sources is a government initiative to deal with the shortage of nurses. In order to facilitate their introduction to the Irish Health System they have six weeks to acclimatise. Aideen’s professional strategy when integrating international nurses is to support them during this process. Feedback from these nurses is used to inform future adaptation courses.

Nora has embraced the support of care attendants (which is a relatively new role in Irish hospitals). She delegates work where appropriate and frequently co-operates with this grade of staff in order to complete tasks efficiently.

### 5.2 Restructuring and generations

Given that there were only three informants in our study who work in the same hospital and specialty, a degree of homogeneity is inevitable. Indeed Aideen commented that people with certain characteristics might be attracted to particular specialties because it suits their mindset. In addition, Aideen suggested that observed differences might arise as a consequence of variations in role rather than generation.

All the nurses expressed dissatisfaction with their pay. They agreed that they aren’t adequately paid for their level of responsibility. This perception is also shared by a majority of nurses who recently voted to strike for better pay and conditions.

The nurses’ pursuit of postgraduate education has been facilitated by the proliferation of programmes that are available. Nurses of each generation showed considerable initiative and dynamism in terms of expanding their professional knowledge and skills through further education. There did not appear to be any difference between the generations in terms of their commitment to continuous professional development. The similarity may be understood when one considers the manner in which the nurses were recruited for the study. A nurse manager sought their participation. Hence, it is possible that the manager was more disposed to approach committed and motivated nurses. Equally, the specialty might attract nurses who are academically oriented.

There was agreement among the generations with regard to intensity of workload and lack of resources. This is unsurprising given the socio-demographic changes and operational constraints referred to previously.
A measure of frustration was expressed by the nurses working in the clinical area with regard to decision making. It was felt that in certain circumstances it was possibly not in the interests of timely delivery of patient care to wait for a doctor to sign a prescription prior to administering a drug.

Interestingly, each nurse had experience of either studying or working in a different field for varying amounts of time prior to becoming a nurse. Nora worked with an airline, Ellen worked in hotel reception and Aideen studied Science for two years. This would suggest that rather than being steered into the profession, the nurses made a conscious career choice.

Nurse education has undergone a transformation in recent years with the introduction of a degree programme in 2002. However, the three nurse participants graduated prior to this development. In two cases pre-service education was somewhat similar in that they both completed a certificate programme. In addition, their training was based in schools of nursing within the hospital. Unlike Aideen, Ellen did not have to live in the hospital during her time as a student nurse. It also appears that the nuns had greater influence and were more involved in nurse education during Aideen’s time. However, the greater involvement of religious personnel may be related to Aideen’s choice of training hospital. Ellen deliberately chose a hospital that was not run by nuns. As for Nora, she completed a diploma programme and a greater proportion of her course was devoted to theory as compared to the certificate programme which was possibly more practice oriented. Given that the nurses work in different positions with different responsibilities it was neither possible nor desirable to compare and contrast the impact of their training on their practice.

Recently there has been emphasis on building nursing research capacity. There were differences among the generations in terms of the degree to which they participated in research. However, it is less likely that the differences are due to their generation but rather their position and tasks and responsibilities. For instance, Ellen’s job description specifies that she must keep up to date with relevant current research to ensure evidence-based practice and research utilisation. Similarly, she must contribute to nursing research which is relevant to her particular area of practice. It is unsurprising therefore that Ellen appeared more involved than the other two nurses in research activity.

There was a difference between the generations in terms of their access to flexible working conditions: namely parental leave and jobsharing. Nora (the most recently qualified nurse) has been able to choose working conditions (parental leave) that possibly contribute to a more satisfactory work life balance. However, the observed difference in working conditions is not directly related to years of experience but rather the nature of their positions and responsibilities. Aideen does not have the option to jobshare in her position as a divisional nurse manager.

Nurses of each generation referred to the importance of being caring, patient focused and responsible practitioners. Aideen’s discourse seemed to resonate more with the rhetoric of nursing as a vocation when she talked about nursing being ‘not just a job’ and ‘going that extra inch’. Perhaps this perception was established during her training when nursing was (arguably) considered more of a vocation than a profession.

5.3 Restructuring and periodisation

Periodisation refers to the historical succession of changes as they happened in Ireland. As described in detail in Workpackages 1 and 2, and throughout this report, significant shifts have occurred over the last three decades and in the past fifteen years in particular. The evidence presented here suggests that the nurses are highly responsive to change and have successfully
adapted to different working conditions. The delivery of quality patient care seems to be uppermost in their motivations. In addition, self-development appears to be a further impetus for embracing change. However, the shortage of staff and the implications for workload may contribute to poor morale among nurses at times. Similarly, the fact that nurse pay rates are at a lower level than all other graduate health professionals is cited as a source of frustration.

Bibliography


*The Parental Leave (Amendment) Act 2006.*

CHAPTER 4

Greek nurses’ work and life under restructuring: Professional experiences, knowledge and expertise in changing contexts

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1 Introduction

This University hospital was chosen for the study because a member of the project is on the hospital medical staff and has good working relations with the medical and nursing staff. This fact was very important since in the Greek society the personal factor determines the outcome of all transactions. In addition, the overall favorable research climate in this hospital made it relatively easy to set the stage for the required research design and to obtain the cooperation of supervisors and of the selected nurses. Also because the research is funded by the European Community and involves comparisons with nursing conditions in other European countries the acceptance of the research procedures and the cooperation of the nursing personnel could be easier obtained. All nurses are quite interested to find out how their working conditions and their professional status compares with that of nurses in the other European countries involved.

This university hospital is smaller than other public hospitals and there is no evidence that the working conditions of the nursing personnel are to a significant degree different than working conditions in other public hospitals.

It must be noted that the entry of men in important numbers in the nursing profession dictated the need to involve not only women nurses belonging to different generations but also at least one man with intermediate work experience (14 years), since in Greece men’s entry in the nursing profession is a recent phenomenon.

The three nurses selected to be interviewed and observed include the supervisor of Outpatient Services with 27 years of service; the male nurse in the Blood Donation Service with 14 years of service; and because it was not possible to find a nurse with 1-3 years of service in Outpatient Services, a woman nurse was selected in the Women’s Ward with 1.5 years of service.

While some questions were asked regarding the modalities of the observation by supervisors and Section Leaders, there were no problems encountered during observation days and all three observed nurses were quite comfortable in performing their usual tasks and in discussing different aspects of their work.

The days of observations were selected in such a way as to include a morning shift of very busy day, an evening or a weekend morning shift in which the selected nurse was alone and a morning shift in a moderately busy day.

It must be noted, however, that the organization of the focus group interview was quite difficult because it was a major challenge to find an hour and a half during which all members of the nursing personnel with the generational and gender characteristics would be free and available for this group interview. The characteristics of the nurses included in the focus group interview are given later on in Section 3 “Collaborators’ Life Courses”.
My conceptual position for the study is greatly influenced by the overall cultural context regarding science and knowledge. While some people do not like to expose the negative Greek attitudes toward science and knowledge, the reality is that scientific knowledge and expertise are not appreciated or rewarded. Furthermore, highly competent professionals are usually viewed negatively and often eliminated from competition for important positions because “they ruin the market” for the others.

Within this context, it can be expected that even ambitious nurses that would like to become successful in their profession may be caught in a cultural dilemma between their desire to learn more and become competent and the reality that scientific knowledge and competence may not be the factors that secure professional success. Within this dilemma, the ‘caring’ element of the nursing role may win over the ‘curing’ element since it represents an acceptable and ‘moral’ way out. Furthermore, the caring dimension of nursing is compatible with the feminine stereotype of the nurturing role of women. It is not surprising, therefore, to read articles that admonish nurses to withstand the pressures of modern technology and scientific knowledge as well as those of a selfish mentality resulting from “a deep crisis in the fundamental values of life”. Nurses are told that Greek nursing does not need a lot of research (there is very little anyway), since Greek philosophy provides nursing with a “sound background” that shows them how to resist the “indifference and passive adaptation to the demands of our technological society”. In short, nurses are urged to provide holistic, humanistic care to their patients regardless of their social, cultural and educational characteristics.

Male nurses who are not hindered by this stereotype can be expected to opt for the curing dimension and the scientific knowledge that accompanies this dimension. Of course, again gender stereotypes play an important role since men are expected to be more rational and instrumental, characteristics more compatible with the curing dimension. Although male nurses are also influenced by the ambivalent Greek attitudes toward scientific knowledge, the masculine “mastery” stereotypes may sway them more often toward the curing dimension.

However, even women nurses who define their role mainly in terms of caring for patients need to acquire sufficient scientific knowledge (medical and psychological) and to learn from ongoing research new methods and techniques that can help them care better for patients. It is expected, therefore, that many of them would find themselves caught in a dilemma between curing (that requires much more scientific knowledge) and caring. They have a excuse for not keeping their scientific knowledge up to date because of the shortage of nursing personnel that does not leave them sufficient time for continuous training and that does not allow them to use the additional knowledge they have acquired. The second assertion is quite suspect since applying new or better scientific knowledge does not necessarily involve more time; it simply results to better caring, if not curing the patient. Because, however, they are civil servants and their performance is not evaluated, their promotions are based on years of service rather than on the quality of their performance. Hence, within the security cocoon of civil service, there is little motivation to continuously seek scientific knowledge.

However, it must be pointed out that the dichotomy between ‘caring’ and ‘curing’ may not be appropriate since the nurses often have to interpret the doctors’ words to the patients and to provide psychological support rarely provided by physicians. Since psychological support is an essential component of ‘curing’, we could say that Greek nurses are involved in the curing process, even when they lack advanced scientific knowledge.

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2 A University Hospital in Athens

The chosen University Hospital was founded in 1898 through the endowment of a wealthy man and continues to receive substantial donations on the part of private donors. It is a 160-bed public hospital and belongs to the Medical School of Athens University.

It is the only [supposedly] fully computerized hospital in Greece and has participated in European R&D Projects as a place to validate and assess the feasibility of newly developed technological tools in Information Technologies and software applications. However, despite computerization efforts, the utilization of the system has never been fully utilized by the medical and nursing personnel. At present, only hospital administrators are widely using computerization facilities and physicians, only when they prepare discharge notes.

In regard to the structure and clinical activities in this University Hospital, the following departments are in full operation:

- Surgical Department with a Liver Transplantation Unit
- Gynaecology-Obstetrics Department
- Anaesthesiology Department
- Intensive Care Department
- Radiology Department with CT scan and MRI
- Radiotherapy Department
- Nephrology Department with a Hemodialysis Unit and Blood Bank
- Outpatient Department with additional units of Endoscopy, Urology, Oncology, Pain and Sterility.

In parallel, there are the Laboratories, which include the following units:

- Nuclear Medicine
- Hemodynamic
- Betatronion
- Radioisotopes
- Ultrasound
- γ-camera
- Microbiology
- Biochemistry
- Hematology
- Hormonology
- Pathology

The main functions of this University Hospital are the following:

- Provision of health services
- Education and training of medical students and post graduates candidates
- Research in the medical field
- Biotechnology
- Telemedicine and clinical information systems
- Contribution in handling public health issues and organisational aspects of health care delivery.

Within the hospital, an experienced team of health professionals has been formed and effective working relations among multidisciplinary hospital teams have been established. This hospital does not accept emergency cases and patients’ admission is based on existing patients’ lists. Also admitted patients enjoy better “hotel services” and the overall ambiance is considerably better than that in other public hospitals.
The efficiency of the hospital can be seen by the fact that approximately 6,000 patients are admitted annually in all hospital departments in the 160 beds or on average 33 patients per bed. The thoroughness of patients’ examination and treatment can be seen by the fact that on average patients stay in the hospital 4.8 days while this average is much lower in private hospitals that encourage fast patient turnover. Moreover, 23,000 patients are visiting the Outpatient Department of the Hospital; and in 2005, 3,030 surgical operations were made (1690 in surgical department and 1340 in the gynecological department). The total number of hospital staff are 507 employees, out of them 140 are physicians and 142 are nurses with the remaining being administrative personnel. It is noteworthy that while overall in Greek hospitals the number of doctors is much larger than the number of nurses, in this hospital these numbers are equal suggesting a relatively better nursing coverage than in other public hospitals.

It must be noted that the six nurses participating in the focus group interview think that this University hospital is better than other public hospitals in Athens because it is relatively better organized and better provided with material (e.g. gloves that are never enough in other public hospitals). It is a small hospital and nurses are better able to relate with each other in the different services and to learn how to function effectively.

3 Collaborator’s life courses

3.1.1 Profile-Nurse Supervisor

The supervisor of Outpatient Services is 58 years old. She studied nursing for 3 years at the nursing school of Evangelismos Hospital and has also received one-year specialization in surgical nursing. She came from a small town and her parents couldn’t afford the cost of University education. She didn’t choose to become a nurse but she was able to get trained and receive a diploma of nursing at no cost by offering her services to the hospital. Despite the fact that she went to the nursing school unwillingly, she ended loving the profession because she likes being close to people and being able to help them when they undergo a crisis because of their illness. After she entered the field and started reading and learning, she found nursing very interesting and she has never regretted being a nurse.

After working for two years at Evangelismos hospital, where she was trained, she stopped for 10 years when she got married in order to take care of her children. She started working again in 1980, so she has been working for 27 years. She didn’t go back to Evangelismos to work because they had their own insurance system and she wanted to belong to the national insurance scheme, IKA, that the University hospital has.

Her formal duty is to supervise and manage the Outpatient Services that include surgery services, the clinic of pain (for last stage cancer patients), the cancer clinic, angiosurgical services and short hospitalization services. She supervises 4 nurses, one with three-year TEI training and three with a 2-year nursing training. She says:

I must control the work of the nurses I supervise, I must be correct with them, cooperate with them and promote them with continuous training. I must ensure that the patient’s problems are solved and that are well treated.

Her informal duties, however, include everything that has to be done and for many reasons does not get done, mainly because there are few nurses. If needed, she will even carry herself wounded people. Indeed, her work is quite strenuous since most days she stands and runs from the one service to the other for many hours and has to perform several tasks simultaneously.
She feels that the most serious problems in the nursing profession are the long hours of work and work during night, Saturdays and Sundays, and holidays; and the shortage of personnel, especially of well-trained nursing personnel. This lack of sufficient well-trained nursing personnel does not allow nurses enough time to perform well their duties; and they are sometimes obliged for the afternoon duty to leave an assistant nurse with only a 2-year training in charge, despite the fact that she is supposed to be supervised by a nurse with a 3-year or 4-year training. While she feels that the nursing profession has improved from the point of view of nurses’ education, she feels that they are not yet paid what they should.

Since the 80’s, every Friday she teaches nursing at a TEI three and a half year nursing program of Evangelismos and she is a member of the nurses’ syndicate. She says that she does not care for promotion and a higher position. What she likes mostly is to continuously learn new things about science and technology so that she can do her work better. She shows an exemplary interest and devotion to serving outpatients and to ensuring that physicians see them and outpatients comment positively about her positive attitude and behavior.

3.1.2 Profile-male nurse

The male nurse is 38 years old and has had a three and-a half- year nursing training from a TEI. He did not intend to become a nurse, he wanted to become an archeologist; it was a pure coincidence that he became a nurse but he never has regretted it. He says that most probably he would not have a job, if he had become an archeologist, as he originally wanted.

At the time he studied nursing, it was almost prohibitive for men in nursing; there were 300 women and 5 men in his class and few specialties welcomed men: mainly intensive care and surgery. So when he graduated, people suggested to him to go into a specialty such as surgery or kidney transplant but instead, he chose blood donation when in this University hospital he discovered another aspect of nursing... ‘there are labs, there is research, and there can be progress’. So he received 8.5 months specialized training in blood donation and has been working for 14 years in the blood donation unit with three women nurses and under a woman supervisor. He says: "I know now that this is what suits me best and I believe that here I contribute more than in an open ward”.

He feels that the whole profession of nursing has become elevated, now there is much more knowledge, more specialties. For example, in Evangelismos they do breast transplants-they carry out productive work.

He feels that the presence of men in nursing has helped improve the professional image and now the situation has changed and men can choose the specialty they want, instead of being steered only to surgical and intensive care nursing. He feels that patients and their relatives confront differently men than women nurses and even relationships between men and women colleagues are different. It’s different when only women work in nursing and different when there are also men.

He reports that even when there are emergencies and work becomes hectic in Blood Donation unit, they cannot get help from nurses from other units because of the necessary specialized knowledge about blood. He is satisfied that because of this need for specialized knowledge, the nursing personnel in the unit have been together for many years and have developed close relations and an excellent working ambiance. The observations confirmed the fact that they work smoothly like a team.
His wife is an art teacher in a high school in a city outside of Athens and he has digital photography as a hobby.

3.1.3 Profile-young nurse

She is 28 years old; she has received four years of nursing training (without a specialty) and for one and-a half year she has been working in the women’s ward. Nursing was not her choice. She wanted to be a journalist or a teacher but at the entrance examinations the obtained grades allowed her to go to nursing; she entered nursing ‘just to see how it is’. She liked the courses, she was learning something for herself, for her family, and for the family she would have later on. Finally she took it very seriously, she finished the school with good grades and she got a job fast (within five months after graduation).

At the start, she didn’t like the hospital setting, the ward was small, the building old with little space but finally she thinks it is a good hospital. Because it is a University hospital, she feels that the quality of care is better; there are more patient examinations. She also feels lucky that they placed her in the ward that what she always wanted.

She never regrets having become a nurse. She thinks that it suits her better than being a journalist, her original choice. She would like, however, to do something more, perhaps postgraduate training because definitely she does not want to stay with only the TEI degree, to continue like this and get pension as a simple nurse. This is regardless of the fact that she likes her profession and she likes offering service to patients. Simply she cannot limit herself to just this. She would like to do something more, perhaps a specialization in physiotherapy but she does not know if she can manage this with possibly a pregnancy in a little while. She feels that becoming a physiotherapist would be better from the point of view of working schedule: she would not have evening and night duty and no duty during weekends and holidays, she would work only morning duty. Also she would be able to work in the hospital as well as outside the hospital.

Her work commitment is high as evidenced by her determination to not stop working when she will have children. She feels that now you cannot live with one salary and when you cannot realize career ambitions if you stop working. She is adamant about not stopping work despite the fact that she realizes that it will be difficult because both her mother and her mother-in-law are still young and working.

She is a very intelligent, serious and responsible person with a good judgment. In fact, she carries out all tasks with a sense of autonomy and without anyone having to tell her to perform any particular task. She is truly a professional nurse. In fact she is continuously running from the one task to the other, often volunteering to perform tasks of practical nurses when they are late in appearing. She hardly ever sits down. Even the supervisor tells her once to sit down and have some coffee. She sits down only when she has to write in the dossiers or to fill out appropriate forms. When all treatment tasks are done, she organizes hospital material and supplies or cuts and rolls cotton.

Because of her recent marriage (three months before the interviews), she has not followed any further training but now that things have calmed down, she is looking for seminars, some type of training, despite the fact when she leaves work she is tired and would like to relax at home.

3.1.4 The Profile of the Participants in the Focus Group

The group included two women supervisors with 20-25 years experience; one woman nurse working in surgery with 10 years experience and another working in Outpatient Services; two
male nurses, the one with ten years work experience and the other with long experience in a private hospital of a small town, who joined the University hospital only one week before the meeting of the focus group.

The focus group discussions brought out the importance nurses place on further professional training despite their frustration that such training and competence in job performance do not lead to advancement in their career. They find that it is very difficult to get further training because they are given very little time, 4-5 days/year for training, and no incentives to get further training. Promotions follow the public servant model in which years of service and seniority are the most important factors and further training or competence in job performance do not count. They reported that only if a particular supervisor is interested in facilitating nurses' training, they could have a better chance for training. Furthermore, nurses who have already had advanced training find that they did not have the time to use their training to provide better quality health care because of time pressures.

4 Thematic analysis

4.1 Working Conditions

4.1.1 Organization of work

At the first level of the nursing hierarchy is the Director of Nursing Services for the entire hospital. The second level of hierarchy is represented by the Nursing Officers (Tomarhes). At the third level, there is the nurse supervisor who is responsible for a specific ward or for the outpatient services. Staff nurses and nursing assistants are the next levels in the hierarchy. The Director of Nursing Services represents the profession in the Hospital Council, the administrative body of the organization, and handles all nursing topics during the Council meetings.

There is no clear differentiation between the tasks undertaken by nurses and nursing assistants mainly because of the shortage of professional nurses. The nurse supervisor, therefore, assigns tasks not only on the basis of nurses' education and effectiveness but also on the basis of needed services. Also nurses are expected to regularly undertake time-consuming work (such as intravenous drips or taking blood from patients) that the physicians do not like to undertake but they do so without legal coverage, if something goes wrong with the procedure. On the other side, because in Greece there is a paradox of many more physicians than professional nurses, the doctors sometimes perform interventions that in other countries are performed by nurses. Since as we have seen, however, that in this University hospital the number of physicians is not larger than the number of nurses, physicians rarely, if ever, perform interventions that are usually performed by nurses.

The most prevalent theme coming out of all interviews and observations is the intense dissatisfaction with the shortage of nursing personnel and the negative impact of this shortage on their own work programs, their ability to get further training and to provide a high quality of nursing care to patients. This dissatisfaction prevailing all over Greece led in September 10,


59 Zambeta, et al., 2005, ibid..

60 It must be noted, however, that the interviewed young nurse mentions a positive impact of the nursing shortage: "Because there is a shortage of nursing personnel, I have more direct contact with patients".
2005 to a sit-in protest at a 24-hour strike organized by the Panhellenic Union of Nursing Staff during the nation’s largest trade fair in Thessaloniki. The nurses’ union was asking the Government to hire more nurses in public hospitals where, according to them, there is one nurse for every 40 patients.

WHO statistical data for 2004 indicate the number of nurses per 10,000 population in different countries:

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<tr>
<th>Country</th>
<th>Nurses/10,000 Population</th>
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<td>USA</td>
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<td>Australia</td>
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<td>Japan</td>
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<td>Finland</td>
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<td>Spain</td>
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<td>Greece</td>
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<td>Turkey</td>
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The above data show that all Southern European countries and Turkey have limited nursing personnel. It should be noted, however, that in Greece the vast majority of nurses work in a hospital setting and only a few in primary health centers.

The very recent decision of the new health minister to hire 4500 nursing personnel in the next 3-4 years may be problematic since it will entail an estimated government spending of about 55.5 million EURO. Instead, in view of the necessary continuing limited allowed spending of government funds, the hiring of about 2000 nurses is said to begin in 2007 and although this increase may represent only one-tenth of what is needed, it would help alleviate to some extent the shortage of nurses.

Although there is a considerable number of nursing jobs in private hospitals in Athens as well as in other cities, most nurses prefer to work in public hospitals because of job security. They also correctly perceived that in private hospitals work requirements are much harder and if their performance is not satisfactory, they can get fired. However, job security in public hospitals has a negative side since the government does not want to increase the number of permanent public servants (that cannot be fired) and resorts to short-term contractual hiring of nurses. Despite the discontinuous and uncertain nature of such contractual work, most nurses prefer it while they are waiting to become civil servants rather than accept a job in a private hospital. On the other side, the eight-month long contractual work proves to be quite disruptive for efficient hospital management and the smooth performance of nursing duties. The interviewed nurses reported the existing problematic situation and they complain that they have at least twice a year to explain and assist newly hired contractual nursing personnel so that they can effectively perform their duties.

"... the need to hire contractual nursing personnel creates problems because by the time that they get adjusted to the work, the 8 months have passed and they have to leave. This is very difficult for the permanent personnel who have to “teach” them or at least to guide them and to help them adjust. (the young nurse)"

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61 “One Nurse for Every 40 Patients”, Kathimerini, September 10, 2005 (online in www.nursingadvocacy.org, the website of the Center for Nursing Advocacy).
Also because there is nursing personnel shortage and these contractual appointments are not continuous, often for several months some wards and services lack a sufficient number of well-trained nursing personnel and have to program assistant nurses to staff by themselves some of the evening and night shifts\textsuperscript{62}.

The discussion during the focus group interview also showed that some negative aspects of their work result from the lack of sufficient nursing personnel are the cyclical duty programming and frequent evening and night duty and the lack of time for further training. Other negative aspects of working conditions mentioned include low salary and little possibility for further training and advancement on the basis of one’s quality of performance. They report that if they could change some things in their working conditions, priority would have the hiring of more permanent nursing personnel; computer training for everyone and complete computerization of all nursing tasks and services.

4.1.2 Management of Work: Autonomy, decision-making, supervision, evaluation

Regarding the autonomy of the nursing profession, the interviewed nurse supervisor is aware of the fact that physicians relegate unimportant and time-consuming medical tasks to nurses without giving them credit for this when she says:

\textit{I feel that the profession of nursing is not an independent profession. Nurses depend from doctors; they always need doctors’ orders and because of this there is sometimes considerable conflict and contention. Nurses often perform treatments because the doctor does not feel like bothering with them but formally the medical profession doesn’t agree to classify these activities as nurses’ actions.}

It was observed, however, that the nurse supervisor of outpatient services shows initiative and autonomy in evaluating patients’ condition and in creating a hierarchy in terms of need for immediate examination by a physician. The physicians respect her evaluations and seem to rely almost entirely on her.

Furthermore, in all observed settings she as well as the other nurses work very well as a team with the physicians in their effort to best serve patients. The only difficulty observed was when physicians, especially surgeons, were very late for their appointments with outpatients and the supervisor of outpatient services had to spend a lot of time tracing them (especially when physicians closed their mobile phones).

It was observed that the young nurse follows faithfully but not necessarily unquestionably physicians’ orders and occasionally makes tactful remarks or addresses questions to the physicians. In fact, she has a professional attitude and carries out all tasks with autonomy and without anyone having to tell her to perform any particular task. She does not want, however, the burden of more autonomy:

\textit{I don’t feel that I have autonomy but I would not want to have more autonomy because it would be too much responsibility. As things are, the doctor can cover me and I can cover the doctor.}

The male nurse, on the other hand, feels that he has considerable autonomy in decision-making, although he has a supervisor and a unit director:

\textit{Yes I have considerable autonomy in decision-making in my job. I take orders for the quantity and type of blood that is needed. But then, I in collaboration with my colleagues}

\textsuperscript{62} There are no legal implications to having a nursing assistant alone during an evening or night shift.
can manage everything; we handle existing problems and have a certain degree of responsibility and power. If, for example, too much blood is needed but the supply is limited, we suggest to the surgeons to postpone surgeries that are not urgent. Of course, there is also a supervisor and a director who is a physician blood specialist with whom I discuss when there are problems and she is the one who takes the final decision. There is also a physician, microbiologist on duty.

Regarding evaluation, while there is a provision for evaluation and there are evaluation forms, there have not been such evaluations for many years. But even when such evaluations were taking place, the evaluation questions on the forms did not refer to scientific standards of nursing performance or to the level of scientific nursing knowledge. Whenever in any setting evaluations take place, the standard procedure of supervisors is to give very high marks regardless of the quality of performance. Also it must be noted that at all levels and fields in Greece there is a very negative view of evaluations since even university professors refuse to be evaluated and go on strike and demonstrate in protest as it has been happening recently when efforts are made to institutionalize performance evaluations.

4.1.3 Work Documentation

The observations showed that the documentation by hand of nursing information and of nursing tasks to be performed represents probably the most negative aspect of nursing work and it is also perceived as such by the interviewed nurses. The most extreme case was found when observing the work of the young nurse. The recording of nursing information about each patient is an extremely time-consuming activity that takes at least two hours when she is alone during weekends and about 40-50 minutes during weekdays when the supervisor is present and she undertakes most of the recording. Every day all information regarding each patient’s condition, tests and treatment is repeated so that endless pages are written about each patient. The large dossiers, that are endlessly filled with this information, last for about 10-15 days and then have to be stored, thus creating serious storage problems and an extremely difficult, if at all feasible, retrieval of patients’ medical history, as it was shown by observations.

The young nurse rightly feels that this endless recording of information represents a serious waste of time when it could be achieved in much more efficient way by means of computerization. She thinks that the justification for not using computers are not the claimed financial reasons but the fact that the supervisors who are in their 50’s do not know how to use computers and resist having to use them. In fact, her supervisor admitted that she does not like or trust computers and feels more comfortable following the “best practice” of recording all information manually. The interviewed nurse supervisor reported having followed the obligatory training seminar in computers and another one on a voluntary basis but since computers are not used, she as well as the others forgot what they learned because of lack of practice.

The young nurse’s assertion is supported by the existing well-documented societal technological lag between generations in terms of digital learning and computer use, exacerbated among middle-aged men and women, even among professionals. Her assertion is supported by recent surveys showing that in September 2006, 37.6% of the Greek population were computer users but half of them were under 30 years old while only 19% of persons 45-54 years old and 7% of persons 55-74 years old were computer users; and in all ages, there were more men (61.5%) than women computer users63. It seems that digital learning and computer use has generational dimensions. These societal trends are reflected in the nursing personnel’s attitudes toward computerization. Nurse supervisors over 50 have not learned to use the computer, despite the initial training they received, and are not interested in further training and using computers. The younger generation of interviewed men and women nurses is quite comfortable and proficient

63 “Greeks as the most unrelated to computers among Europeans” 2006, in M.Yaegean.gr of Aegean University.
with computers that they are using at home and feel strongly that computerization of all recorded nursing information would free them of the very time-consuming and boring task of recording manually; would help alleviate the nursing shortage; and would facilitate the retrieval of patients' medical histories.\(^\text{64}\)

The male nurse observes:

*I have a computer at home and I am a skillful user but I am pessimistic about the future of computerization in the hospital. I feel that the older generation has a different mentality, they are negative and they cannot accept computerization. I am afraid that, if computerization would become the rule in the hospital, only the men and only 1-2 young women would follow.*

Although we have no direct data, we suspect that physicians of similar ages may have the same resistance to computerization that would impose on them to learn new skills, while they can now primarily rely on nurses (practically as secretaries) to record all needed information.

Nurses who had worked before in private hospitals report that in private hospitals, computerization is advanced and nurses learn how to use it because business has to be efficient and profitable and cannot afford to waste nurses’ time by endless recording needed information manually.

It must also be noted that the observed attempt of partial computerization in the University hospital of requests for blood tests from the wards was very poorly handled and had as a result increased delays and waste of time.

4.1.4 Social Relations and co-operation with Colleagues and Doctors

It is fortunate that despite the considerable overlapping between the tasks of different health care professionals, the observations confirmed that there are no serious problems in the everyday nursing work and cooperation is usually good.

*I love all people with whom I am working, I love my colleagues, and I want things to improve further. I have no problems with my colleagues. I try to be correct with them, with all of them, colleagues, managers, etc. as much as I can. I try to be correct.* (nurse-supervisor)

At present, nurses with different levels of nursing training co-exist within the hospital setting. Nurses who have completed 4-year university level education are the highest in the hierarchy, followed by those who have completed 3 or 4-year higher education (TEI) training and followed by those who have only had a 2-year training in public and private nursing schools [some of them sponsored by large public hospitals]; and hospital orderlies without any nursing training except some practical on-the-job-training. The existence of nurses and assistant nurses with different levels of education creates a hierarchy among nurses that could under some circumstances lead to tensions. The observations showed that although there was a tendency (primarily among older nurses concerned about the prestige of the nursing profession) to clearly downgrade nursing assistants who are not university graduates, there were no indications of the existence of important tensions. Instead, there was good cooperation, despite the existence of

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\(^\text{64}\) It may be to some extent debatable to what extent the differential acceptance of computers is a generational or an age issue. It is possible that it is a combination of both factors. The issue will be settled when the younger generation that is quite familiar and comfortable with computers will reach 50+. If those 50+ will be much more resistant to newer type of digital learning and recording than younger people, it will be an age effect. But if they will be better prepared to accept the new technology and adjust to its requirements, it will be clear that it was a generational issue.
observed occasional delays in the delivery of care services on the part of nursing assistants. The interviews also reported no problems:

> [Relationships with other colleagues are] quite good despite the fact that this hospital functions mainly with contractual nursing personnel that come for 8 months and leave. I am here for a year and a half and we have changed many colleagues. But usually those who come are very good and we have excellent relationship. (young nurse)

The same holds true for relationships with doctors:

> Most doctors that I come in contact are young and are doing their specialization and we get along very well. (young nurse)

On the other hand there are some indications that there might be differences in the social position and prestige held by nurses in specialized units - ICU, surgical, blood donation, kidney transplant, hemodialysis and nurses working in the wards or outpatient services.

Nurses working in the blood donation unit, for example, seem to have a higher social position than other nurses in outpatient services because nurses from other units cannot replace them or assist them due to the necessary specialized knowledge about blood. As a consequence, these nurses have been together for many years and have developed close relations and an excellent working ambiance. The observations showed that they really work smoothly like a team, this considerably facilitated by the existence of a legislation that ensures the permanent position of those working in blood donation (they cannot be moved to other services).

The male nurse works closely with his colleagues because of the responsibility they share concerning the suitability of blood for patients.

> My responsibilities are taking medical history and blood from blood donors; determining the blood type of patients and donors and blood compatibility; and ensuring that there is adequate blood supply for the hospital and cooperating hospitals. Because of the sensitive nature these tasks, I share with the other nurses in the unit considerable responsibility, both moral and legal, in case some mistake is made regarding blood compatibility. (male nurse)

The observations showed that this forces him to crosscheck with his colleagues the results of the type of blood groups and especially the compatibility of the available blood with the patient’s blood (tested also by different methods) and to occasionally spend considerable time on the not entirely clear-cut cases and to keep blood samples for at least a month in order to be legally covered.

### 4.2 Professional Knowledge

A research study of nurses working in a military hospital near Athens showed that although the knowledge base of many of the nurses was good on relation to ‘risk factors’ and ‘areas at risk’ regarding pressure sores, a significant proportion of them were unaware that the methods they were using were no longer recommended. Also a significant proportion of these nurses could not access, read or understand research findings, thus encountering a severe barrier to new knowledge about best practices. The disturbing results of this study support my conceptual position regarding Greek nurses’ definition of professional knowledge since many of them are

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not aware that their knowledge is faulty and they are not able to read and understand new research in subjects relevant to their work.

Unfortunately, the study did not distinguish between university trained and 2-year trained nurses, especially since still the number of 2-year nursing training is much larger than the university trained nurses. It could be expected that at least some of the university trained nurses (at least those who go on for postgraduate study) may be able to read and understand research studies, although the typical university training in Greece does not prepare students to understand or appreciate research studies.

It seems that Greek nurses vacillate between valuing technical, professional formal nursing knowledge and the more humanistic, emotional components of their role. They attach importance to training since this allows them to draw a clear line between themselves and the assistant nurses. However, working conditions under the shortage of personnel and the type of promotion system in the civil service model leave little time and provide little motivation to seek professional knowledge. Nurses have to be internally motivated to acquire more scientific knowledge for the sake of learning regardless of whether they will receive rewards or will be able to routinely apply it in their job.

The focus group interview also showed that the participating six nurses defined as the positive aspects of their work the permanent position they have that provides them with security and contact with patients. They see their work as humanitarian since they deal with people and especially people who are sick and in need of help and care and they would like to provide quality care. They feel satisfied that some patients thank them for the care they provide, but they feel bitter that despite the fact that physicians see patients only for a few minutes while nurses see the patient all day long when he/she is hospitalized, still patients tend to thank more the physicians.

The crucial role of nurses for the caring of patients came very strongly from the nurse supervisor:

*I love people and I want to offer help. I like my profession because I love people and I love sick people, we must help them. I always have people as the focus of my efforts. In my work, the greatest satisfaction is that I am able to help people when they face a crisis, their illness.* (nurse-supervisor)

The observations confirmed that the Nurse-supervisor tirelessly manages patients' impatience and complaints when they often have to wait for several hours before they can be seen by a physician; physician's nagging about the imperfection of situations and the lack of space and their quarrelling as to who will go to what examining room; and she tries to find solutions for all kinds of problems so as to best serve the patients. During observations, I was told many times by waiting outpatients how grateful they were that she really cared about them and did everything she could to help them (it must be noted that they had no idea who I was and what was my role; they might have thought that I was also a waiting outpatient). In fact, some of them have acknowledged her genuine interest and her sincere efforts to serve them and voiced their gratitude by writing letters to papers (example of a letter sent to Kathimerini, a leading Athens newspaper).

It is also noteworthy that the interviewed women nurses like very much the University hospital despite uncomfortable working conditions, because they think that it provides better quality health care to patients than other public hospitals.

*The hospital is quite old, from 1880 and is not designed with the new conditions and requirements in mind. There is not enough space to work comfortably but I feel that all*
are trying to adapt and to work within these constraints. I like the hospital because being a University hospital it offers good health care to patients and good training to students. I prefer it to other hospitals because it offers quality health care. (nurse-supervisor)

The male nurse, on the other hand, appreciates the specialized, technological, scientific aspects of his work more than the direct contact with sick people but is also proud about the crucial role that he can play in surgeries by providing sufficient quantity of the necessary compatible blood that can save the patient’s life.

When I started working in the university hospital, I discovered laboratory work and research and decided that is what suits me best. Although initially what I liked most was the direct contact with patients and now although there is no direct contact with sick people, I am satisfied since there is contact with doctors, with surgical services, with the operations and with blood transfusion. In addition, I feel that it is most important that if a patient needs surgery, blood donation is at the first line. In this way, I have the satisfaction that I contribute to patients’ recovery although from far away. Some patients I had never seen come to thank me and the entire unit when they get well, a source of tremendous satisfaction that has made me love my work. (male nurse)

It may not be a coincidence that the male nurse values more the scientific knowledge involved in his role than the direct contact with patients, feeling that he cares about patients from a distance. His views are compatible with the male stereotyped ideal expectations according to which men are supposed to be more rational, objective and led by scientific findings.

Some recent research findings show that nurses do not apply their professional knowledge when they evaluate the impact of their personal on their own health. These studies show that although a greater proportion of nurses smoke and are obese than the general Greek population 66, two factors associated with poor health, the studied nurses working in hospitals in North West Greece do not seem to consider these factors as health risks when they evaluate their health status. Furthermore, university or TEI educated nurses did not significantly differ from nurses with only two years of training 67.

In the balance, both the formal and the informal or on-the-job training are valued. While formal knowledge, especially postgraduate degrees could be helpful for qualifying for a higher position or for a position in a specialized nursing unit, informal knowledge and experience can facilitate the everyday performance of duties and adjustment to new work situations.

When I started working, it wasn’t difficult because I had practical experience from my stay for practical training at another public hospital where, because of nursing personnel shortage, the students were used as personnel and in this way we learned a lot. Also because the ward in this hospital is small and there are not many patients, the other nurses and the supervisor were able to explain things and I got adjusted relatively quickly so that after a month I was able to go on duty alone. (young nurse)

Another important aspect of nurses’ professional knowledge is the extent to which they know their rights and are trying to change and shape their profession by participating in the nurses’ union and by proposing and defending professional strategies. The interviewed nurse supervisor has been active in nursing syndicalism and in mobilizing nurses to petition the passing of the

66 47% of the nurses smoked and 36% of them were obese. (P. Beletsioti-Stika, 2006. ”Smoking among Greek nurses and readiness to quit”, International Nursing Review, 53(2): 150-156; and Noula A. Pappas, Yannis Alamanos and Ioannis DK Dimoliatis, 2005. “Self-rated health, work characteristics and health related behaviors”, BMC Nursing, 4:8 (online).

67 Also work characteristics of the nursing population such as rotating shift work, department of employment, total years of employment and positions were not associated with self-rated health after adjusting for socio-demographic factors and health related behaviors. Noula A. Pappas, Yannis Alamanos and Ioannis DK Dimoliatis, ibid.
2004 legislation that gave more autonomy to nurses and the right to be independent professionals.\textsuperscript{68} She said, however, that young nurses are not interested in syndicalism and as she would like to slowly withdraw, she has great difficulty convincing some of them to become active members. She reports that out of the 142 nurses in the University hospital only 10 are members of the nursing syndicate. The young nurse expressed this indifference toward the nursing union:

\begin{quote}
I don’t know anything about syndicalism; it hasn’t preoccupied me. I know there is a nursing union but I haven’t searched to find it and they haven’t also come to talk to me, to ask me if I want to become a member. Perhaps they offer some things but while I have been here I haven’t seen anyone to become interested to approach me and to ask me what problems I have and how they can help me. (young nurse)
\end{quote}

\subsection*{4.3 Social Position}

The male nurse feels that he and women nurses in the blood donation unit have a relatively higher social status than other nurses because they cannot be replaced or assisted by other hospital nurses because they have specialized formal and informal knowledge about blood.

However, while the two interviewed women nurses emphasize their caring role, they use their higher professional knowledge to separate themselves from the assistant nurses and they deplore the fact that the lack of time does not allow them to apply their more technical knowledge in their nursing role.

The male nurse is satisfied with his status because his work resembles research, he has a very positive view of the nursing profession; and he feels that scientific progress has helped the nursing profession to be continuously upgraded and to improve the quality of his work:

\begin{quote}
I feel that the general conditions of nursing have improved considerably from 1989, when I started. Now there are better machines, better technology, more knowledge, many opportunities for training, many conferences and nurses are able to learn as much as they can. I feel that because of these positive changes, it is now possible to control much better the blood given to patients. (male nurse)
\end{quote}

The two women nurses, on the other hand, feel that the profession still needs considerable improvement, the young nurse in terms of social status and image:

\begin{quote}
I think that it’s a profession that is treated unfairly. Although it offers so much, when you say that you are a nurse, they look at you in a way that implies that “you are not important”. Even some patients, not all of them, although we are the ones who spend much more time with them than the doctors, they don’t appreciate what we do and they make us think “why do we do all this, why do we care so much for them?” The value of the profession is not recognized, possibly it is misunderstood because of its past image when there was not much knowledge involved, you finished a nursing school and you didn’t know much while now you finish the university or TEI but still although you have considerable knowledge, it’s not yet recognized. (young nurse)
\end{quote}

\textsuperscript{68} “Draft Law on the Creation of an Association of Greek Nurses and Other Provisions”, Opinion of the Economic and Social Committee, Athens, Greece, 7 July 2004.
The nurse supervisor thinks considerable improvements are needed in terms of standardization of university level training for nurses, better pay and more time available to get further training and to be able to use it in order to provide quality nursing care:

Work conditions are very hard in all hospitals in the country, they work 8 hours a day and the conditions are still difficult in Greece. There is shortage of personnel; the institutions need to get more personnel. In most developing countries one nurse corresponds to 4 patients while here the ratio is God knows what. Also from a financial point of view, the health personnel (nurses) are not paid what they should so here again there has to be an improvement. (nurse supervisor)

Not only the male nurse but also all women nurses find that the presence of men helps improve the image of the nursing profession.

The presence of men in nursing has helped improve the professional image. Patients and their relatives confront differently men than women nurses and even relationships between men and women colleagues are different. It’s different when only women work in nursing and different when there are also men. The changes are positive. When a profession is closed to the other gender, it’s like a ghetto, not a good thing. Work conditions change when it opens up. Men may be able to perform some duties easier than women and vice versa. So the practical aspects of work change for the better. Before nursing schools were closed schools of the hospitals. It’s not the same thing to be boarders in a school than to attend an Open University faculty or TEI where you become exposed and open to ideas, to social trends. (male nurse)

I feel that the presence of men in the profession can help improve the image of the profession because men are more ambitious and more career-oriented. They try to continuously read, learn more things. There is a permanent male nurse in the ward and for a while there was also a contractual male nurse. Because in this ward there are only women patients, in the beginning some women patients were uncomfortable with a male nurse. Now I think that the situation has improved; the male nurse is accepted as well as the women nurses and some women patients even prefer the male nurse and some of them call him ‘doctor’ and show that they have more confidence in him than in the young women surgeons. (young nurse)

Similarly in the focus group interviews all participating men and women nurses reported viewing men’s entry into the nursing profession as positive. This is because men have a different mentality about work and are able to dedicate much more time throughout life without possible intermissions because of childbearing and can place more effort to work and syndicalism.

The status, however, of the nursing profession is diminished by the fact that the nursing shortage obliges them to often perform all kinds of tasks, even tasks that should be performed exclusively by assistant nurses and other auxiliary personnel. Having to spend considerable time on a variety of housekeeping tasks that would be normally undertaken by assistant nurses tends to impact negatively on nurses’ psychological outlook. Such tasks include the checking of existing and the ordering of needed hospital supplies; and the storing of incoming supplies to closets. Storing can take considerable time because of the very limited space available in the different hospital divisions. Furthermore, often nurses are forced to perform a variety of housekeeping tasks such as cleaning consultation rooms, making beds in consultation rooms, etc. that should be performed by service personnel or at least by assistant nurses. There are also often maintenance and functioning problems (such as the telephones not working right), that are not taken care in time and the nurses are obliged to perform them themselves or to spend a lot of time trying to find the responsible hospital caretakers. Although there are no quantitative data available, the
observations show that these conditions further aggravate the existing shortage of well-trained nursing personnel and diminish the time available for the delivery of quality nursing care but also have a negative symbolic impact on well trained nurses who feel that their specialized training is unused and useless.

The dissatisfaction felt by the inability of more prestigious occupations to transfer less important, routine or dirty tasks to less prestigious occupations that obliges members of the more prestigious occupations to perform these tasks is clearly expressed by the women nurses:

*The negative aspect of the nursing shortage is that I have often to be alone during duty and to perform all kinds of tasks, like bringing food to patients (a task for a practical assistant), to clean the room etc.*

*My informal duties though include everything that has to be done and for many reasons doesn’t get done, mainly because there are very few nursing personnel. If needed, I will even carry myself wounded people.* (nurse-supervisor)

In the case of the male nurse, it seems that he tends to be allocated more housekeeping tasks, especially those stereotyped as ‘masculine’ tasks because they require strength, effort, mechanical (such as fixing nonfunctioning instruments or machines) or technological skills (such as computer skills) or a minimum of risk such as climbing stairs to store supplies or to stack cartons with supplies at the higher levels of closets. Supervisors and fellow women nurses consciously and jokingly acknowledge that they assign ‘masculine’ housekeeping tasks to the male nurse. This assignment by no means implies lesser status for the male nurse since the tasks assigned to him are not tasks that women nurses do not want to perform but tasks that are not able to perform (or they like to think that they are not able to perform) and rely on his special masculine qualities and talents for their performance. He, on the other hand, is by no means displeased by these task assignments since they are compatible with the desirable masculine competent image of Mr. Fixit and of the person who can solve all –problems.

### 4.4 Work-Life Balance

Nurses’ work can interfere with their personal and family life through the fatigue they feel after the hard work for 8 hours; with night, weekend and holidays duty; and with the patients’ misfortunes.

*I go home tired and I need to relax before I can start the work at home. In my life, in my family, I like to be in everything but of course as much as I have the time, I can’t find time for all the things. I love very much my family and I like very much dancing and singing. I like to see others to dance well, to sing well but I also like to participate in these. I love very much excursions for entertainment for family, my society and myself. I like to help myself by learning new things, as much as I can about science and technology and whatever can be useful for my family, my society and myself.* (nurse supervisor)

*The work schedule is very difficult. For example, when in X-mas another colleague will be at home, I will be on duty all day. Then when one has to serve during night it’s not easy, especially for a mother who has children. One tries to arrange things in such way that the family doesn’t suffer much. But of course you bring the anxiety into your family.* (nurse supervisor)

*My work influences me, of course. At the beginning it was much more difficult, now I have got used. At the beginning, working in the women’s ward with mainly cancer*
patients and we know that they will have one outcome. I would go home and keep thinking about the one and the other patient and discuss their illness with others. Now I have become cooler about all this, I can now close the door when I leave the hospital, not absolutely of course, because some things keep bothering me, I still think about some things and I discuss it with others. But as I look at myself, I keep getting cooler. I try to limit matters that concern the hospital within the hospital and what concerns the home to limit it at home, something like that. (young nurse)

The answers during focus group interviews showed similar trends in that the participating nurses reported that their work affects their personal and family life in many ways, especially when they are starting to work. First, the afternoon and even more their night duty causes nagging because it upsets family planning and outings. Even the one male nurse who is single reported nagging and displeasure on the part of his girlfriend. Second, when unpleasant events occur to patients they are taking care, they have difficulty forgetting about it when they get home, although after some years they learn how to deal better with these issues.

4.5 Emerging Themes

Some emerging issues that will change the nursing profession relate to the continuously increasing number of nurses with university education and postgraduate degrees and the increasing professionalisation of the nursing profession; the increasing number of male nurses and the defeminization of nursing resulting in a higher professional status and prestige and the potential increased involvement of male nurses in hospital management and decision-making; the increasing use of digital technology and other types of technology to alleviate time-consuming nursing tasks; the increased awareness of patients of their rights and especially their rights to equal treatment regardless of their characteristics (age, gender, socio-economic status, race, ethnic origin and religion, handicap and sexual orientation) followed by their increasing organization as well as by increasing advocacy on the part of MKO’s representing different types of patients. All these changes will lead to a higher level of demands regarding quality care from nursing personnel. Also the increased patients’ demands for quality health care free of discrimination will necessitate frequent and thorough evaluations of nursing performance based on a number of scientific criteria measuring, among others, communication with patients and adequate provision of explanations and lack of discriminatory behavior.

While some or most of these emerging changes might be resisted by the nursing community, as most changes tend to be resisted within the Greek cultural setting, they probably will finally prevail (but after a long time) under EU pressures. All these changes will translate into better quality health care for patients who will be entirely in the hands of very well educated nurses.

The sooner the nursing profession will be able to perceive the opportunities and not only the challenges that these changes represent, they will be able to develop appropriate professional strategies that will help them transform these changes to positive changes for their social status and professional prestige.

5 Conclusion

In examining the validity of the study findings and the possibility of generalizations, it is helpful to compare the present research findings with those of larger survey studies. A study conducted in 2000 by the Centers for Citizen Service showed that the majority of nurses (32%) consider their low salaries as the most serious problem of working in public hospitals; 25% the shortage of nursing personnel; and only 9% the organization and functioning of hospitals. Also the
majority of nurses (52%) is dissatisfied with existing work conditions and consider salary improvement and the hiring of additional nursing personnel as top priorities. In our interviews, the dissatisfaction with salaries did not emerge as a major issue except in the nurse supervisor’s interview.

The nursing profession has undergone the following most important structural changes. However, it must be pointed out that changes in gender roles and the entry of men in nursing are the changes that are more vividly portrayed in the interviews.

1. **The upgrading of nursing education at the university level** has been a very important change that has helped increase nurses’ ability to gain more professional knowledge and improve the image of the nursing profession and its status within the hospital setting. The establishment of a University School of Nursing provides nurses with the possibility to receive graduate training. Available statistical data for 2000 show that: 16% of nurses actively working hold a university degree; 1.17% of nurses actively working hold a masters’ degree; and 1.72% of nurses actively working hold a Doctorate. Since these data are from 2000, most probably by now a higher percentage of nurses have a university degree and a higher percentage have graduate degrees. It can be expected that not only the increasing professionalisation of the nursing profession but also their having to compete with career oriented male nurses for important specialized and managerial nursing positions will motivate nurses to seek additional advanced and specialized training.

2. **In 2004, a new legislation was passed that provides nursing with a professional body aiming to control the profession.** The legislation gives nurses with tertiary education the right to create an Association of Greek Nurses with the public power to regulate the professional rules governing the exercise of the nursing profession. Because, however, the new professional rights are granted only to nurses with tertiary education, the legislation grants them higher professional and social position by underlining the distinction between nurses with tertiary education and all other types of nursing personnel with lesser education. The profession hopes that, when the new Law (3252/2004) will be fully applied, professional autonomy will be achieved and it will be easier for a nurse to become self-employed because by this legislation nursing tasks will be better clarified and differentiated from medical interventions. The application of this Law, however, only now starts and therefore it is rather very early to speak about how effectively it will be enforced and what its effects will be on professional nurses’ lives.

The interviewed nurse supervisor who is a member of the nurses’ syndicate made these comments regarding this legislation:

> Now it’s a beginning, a bill was voted according to which health personnel become legal entities of public law and in this way they will be able to do more. In this way health personnel not only will be able to offer services but will also be able to claim their rights and to better protect themselves. The implementation of this bill is just starting and through this, I believe, that things will improve considerably. (Nurse-supervisor)

3. **There is a number of generational changes between the observed women nurses mostly due to social changes that have taken place in the status of women and the level of fertility as well as the expected standards of living.**

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69 ELeena Fyntanidou, 2000. « Greeks Dissatisfied with the Public Health System », *To Vima* on-line, November 12 (in Greek).
70 “Draft Law on the Creation of an Association of Greek Nurses and Other Provisions”: op. cit.
Changes in the status of women include an increasing number of women working even when they have small children, at least partly due to the small number of children born especially to professional women (who are more often than other women childless or have only one child\textsuperscript{72}) and the realization that the incomes of both spouses are needed, if the couple wishes to enjoy a somewhat satisfactory level of living. While the overall percent of Greek mothers children under six is still lower than the same percentage in several other EU countries, the employment rate of highly educated women is much higher than that of low-educated women (74\% instead of 45.1)\textsuperscript{73}. In fact, 7 out of 10 Greek women with university education continue working while they are bringing up their children. Their career has increasingly become a lifelong goal as it is shown by their delaying marriage and motherhood\textsuperscript{74} in comparison to earlier patterns because they want to ensure their career development\textsuperscript{75}.

The long eight hours of nursing service, night shifts and having to often work on Saturdays, Sundays and holidays make it difficult for mothers of young children. That is why the interviewed supervisor stopped working for a few years while her children were young. The situation seems to have changed in the new generation. The young woman nurse, for example, states with conviction that she does not plan to stop working when she will have a child.

> No I won’t stop, [when she will have children] I can’t do this, how will I progress in this way? When I will have children, it will be difficult because both my mother and my mother-in-law are still young and are working, I don’t know how I will manage, we’ll see when the time comes but I won’t stop my work. Now you can’t live with one salary and when you have some dreams to do some things, you can’t leave. My husband is a public servant; he works in the sanitation department of the municipality. (young nurse)

Her planning to not stop working is shared by a lot of other professional women of her generation, despite the fact that many grandmothers work and refuse to become unpaid full-time baby sitters.

4. The socio-economic origins of nurses have become more diversified in recent than in past generations. In the older generations of nurses, that is in the 60’s and 70’s, young women who became nurses came from families with very limited socio-economic means and wanted to get an inexpensive education that guaranteed them employment. Since in the past nursing education took place within the context of large state hospitals (such as Evangelismos), while getting a training, nursing students could offer their services to the hospital and get food and board in exchange.

Now the new generations of nurses come from a more diversified socio-economic origins, including higher socio-economic strata since they do not have the option to work while studying and their families have to support them through their university or TEI education. Girls and boys from low-income families now tend to attend the two-year nursing programs sponsored by hospitals that train assistant nurses. When recently the continuous functioning of such a nursing training program in Agrinion (a small town) was threatened, a parliament member of PASOK

\textsuperscript{20} Martha Kaitanithi, “Motherhood: Career-Note 1”, TA NEA, 29 March 2005 (in Greek).
defended the need to maintain it because “for four decades it constitutes a significant outlet for young men and women from low-income rural families”\footnote{6}.

Regarding the professional “choice” of nursing, the interviews show that although nursing was not the interviewed nurses’ preferred occupation, after beginning their training, they very much like their occupation and show a high degree of work commitment. In the case of the nurse supervisor, she had no choice, she had to accept nursing because her family could not afford to send her to the university since at her time university education was not free and the public hospital’s training program offered her board and tuition in exchange for work within the hospital. In the case of the younger male and female nurse, nursing was not their preferred option during university entrance examinations but rather their second or third option. They “ended up” in nursing because the grades they received during the examinations did not allow them to enter in their preferred fields (archeology in his case and journalism in her case) but they could follow their lower order option- nursing- since did not want to lose a year\footnote{7}. It is very important, however, to point out that despite the fact none of the three interviewed nurses had planned to become nurses, after they entered the nursing training, they found it interesting, they increasingly liked their work and became committed to their work and to the profession. None of the three regrets being a nurse and the two younger ones recognize that if they had followed their originally planned professions (archeology for the male nurse and journalism or teaching for the young woman nurse) would have great difficulty finding employment. There is evidence that all nursing graduates are employed soon after their graduation in the public or private sector\footnote{8} (NEA, 2003).

5. Another important structural change is the recent significant entry of men in the nursing profession, at least at the beginning motivated by the overall high unemployment rate in other fields and the better chances for young men to find a job when they complete nursing training. At present 17\% of the students attending the Nursing Department at the University of Athens are men. Also although there are no systematically collected data, there are indications that the percent of male nursing students is much higher in some academic years\footnote{9} and in the TEI’s of several Greek provinces.

Equally important is the fact that the men employed as nurses at all levels are very well integrated in the women’s network and do not seem to be in any way excluded from the informal nurses’ network. The observations showed this pattern quite clearly in the case of the interviewed male nurse who is well integrated in the socializing of the informal network of women nurses.

The interviewed women nurses underlined the fact that the presence of men is welcome and beneficial for the professionalization of nursing. It must be noted that male nurses (permanent and contractual) can be found in all hospital services, in the wards- including the women’s ward-, the blood donation service and the intensive care unit. Only in the category of hospital orderlies, men are found in a higher proportion in surgical services. However, in this university hospital there is no male nurse in a supervisory position, most probably because of the recent entry of men in significant numbers in the profession.

The entry of men brought about a change in the name of nurses that has probably played an important role more than just a symbolic one in improving the image of the profession. Male

\footnote{21. “Is the Nursing School in Agrinio closing?” \textit{Agrinion Newsletter} , 13 March 2006.}\footnote{22. For details concerning the rules regarding entrance into higher education see: Zambeta et \textit{al.}, 2005, \textit{op. cit.}\footnote{78} Manos Haralambakis, “The Candidate. The hospitals a ‘Headache’- Opportunities in the Private Sector. They Find Jobs Quickly After Graduation”, \textit{Ta Nea}, 16-12-2003, \Sελ.:N32.}\footnote{79} \textit{Ibid.}}
nurses could not be called “adelfes” (sisters) a word that in Greek also refers to homosexual men. Now the older term ‘nosokomos’ is only used to refer to the hospital orderlies (‘travmatioforis’\textsuperscript{80}) who carry patients, wash them and perform other physical tasks. At present the new term ‘nosilefis’ [that we have translated as ‘nurse’ due to a lack of a better term] is used for both men and women with a university or TEI training, while those with only a two-year training are called ‘assistant nosilefes’. The Greek word ‘nosilefis’ has a connotation of treatment (from the verb nosilevo that means to “treat”) that connotes more professional knowledge and prestige.

As the male nurse predicts, it is quite possible that men’s entry in nursing may further increase significantly:

\begin{quote}
Still there are more women than men but the difference has decreased. In the following generations, it may change even more but I don’t know whether it will ever happen to have more men than women. At least here in Greece, it’s a good way for men to get a job faster than by studying other things. The prospective for jobs [in nursing] is good, so it’s attractive for men. (male nurse)
\end{quote}

If this happens, the increasing entry of men in nursing will be strategically important because it will help the profession escape the marginal position usually accorded to “women’s” occupations. It is expected that this process of “defeminization” will be completed when male nurses will constitute at least one-fourth of professional nurses with tertiary education and a considerable number of them will assume supervisory and management positions. Research in the U.S. has shown that men in women-dominated occupations benefit from the “glass elevator” phenomenon because men assist each other to rise to high management positions.\textsuperscript{81}

\textsuperscript{80} The word “travmatoforis” means a person who carries wounded people.

CHAPTER 5

Portuguese nurses’ lives under restructuring - Case Study Report

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1 Introduction

The production of Portuguese case studies within the PROFKNOW project aims at contributing to a deeper understanding of the impact of structural changes on the life and working conditions of nurses, according to their own views (WP 5).

In order to make possible the comparison among the experiences of professionals in different European contexts, the consortium guidelines regarding access to the field, methods and strategies for data collection and analysis and the writing of the case study reports were followed. These guidelines were crucial for devising the work plan as well as for selecting the interest themes to be analysed.

As regards the research field, a hospital in one of the major cities in the country was chosen (Hospital da Estrela), which is included in the group of Portuguese institutions that – due to government options - have changed their statutes in the last few years in order to adopt businesslike management strategies, also applied to public enterprises.

Access to the research terrain was preceded by contacts with the director nurse and with the institution supervisor nurse. During these contacts the aims of the project and the data collection methodologies that would be applied were discussed. The Hospital Administration Board formally authorized access to the research field.

The hospital supervisor nurse was in charge of the selection of possible participants and, according to the research objectives of the project, she identified three participants (one/one and a half, 12 and 35 years at work). The researcher and each of the participants signed an ethical protocol that determined the responsibilities of both parts during the research process.

The data collection stage at the institution took place between January and March of 2006. Regarding data collection strategies, a first set of low structured interviews was performed. These were then followed by a three-day observation period of each participant’s professional performance. After the previous analysis of the first interviews and the observation had taken place, thematic interviews were performed in order to enlighten and to get a deeper understanding of some themes that were relevant for the objectives of the research process. A single researcher performed the data collection process.

The first and second interviews were totally transcribed and presented to the participants for validation. The complete translation of the first interviews and the translation of the summaries of the second ones were made available to the Profknow consortium members. After analysis of the information, a group interview (July 2006) was performed to five female nurses of different generations and working in different contexts. This aimed at a deeper comprehension of emergent issues in the analysis done and at understanding to what extent the impact of the nationwide structural changes was perceived in the context of the nursing profession.

82 Fake name.
The areas presented for discussion in that interview were determined by the interest areas defined in the project: professional ideals, balance between professional and family life, working conditions, professional autonomy, historical or political changes with an impact on the job, impact of education and training on performing the nurse’s role.

The same procedures regarding informed consent for participation in the research project were followed. The interview lasted about 120 minutes and was totally transcribed. In this report, after a brief presentation of the national and local contexts where this study was developed, some details about the participants will be given, including information about their educational and professional paths.

The data collected through different methods were grouped according to four core areas:

- Knowledge at work: contracts and organization of professional activity;
- Socio-professional relationships at work;
- Professional knowledge at work;
- Professional status.

The chapter on data analysis in this report is structured according to these areas. The organization around these four core areas cannot, however, be regarded in a discrete manner. Thus, structural changes such as the development of the nurses’ educational background (maybe the most striking aspect) are interconnected with all the areas. Therefore, we chose to present throughout the analysis the relationships identified between the different areas and some structural changes, such as: the rise in academic qualifications to enter the profession; the new businesslike management of public institutions; the growing number of beginner nurses at the job market; the establishment of self-regulation mechanisms in the profession.

Similarly, marks of differences among generations will be identified throughout the presentation of the various themes under analysis. Their systematisation and the relationship between them and the conclusions of the study will be presented in the last section of the report.

Taking into account the focus of this project in the analysis and comprehension of professional knowledge under restructuring, it is important to explain that our understanding of this concept is based in three main principles: i) that the subjects are active in their relation with knowledge, ii) that professional knowledge is beyond the official ways and versions (although it doesn’t exclude them) and iii) that it can be analysed and learned from practice and not only from previously acquired theory.

Therefore, one may understand professional knowledge as a group of implicit or explicit competences, that are used and constructed by the active subject in action and reflecting upon it, generated and fed by both the subject’s history, professional culture (models, concepts and legitimate behaviour and action patterns set by the profession) and by the organisational structure of the specific context where the work is being developed.

It is based upon such a global understanding that this report is organised.

2 Background of the study

2.1 The Portuguese Health System Context

In order to understand the Portuguese Health System Context, it is essential to identify and analyse the establishment, expansion and management of the National Health System. We will briefly identify some landmarks that determined its evolution, mainly as regards the hospitals
network, as these employ the vast majority of the health workers and also because they are our focus of interest in the present study. In this section, we will take as reference some landmarks identified in WP1 and WP2 as well as some later developments.

The April Revolution in 1974 is one of the major issues to be taken into account in any analysis dealing with the historical path of the Portuguese society. Until then, the country was ruled by a right wing totalitarian regime. In the pre-revolution context, the health system was highly fragmentary. As regards the health sector there were different institutions, with very diverse origins and orientations: i) a wide network of misericórdia hospitals (centenarian institutions for social solidarity); ii) the “social – medical services” (SMS) (the Portuguese version of an health welfare system); iii) Public Health Services (aiming at health protection – vaccines, mother-child healthcare, among other things); iv) a few state central hospitals and v) private healthcare aiming at the upper classes.  

Through the democratisation of the country and the establishment in the Portuguese Republic Constitution of every citizen’s right to health, through universal, general and free healthcare, one witnesses the establishment and the expansion of the National Healthcare System (1979). It is in this context that the features that would characterize it till the present day emerge: i) funding through the Budget; ii) integration of the various healthcare institutions into a single system (the misericórdia hospitals were nationalized in 1975 and in 1984 the existing Health Centres were merged with the Social-Medical Services).

In the 90’s, following the European trend, the discussion emerges about the introduction of market strategies in healthcare systems through a rise in private funding and the separation between “funding providers” and “caregivers.” By then the concept of free health care is replaced by the idea of predominantly free health care and one witnesses the introduction of taxas moderadoras (a small admittance fare) in the access to health services. The National Health Service has, nevertheless, continued to be taken forward by non profitable public institutions financed by the State.

An increase in the measures towards a businesslike management of the health sector is proposed. It is assumed that the bureaucratic-administrative model of hospital management is out-of-date and thus it is necessary to adopt flexible, businesslike criteria. The most visible aspect of these developments turns around the legal changes and the management models of public hospitals.

In 2002 one watches the transformation of 34 hospital units into 31 SA Hospitals (30% of the hospitals in the country and about 50% of the beds available in the public sector): the management model is changed but the responsibility of the state for healthcare remains the same. Within this new model, human resources’ recruitment is done through individual contracts. After the 2002 reform there are three categories of public hospitals: SA Hospitals, Hospitals from the Public Administrative Sector (SPA) and Hospitals within public-private partnerships.

In 2005, within a new political cycle, new legislation is issued which turns the SA Hospitals as well as five SPA Hospitals into EPE Hospitals (public business entities). Since the beginning of our present legislative cycle, the government has started all necessary procedures to transform public Portuguese hospitals in EPE. In both legal forms capital ownership is public and human resources recruitment is subject to the rules of individual contract. In both situations there’s the

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83 OPSS – Spring Report, 2001
84 Ibid
85 OPSS – Spring Report, 2003
86 Decreto-Lei nº 272 a 302/2005
87 Decreto-Lei nº 233/2005
possibility of moving personnel from public service into the individual work contract system. However, in EPE Hospitals, the Health Minister’s superintendence power (regarding the approval of the hospitals aims and strategies, among other things) is more striking, the capital remains public and bankruptcy on economic grounds is not allowed. 88

Under the new legal status (first SA and then EPE) the purchase and human resources recruitment policy became more flexible. However, in the majority of the hospitals the same organizational design was kept. The update in technological evolution and in human resources’ recruitment was not followed by a real organizational change. 89

2.2 The “Hospital da Estrela”

“Hospital da Estrela” is a medium sized hospital that has begun its activity in the 70’s. The inauguration of new facilities in the late 80’s constitutes a landmark in the history of the institution, as it made pace for a wider variety of services by opening and enlarging the existing diagnostic, consultation and treatment units.

The hospital has always depended on the state and the Health Ministry rules it. In legal terms, it became a part of the group of hospitals who got the status of private limited enterprises supported exclusively by public capital (SA hospitals) and in January 2006, under new legislation, it turned into an EPE hospital.

In its mission statement there are three intervention areas: a clinical area, teaching (pre- and postgraduate education of doctors and other health professionals) and basic, clinical and epidemiological research.

In order to cover the three intervention areas, the hospital possesses an autonomous research centre and collaborates in the education and training of doctors, nurses and other professionals who get their clinical training there, supervised in the practical areas by some professionals of the institution.

However, from its intervention areas, the clinical one is the most visible outside the institution.

The services in the area of oncological diagnosis or treatment are provided on an outpatient and inpatient basis. Outpatient care is rendered in different departments: outpatients, day care hospital, outpatient surgery, complementary means for diagnosis and treatment, unscheduled consultation service. Inpatient units offer a total of 352 beds. This offer is divided by surgery services (160 beds), medical specialities services (55 beds), and other care units such as Intensive Care, Paediatrics, among others (for the remaining capacity).

According to the available data, in 2003 the Hospital da Estrela 11443 patients, carried out 207348 consultations, and performed 5253 surgeries in central operating rooms and 4939 in outpatients.

An Administration Board appointed by the government runs the institution. This board comprises five members including a medical director and a director nurse, who are responsible for their specific technical areas. Being a businesslike public entity, the hospital enjoys financial, administrative and patrimonial autonomy.

89 OPSS – Spring Report, 2006
When considering personnel recruitment, nurses are the most representative professional group. This is a significant development; they were less than 200 in 1993 whereas in 2003 they were about 500 and at present they are 550 (the medical class comprises about 250 doctors and the auxiliary staff are close to 350 people).

Under the new management models (after 2002), contracts with the new professionals are signed for a 35 or 40 hours weekly schedule, according to the nurse’s own choice. Usually the first contract lasts for 6 months and is followed by two one-year contracts (fixed-term contracts). After this period, and taking into account the evaluation of individual performance, indefinite term contracts are concluded whereby the nurses become a part of the institutions personnel. The remaining vacancies occupied by nurses under the status of civil servants are extinguished as these for some reason leave public service or the institution.

There’s no shortage of nurses in the institution (1.7 nurses per attended patient). The calculation to determine needs of personnel is made according to the number of “minimum number of care hours”. In some services there’s a daily classification according to the inpatients’ dependency levels, which determines the number of hours of nursing care necessary for the following 24 hours. That system helps to determine the number of nurses needed for a certain period.

The institution was granted full certification by the Health Quality Service. This demands the recognition by an external body that the institution complies with pre-defined criteria applicable to all of its care and support systems. Obtaining the certification is only possible through restructuring the different services and the performance of the different groups towards the attended customers (whether directly or indirectly). The certification process was regarded as a strategic commitment to the improvement of the quality of the provided services and is supported on internal mechanisms of training and supervision.

3 Participants’ life, education and professional career

As has been previously stated, the data collected included information given by nurses from different age groups as well as distinct professional contexts. According to the basic principles about the concept of professional knowledge shown previously, it is important to characterise, yet briefly, the personal historical, educational and professional paths of the participants (special attention will be given to the three major informants).

In order to protect the participants’ identities, we used pseudonyms: Alexandra is the beginner nurse (approximately two years of professional experience); Paula has been in the profession for twelve years and belongs to the first group of nurses who graduated with a bachelor’s degree and Ana is at the end of her career and has been working as a nurse for 35 years.

It is important to state that two of the nurses interviewed – the beginner nurse and the one who had been at work for 12 years – work not only in the same institution but also in the same service. Besides facilitating observation, by allowing the researcher to be present for a double period of time at the same workplace, this fact also facilitated the identification of a group of opposite perspectives of the two participants belonging to different generations but sharing the same professional setting; one which is clearly limited not only as regards physical space but also regarding relational space. These opposite perspectives were particularly noticed in the issues such as the academic background and its contribution for the development of the profession, the importance of qualifications to enter the profession or the way development of professional knowledge is regarded.
The Focus Group, in turn, included five nurses working in diverse contexts. Each of the nurses was attributed a code, which was then used during the interview: a 47 year-old nurse, 23 years in the profession, working at an Operating Theatre Service; a 45 year-old nurse, 23 years in the profession, in charge of a General Medicine Inpatients’ Service; a 43 year-old nurse, 19 years in the profession, working in the area of Primary Health Care, at an Health Centre; a 37 year-old nurse, 13 years at work, practicing at an Oncology Day Care Unit; and a beginner nurse, about an year at work in a General Surgery service.

Except for the beginner nurse, all of them have recently concluded an additional school year in order to get the academic degree of nursing licentiates.

Alexandra is 24 years old and single. Up to the moment of selecting a course she had never thought of becoming a nurse – until then she had always intended to take a degree in pharmacy. It was only at the moment of choosing a degree that she decided to become a nurse - she admits the influence of her colleagues in this decision. As she didn’t manage to enter a public nursing school, her first choice, she applied and was accepted at a private school in her neighbourhood where she attended a nursing school for four years.

Her final training took place in a Medicine ward devoted to oncology inpatients. As soon as she got the degree, she was immediately invited to join that service as a professional and had, therefore, no difficulty in getting a job. As a nurse, she has only worked at this service, and has enjoyed stability as regards weekly schedule, workplace and, even, regarding the content of her professional performance.

She is currently taking a master degree, as she considers that she always aimed at post-graduate education. “(...)I’ve always said that I wanted to take a master's degree, a speciality, I never wanted to stick to basics and this year I entered a master in bioethics here at the university” (Alexandra).

Alexandra has the feeling that the fact of being a beginner nurse and investing in post-graduate education right after taking a degree was not well accepted among the team members: “Sort of: so, you’ve just left faculty and you are going to study again, what’s going on?” (Alexandra).

She thinks that this attitude of her older colleagues is due to fact of nurses being settled in their workplace. She identifies two crucial aspects that explain the current urge of young nurses to attend various kinds of masters right after taking their first degree: the fact of having a licentiate’s degree (whose curricular plan includes research in nursing) and the work instability at the beginning of the career, which forces beginner nurses into attending courses that may be useful in the future. She is at the beginning of her career but she feels disappointed with the progression and salary perspectives when she compares them with the expectations she nurtured during the course. She feels that at the moment the nursing career is at a standstill “I don’t see any of the changes they talked about, isn’t that so?” She thinks that the rise in qualifications didn’t bring about any changes and also that the nurses didn’t get their due profits from the growing qualification demands placed on them. This aspect will be dealt with more thoroughly in the section on the issues of professional status.

Paula is 36 years old and single; she is a staff nurse. She didn’t take a degree in nursing out of vocation. She had always figured herself more into economics and she didn’t really have a notion of what it was like being a nurse. In her decision to apply for a nursing course she was also influenced by her secondary school mates. She took her nursing course at a private school because, just like Alexandra, her grades were not good enough to ensure a vacancy at a public nursing school. The school she attended belonged to a religious congregation and up to then it had always been an all-girls school. She belongs to the generation of nurses who went through
the integration of nursing education into Technical Higher Education, which required a 12th grade qualification to be admitted. Through her course she acquired a bachelor’s degree in nursing and from then on access to the nursing career depended on the acquisition of a higher education academic qualification.

She has been working at the institution since the beginning of her professional life and she says that she is satisfied both with her professional choice and with the institution where she works. She has always worked in services in the area of Medicine Wards. She has been at the present service for several years and has participated in its restructuring. She is one of the oldest members of the present nursing team.

When nursing initial education changed into a licentiate’s degree Paula attended an additional school year to get that academic degree, harmonizing classes with professional work.

Yes, it was very hard work, and... I was busy, wasn’t I. Because, I had a strict timetable, I had to study in the morning and I worked in the afternoon, till 11 p.m. here, and all, every single weekend working, it was a... difficult year, wasn’t it? During which one has almost no personal life, as there’s no time for it. (Paula)

She believes that taking a licentiate’s degree was important in terms of personal fulfilment, although it didn’t have any effect on her performance as a nurse. In fact, her perspective on academic education and on its usefulness for the profession is quite different from the views expressed by Alexandra. She seems to regard professional education as something more connected to context and supported by professional practice than as formal post-graduation in higher education context. In terms of her future professional development as regards education, she has some doubts as to its direction, but some certainties as to its content.

I’m drifting around a little, I admit it, because it is so: I thought of taking a speciality? But, then again, I don’t want a speciality for speciality sake. A Master doesn’t mean anything to me, I don’t want to get a Master just for the sake of it, with all respect, absolutely, I’m just trying to explain, because what I see now and I sense it a lot now, and I didn’t use to sense it that much in nursing evolution, is that everybody wants to become a doctor. (...) to me, I mean, there are Master’s degrees, that’s for whoever wants to be a teacher, whoever follows that... (...) But then, taking a Master’s degree just to say you are a Master... that doesn’t mean a thing to me. (...) It doesn’t mean a thing to attend... just to say that I am... do you see what... what I mean? ... How come young people are already taking Master’s degrees, but... if they’re not structured as nurses, how come they are already taking Master’s degrees? (Paula)

The career and education issues seem to be problematic in terms of balance with other professions. In her opinion, the licentiate’s degree and the social responsibility required for the profession should correspond to a better pay. She chooses the teaching profession for comparison.

my cousins earn more than I do, they work much less than me, they have much less responsibility than me, they surely don’t get half as beat as I do and they earn a lot more than I do, but... it’s unfair... but... that’s it. I think we don’t earn enough considering what we go through. (Paula)

The very same theme is common and spontaneous to all participants of the Focus Group:

Nurse – (...) Then, I got a bachelor’s degree, in that moment I am a licentiate, in inverted commas, aren’t I? Unfortunately, it’s in inverted commas...
Interviewer: Why in inverted commas?
Nurse – Because... it is so...I don't do in terms of... in terms of... in the whole organization of the health centre, I am not, I am not classified as a licentiate, I am a bachelor, even though I have a licentiate's degree for four years now, I am not... I keep, in terms of income and in terms of recognition, I am not, I am not recognised as such, I am still a bachelor in nursing.” (Focus Group: 43 years-old nurse, 19 years in the profession)

This feeling is shared both by the older nurses who chose to attend complementary education and by the new nurses who enter the job market with a licentiate's degree. The reasons for dissatisfaction are to be found not among peers but in comparison with other professional groups.

Ana is 54 years old; she was married twice and has got an adult son. She is a staff nurse. She attended the three-year Nursing General Course because, as she puts it, in those days there were not many career choices for 5th graders: it was either becoming a nurse or a primary school teacher.

Her career path makes it possible to establish different links not only with the changes that took place within Portuguese nursing but also with the recent political-historical developments in the country. After graduation she worked for several years at a private clinic where she ended up performing the function of nurses' coordinator. She mentions that there were no difficulties in getting a job in those days. The beginning of her professional activity made a strong impression on her and it is somewhat mixed with the instability experienced in the country following the (left wing) political revolution of the 25th April 1974 against the totalitarian regime in charge until then.

She mentions that she was dismissed by a workers' committee because they considered she was too close to the direction board and also because, according to her, she was not of the same political orientation as the revolution. Later she was hired by an analyses laboratory where she performed all sorts of tasks, not only did she collect the samples, but she also kept the accounts, performed some analyses and helped at the front desk when no one else was available. She regards the entrance in the institution where she has been working for the last 25 years as the turning point in her professional career. She thinks that the fact of having worked in private institutions at the beginning of her career (with the features that they presented at the time) has inhibited her in her career and education path, namely as regards becoming a specialist nurse.

Not having anyone from the family nearby and having a child, living almost on one’s own, because the father is always absent, having to take him to school, pick him up from school, I think it is a bit limiting, isn’t it? And that was it; I settled in, I didn’t do anything, I was in the private area and all and I didn’t do anything. When I got here they always selected the ones who had been here longer to take a speciality, you see? (...) That’s it, I got surpassed and all and, then, I also settled in. And as I didn’t get a speciality, then, also, meanwhile, to become a charge nurse, one had to be a specialist. No, I fell behind. (Ana)

In her professional path at the institution she has worked most of the time at the Day Care Unit, a service she still identifies herself with, and from time to time she has also worked at the samples service. At present she is working at the blood donors’ service, where she performs the role of coordinator of the nurses’ service just as she did on some occasions when she worked at the Day Care Unit, in spite of the fact that she is not a career chief. She has a fixed weekly schedule of 42 hours, from Monday to Friday. She decided not to take the complemento course because she
considers that it wouldn’t bring her any advantage as she is at the end of her career, waiting to be retired. The decision to take retirement was the latest dilemma she had to face.

*It was complicated, you see, it was a struggle, because I believe that I am still quite fit to work, for three, four or five years, maximum three, right? At 57, maximum is three years... but... (laughter). I’m sure everybody thought the same as me. Well, leaving now, with a penalty, or leaving in three years, or not being allowed to leave in three years and leaving with an even bigger penalty, then, now would be the ideal moment. That’s what I thought, because I believe I can still work for another three or four years, can’t I? But, if they won’t allow us to leave in three or four years time, then, it’s best to go now, because I won’t, I won’t pull my socks up now, I’ve reached the last step as a graduated nurse, the wage is always the same, isn’t it? (...)can you imagine; I’ve reached 35 years at work, two years ago, 35, right? With the bonus and so on I could have left two years ago without any penalty. (Ana)*

Until 2006 nurses, just like other professional groups recognized as wearisome-prone jobs (teachers, doctors, security agents), enjoyed special retirement conditions, namely through a reduction in the age at which they could retire without any losses of income or any other perks (they could retire at 57 provided they had completed 35 years at work or after completing 36 years at work no matter the age). Besides these specific professional groups, the retirement age for civil servants was 60 years. There were big differences in the conditions to get retired for many sectors when compared to the general retirement legislation, which determines the workers’ retirement at the age of 65. In this context, nurses who had been given a longer working schedule (with a bonus regarding time at service) could reach the number of service years considered for retirement purposes without being 57 years old. The new legislation recently approved by the government aims at progressively unifying (till 2015) retirement age for all the workers regardless their professional group. This situation caused a real reforms race as it led some of the professionals who fulfilled the terms for retirement, such as, for example, time of service despite the age, to ask for retirement, even under penalties, instead of prolonging their time at work.

4 Life Stories Themes: analysis of the collected data

We chose to aggregate the information collected through the interviews and the observation of the three participant nurses according to four areas that were meaningful according to the interest areas of this project: i) working conditions, ii) socio-professional relationships at work, iii) professional knowledge, iv) professional status.

Along this section we will highlight the subjective perspectives of the different participants regarding components of the above-mentioned dimensions; later we will relate the identified relationships with the structural changes identified in WP1 and WP2 and the ways these affected the professional development.

4.1 Working conditions: contracts and organization of professional activity

Until recently, Portuguese nurses had no significant difficulties in getting a job or a permanent bond with an institution as there was lack of professionals at the job market. Precarious work was not an issue; on the contrary, it is quite common to come across professionals who work at
more than one institution. In order to deal with situations of lack of nurses at the services, the so-called extended work schedule was established, in which the weekly work schedule reaches the 42 hours in exchange for a 37% increase in salary and a bonus of one-year for retirement purposes per each four years of service under an extended schedule. This sort of schedule is applied in time periods defined according to the documented needs of the different institutions.

Alexandra’s experience, as well as that of her recently graduated colleagues, does not totally support this idea, but it doesn’t either confirm the existence of precarious work where very short-term contracts are concluded. Alexandra did not go through that stage of precarious work. She mentions that when she entered the nursing course this was regarded as a course that would guarantee a job. She thinks that in two years that situation has changed and that now there are Health Units that resort to different strategies for having nurses at their service without offering them a permanent bond.

*It’s three months, they have a period of holidays, generally, they work for three months more, they reach the end of that half year term and they are fired, two days later they are hired again only and exclusively in order to get another contract, because after three contracts, we are obliged get a bond with the institution. That way, they are fired and there’s no such obligation and that doesn’t provide stability to anyone.* (Alexandra)

In the Portuguese context the vast majority of nurses still enjoy the status of civil servants according to a career (dating in its core aspects from 1991 with minor later adjustments) applicable to all nurses on duty at the National Health Service institutions and dependent upon the Health Ministry (whether they work in hospital context or in primary health care).

This career determines a weekly workload of 35 hours and has three different levels: level I – nurse and staff nurse (access is done through documental application and progression is based on the number of years at service); level II – specialist nurse (requires adequate academic education in a specific area and application with public demonstration) and charge nurse; level III – supervisor nurse (requires a specialist nurse status and application with public demonstration). This career has been the visible face of the terms for access, progression, income and qualification of the nurses in this country.

Under the new management models many of the institutions of the National Health Service Network turned into SA and later into EPE. In this modality there’s more flexibility regarding staff recruitment: individual contracts are closed by the institutions and are subject to general legislation. The personnel get permanent bonds with the institution but are not regarded as civil servants. Staff already working at those institutions was given the possibility to choose; almost all of them remained in civil service. In practice, in the institutions there are nurses under different types of bonds: those who are civil servants (generally those who entered before the institutions change of status); nurses who have a permanent bond with the institution under an indefinite-term contract and the newcomers with shorter, fixed term contracts.

As regards new admissions, it is common practice at the institution to sign two or three fixed-term contracts for a period of sixth months or a year and later to close indefinite-term contracts with the nurses. This moment when they close an indefinite-term contract is a reason for some stress among the new professionals. It is not that the indefinite-term contract brings new advantages or a different income, but it allows them a new stability in personal terms.

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90 Rosa & Oliveira (2005), in a study on the Portuguese nurses’ working conditions (N=2492), identify that in 58.1% of the cases the weekly workload is over the 35 weekly hours and that in 50% of the cases it is over 40 hours; 20.9% of the interviewees work at more that one institution; 30% work under an extended schedule system and 40% do overtime with some regularity.

91 Decreto-Lei nº 437/91
A: It is. And I noticed that on a colleague of mine who entered one year ahead of me who was always under such a stress until she changed into an indefinite-term contract, my God, then there was the parents’ stress, her stress, okay, people end up not having this stability to take that step forward and think about the future while they don’t have professional stability.

Q: When you say think about the future what do you mean?

A: In that particular case, for example, in that particular case I’ve just mentioned, at economical level, thinking of marrying… having another life, buying a house, getting a car, because we face the risk of being sacked, there’s always that thing, isn’t that so? As things go nowadays… (Alexandra)

The differences between the new nurses and the ones who are civil servants are not meaningful. The issue that seems to be a bit more striking, also mentioned by the nurses, has to do with the specific area of intervention of the institution in terms of health and with the fact that, by law, nurses working in oncology areas as civil servants are entitled to five extra days for holidays.

No, because civil servants … those who have been here longer, I don’t know how long this has been established, they get a five day bonus for working in oncology and the younger ones don’t get it. So, I ask: so, aren’t we all beat? Aren’t we? (Alexandra)

In terms of the number of nurses needed the institution apparently manages to keep a suitable number of professionals. Through the interviews made to nurses in top management positions at the institution or during the conversations with nurses from the different services, it is admitted that the Hospital has a good reputation as a quality caregiver, that this image is taken very seriously and that there’s a commitment to maintain that level. The nurses themselves admit this fact when comparing their institution and the conditions available with other realities.

In that matter, we are somewhat privileged, having enough personnel to work and well … and material and all that to work. (Paula)

The contracts of Paula and Ana were signed prior to the new rules of hospital management. They remain in the institution as civil servant nurses. Both have been attributed an extended schedule (42 hours a week, from 8 a.m. to 4.30 p.m.) as they work on a fixed schedule, preferably mornings from Monday to Friday. At the institution the assignment of that type of schedule is limited and apparently it works as a stimulus provided to the people who are asked to take some responsibilities (such as coordinating a service or supporting the charge nurse). This way they are compensated for the loss of income resulting from leaving the shift schedule and its corresponding supplements.

However, his continuous and fixed schedule is also regarded as limiting when it comes to balancing professional development with personal and family responsibilities.

Maybe the work schedule and, then, and, then, the long work schedule, right? Because it’s 42 hours a week, it’s also a very heavy work schedule, right? It’s 42 hours. It means coming in at 8 a.m. and leaving at half past four, five, p.m. It is a lot of time inside, isn’t it? Because there are certain jobs where one, there’s time to go home, do something; one has lunch, does something, goes shopping, then comes back, isn’t that so? (Ana)

At the institution the nurses’ contracts have an estimated weekly schedule. Contracts of the nurses who do not belong to civil service are usually closed with a workload of 35 or 40 hours. That estimated weekly workload does not necessarily have to be fulfilled in one week. By the
end of the month the number of missing hours is calculated and distributed and not everybody appreciates that type of schedule management.

“Nurse M. disagrees with the way the planning and organization of schedules is done. He says that there is no logical sequence in the schedule and that therefore one cannot make any medium term plans regarding personal life. Anyone who doesn’t have a fixed schedule must complete x hours by the end of the month.” (Field notes at the service from nurses Paula and Alexandra)

It is the charge/in charge nurses’ responsibility both to determine the nurses’ schedules and to decide the distribution of the nurses in the service according to the different work areas available.

It is also their functional role to run the auxiliary staff in charge of distributing meals, sending patients to other services, establishing links with other services and supporting the nurses in patient care, when required.

The organization of the shift, the evaluation of care needs, its implementation and evaluation is done according to the nurse in charge of a specific area. One can say that the specific daily work area and the general definition of its inherent responsibilities are established by the charge nurse’s planning, but also that the operational procedures depend on the initiative and decision-making of each nurse.

At Paula and Alexandra’s service the different activity areas for each shift and their general inherent responsibilities for each nurse in charge of that area in that day are clearly defined and posted at a visible place. For example, the nurses responsible for care giving at a ward can read in a specific description of their responsibilities that they must “give global care to patients” or “prepare the patients and the ward for the medical round” or “orientate visiting hours”. What the nurses do and the way they choose to do it will be their responsibility. There are two types of activity areas: the ones aiming at global nursing care to inpatients, in which each nurse is responsible for taking care of 4, 8 or 16 patients according to the shift (morning, afternoon or evening), activities focused on the performance of tasks such as collecting samples, preparing chemotherapies or the ones having to do with administrative care, such as the role named ‘medical round support’.

Among all those? I prefer working in the wards. But then it is obvious that when one has been working for several days in a row or working in a morning afternoon or in a morning night shift, obviously, the lighter tasks are the collections, the chemo and the medical round, obviously, and we prefer doing these tasks in those days. (...) Apart from that, contact with the patient, it was for that... I think that it is... the essence of nursing. (...) The other tasks are a little bit apart, more like paperwork. (...) I think that sometimes we are closer to secretaries than we are to nurses (...) putting things down on paper, transcripts, being on the phone scheduling examinations and being in touch with the doctors. But it turns out to be, a little bit, sort of, a secretary’s role and not so much a contact role. (Alexandra)

Being one of the oldest in the service, Paula is the person who usually takes care of the area called ‘medical round support’. This implies not only the articulation of the two professional groups (in the management of therapy changes, in the coordination of examinations scheduling) but also the coordination and interface with other services external to her unit. When fulfilling these functions, she is not directly responsible for physical inpatient care; it is, however, her responsibility to keep a global integrated view of the whole of the ward. The thing that left a stronger impression on her in her personal adaptation to that type of activity has to do with the specific nature of the work, whose focus is not the relationship with the patients.
As I’ve told you, I am there where you saw me, in the administrative area, it’s that thing, paperwork as we call it, and when I was invited to move to that area, it was very frustrating for me because I thought I was going to fail... that... in the personal field I was going to fail my patients, mine, you see? Ours. Then, when my shift ended I used to play my human role (laughter), so I used to go and talk with all of them because, I wasn’t even curious, it was in my own interest, I missed that, of course, all this happened at the beginning, now I can articulate more both things, but sometimes I need that, right. It’s only if I don’t have time left except at the end of my shift, the exchange of personnel, this is all under control and all so I am going to talk to a specific patient in the specific ward, it doesn’t matter because that is important to me. (Paula)

We will go back to this aspect when dealing with the issues of professional knowledge and of the nurses’ motivation for the job. Although Paula describes her task as “paperwork”, this is not confirmed by the observation periods. Besides making sure that the patients are sent to the examinations and that the therapy changes prescribed by the doctors are applied, Paula also helps the colleagues who are delayed in care; enlightens and orientates the younger nurses who come to her for help; runs to help a customer who has just arrived in the service and is having difficulties; makes a bed for a new inpatient; gets a wheelchair to carry someone; receives and makes herself available to give information to patients and inpatients’ relatives and sometimes to listen to them.

Likewise, service management performed by nurse Ana follows the same tune:

I don’t get on very well with papers, I don’t get on very well, you see? I’ve already told you that I am lazy and as regards papers I... this office is mine, I come here in the morning and, later, in the afternoon to change clothes. I don’t come here in any other moment; I am not an office nurse; I don’t feel well with paperwork, where I feel well is by my colleagues and the patients, you see? I am a collaborative person; I am... more like, you see? (Ana)

“Being in charge of the service, nurse Ana has a large office, which she doesn’t use. She says she doesn’t feel like a chief, she doesn’t like being away from care giving areas. The office lacks any personal touch. I used it to write my notes and I was never interrupted. Nurse Ana, carries the papers with her, schedules or request forms, she places them strategically at the collection site and she deals with the management issues during the intervals between patients. Nurses are distributed among the collections site, the transfusions room and the blood collection room. The nurse in charge moves into any of these work areas.” (Field notes at nurse Ana’s service)

Ana regards the management of the nurses’ service in her unit as another task, something extra that she adds to patients’ care – she feels quite comfortable with this situation. This attitude may have something to do with the fact that she seems to value direct care, based on an interpersonal relationship, to the detriment of other functions relates to managerial issues, but away from contact with the users, which ends up being the major source of fulfilment within professional performance.

4.2 Social/professional relationships at work

In the two work contexts where we were, although there are other professional groups, the most visible relationships are the ones between the doctors’ and the nurses’ group. The type and quality of the relationships established between the two professional groups seems to affect the
nurses when establishing, expanding and reinforcing (or not) their own areas of practice and professional responsibility.

The weight and the action visibility of these two professional groups and of the relationships that they establish between them are marked by the impact of their actions on the production of the services expected by the users.

Nurses and other health professionals

At Paula and Alexandra’s service the social relationship between nurses and doctors is highly valued.

_It’s great here. Here it is so, it’s a relationship that I’ve never seen anywhere else. (...) there’s a friends’ relationship, because we socialize outside and all and... and here there’s no... doctor and nurse, there’s the first name, and that is... I think it’s great._ (Alexandra)

“After observing the patients, doctors share the central work area in the unit, where the patients’ files and the analyses and exams request forms are kept. There are no specific places attributed to any professional. The relationship with the doctors coming to the service was not only friendly but also close. That sort of behaviour was observed not only as regards the older nurses in the service but also regarding the majority of the younger nurses. They addressed themselves by their first name without using any professional titles and in many cases there was physical proximity (initial greetings and touching during conversation)” (field notes at Paula and Alexandra’s service).

Building this kind of personal and professional relationship, which is clearly distinct from the historical pattern of a subordinate status for nurses’ and their actions towards medical power, allows the negotiation of empowerment areas by the nurses. There’s an implicit recognition that the “modus operandi” informally established in the service does not match the pattern of the hospitals or the general reality of the country.

_Here one doesn’t do things just for the sake of it. (...) It’s a lot like, it doesn’t... we don’t accept everything like: he prescribes it and this is right.(...) But, as in most cases, there’s always the opposite side of the coin, isn’t there? (...) Whenever we fail, it comes down hard on us. Whenever we fail, we resent it a lot more... or whenever they fail... as... then we didn’t really work as that net, that sieve, or whatever, or that filter, we fail together with them, don’t we?_(Paula)

It was not possible for us to understand if the social relationship observed results from negotiated or defined areas in the process of establishing and building a multi-professional relationship, with equally valued specific functions and responsibilities, or if, otherwise, this social relationship, which promotes the autonomy and motivation of the nurses, is, in fact, authorized by the group that traditionally holds the power in the health field. The expression used by Paula, when considering that “there’s always the opposite side of the coin” seems to support this last hypothesis.

In fact, there’s no direct functional dependency for the nurses’ performance at the services. Besides, the law defines the autonomy of their performance; for example, since 1981 the _Nursing Career_[^1] defines the functional contents for each of the nurses’ categories and determines that

[^1]: DL nº 135/81
these professionals can only be evaluated by their peers. In 1996 the REPE\textsuperscript{93} - which constitutes a regulating mechanism of the profession – determines that “nurses’ practice is complementary to that of the other health professionals, but sharing the same level of dignity and professional autonomy” (artº 8º). Although there isn’t a direct functional dependency between the nurses’ work and medical power and even tough this autonomy is determined by law, that doesn’t prevent the perpetuation of both formal and informal unbalanced power relationships.

At formal level, for example, the service director is always a doctor, whose name and rank is always clearly identified in the organograms that present the services to the users and who is always the ultimate responsible for the service performance, including the professionals’ performance (even if safeguarding the technical competency of each professional)\textsuperscript{94}. Informally, one has to bear in mind the recognition that each participant (doctors, nurses, users) evaluates his role in comparison with the others’ roles, the weight of its historical path and even the management of the areas where each one is allowed to perform his role. Balance between formal and informal aspects may be useful to read and re-interpret doctors’ and nurses’ relationships at different settings within the same institution.

This discussion is clearly illustrated at Ana’s service. It is a service in charge of collecting blood and blood donations, and responsible for outpatient haematological care, and as such, besides doctors and nurses, the lab technicians’ group plays a particularly important role in the service dynamics – even though their external visibility is reduced as their action takes place in a restricted closed area away from the service users. At this service the functions of each person are clearly defined and there’s no cooperation culture.

\textit{We get on very well but no one interferes with the others’ job. But we get on very well, perfectly, nurses, technicians, doctors, perfectly, but no one interferes with the work of the others. The technicians are not very keen on collaborating with nurses but they do not interfere with our job, not at all. If something is not right, let’s imagine, some blood that, that is clotted, they do not come to us, they go directly to the one in charge, (...) the service chief (...) they do not come, they do not address me, they go directly to the director, the service chief.}(Ana)

This feeling expressed by Ana is confirmed by observation. This type of relationship between the two professional groups is partially caused by the lack of a clear boundary definition and some overlapping of competencies in the roles committed to them. Ana mentions the fact that before the establishment of the transfusion department at the service, the technicians were the ones who used to do all the work, including the collection of donations. In turn, Ana points out that most of the work she does is a preparation for the medical evaluation consultation as well as for collecting blood donations, which could be done by technicians. So, she considers that the functions performed mostly by nurses, and which occupy most of their time at work, are activities that do not necessarily require that type of professional. This lack of definition or this overlapping of competencies could partially explain the tension identified.

Unlike the situation at Alexandra and Paula’s service, the lack of proximity and social bonds among the different professional groups and especially with medical power, which is in charge of directing the service, seems to be an obstacle to the development of a more autonomous professional activity.

\textsuperscript{93} REPE – Nurses’ Professional Practice Regulation - Regulamento do Exercício Profissional dos Enfermeiros (DLnº 161/96)

\textsuperscript{94} The DLnº 188/03 determines that only doctors can become service directors and defines their competencies in this area.
Nurses are not very autonomous in here, I think they aren’t. (...) the service chief and the director, and the director are the ones who establish the proceedings. (...) So, there we... play the role of collection nurses and... and... we try to do our best, but there really is very little autonomy in this service. (Ana)

Some of the autonomy in the nurses’ practice seems to be found in the area of contact with the users and in the establishment of a lasting relationship (which in a service like the one where Ana works reduces even more the feeling of autonomy and of the importance of the nursing role). Contact with the users is occasional, very instrumental and it usually aims at collecting a donation and not at intervening to help solve some sort of health limitation a person may have.

Nurses/nurses

Paula and Alexandra’s job is characterized by the continuity of care taking on a 24-hour basis, by the prolonged stay of inpatients and by daily distribution of an intervention area. Global acquaintance with the inpatients, made possible through their long stay at the hospital and through rotation of nurses among the different areas, creates spontaneous interaction and cooperation dynamics among colleagues. Global knowledge of the inpatients and of what every nurse is expected to perform in each area together with the fact of tasks being performed in an open space accessible to observation by everybody make colleagues more available and eager to support one another spontaneously. These informal dynamics are regarded as natural and, for example, make it possible for everyone to have a coffee break in the middle of the morning or to leave service for lunch and also make it possible that at the exchange of shift everybody has fulfilled the programmed tasks so that the new team may carry on with the work. In short, although the responsibility for a specific client/activity is clearly attributed to a specific nurse so that he is the one responsible for it, there’s a natural cooperative attitude in the teams sharing the same shift. Various factors seem to account for this cooperative attitude: working in open spaces under mutual observation, sharing information about the patients and the fact that, in rotation, all the nurses are responsible for the different areas of intervention in the service.

Although Ana’s service cannot match all these criteria, as there are no inpatients and the number of donators is very changeable, there’s also a nurses’ rotation at the different areas (collection and medical evaluation consultation, blood collections room, transfusions room, etc) and the same dynamics is observed due to the nurses’ knowledge of the activities within each area of responsibility. Nurses move from one place to another according to the needs of the areas (whenever their intervention area is less crowded) so that donators spend as less time as possible in the service; they do this, even if they are not officially in charge of care in that area.

Constant teamwork with the possibility of mutual interaction and observation, promotes a process of informal division among the teams into two different groups, with implication both for the establishment of relationships and for work organization. We’re talking about the “younger’s group” and the “older’s group”. The different participants admit this informal distinction and the transition process is not determined by age or time in the job; rather an informal process of proof and individual competence recognition determines it.

We were (...) much eager to learn when we started working, we... had to know, to learn, I don’t mean to say that now they don’t learn, but it’s different, I don’t know... Nowadays, as soon as they get here, they start giving opinions, nothing seems to be right... nothing at all... (Paula)

What I feel... maybe, we feel that sometimes the younger ones, because they are labelled as such, are not entitled to an opinion. (...) No, I don’t feel that as regards colleagues
from our generation, sort of, around twenties or so, one doesn’t feel that and, then, from that age onward, one feels it a little bit... (Alexandra)

The process of competence recognition among peers emerges through demonstration in the contexts of practice and is informally sanctioned according to the distribution and organization of work on a regular basis. In this relationships game “younger’s group”/ “olders’ group” some sources of tension regarding different perspectives of personal development were identified (academic vs. professional path). These differences reflect the historical context that brought together nurses who have just graduated, and are going through a process of professional integration, with experienced nurses with lower academic qualifications but possessing the status and the knowledge acquired through practice.

During the observation days some beginner nurses mentioned that their introduction into the service occurred during one month under the monitoring of an older nurse. From then on they were regarded as full members for service distribution in the team. This type of brief induction is compensated by informal mechanisms, which emerge from cooperation and training attitudes of some of the more experienced peers. These attitudes of training and performance control by the “older colleagues” emerge spontaneously and play no role in the formal mechanisms of performance evaluation, but are accepted and regarded as natural within the profession.

When one is a professional there are always some older colleagues who help us just as there are the younger ones that keep coming, whom we are going to help and ... (Focus Group: 37 years-old nurse, 13 years in the profession).

It is only natural that in a medicine service, as these people are very young in the profession, that they are not at ease to take some decisions, isn’t that so? Sometimes one searches inside the service and in our reality, as we all work as a team, don’t we? ... So, there’s always a reference person or an older element who helps the younger ones to take some decisions, isn’t there? (Focus Group: 45 years-old nurse, 23 years in the profession).

Another of these moments devoted to informal peer training processes is the period named as shift exchange. Whenever a team of nurses replaces the previous one, the nurses who are leaving and those who are beginning the shift get together and read the information recorded about all the inpatients.

“The shift exchange lasted approximately 30 min. At that moment nurse P., as she was rendering the shift to younger elements of the team, would take the opportunity not only to tell them about the patients but also to add some reflections on the effects of the pathology and on the effects of the treatment on each one of them. In other moments of shift exchange the information is more organized and focused on the condition of the patients and their needs. The differences seem to lie in the people who hand the shift over and in the moments when this occurs.” (Field notes at Paula and Alexandra’s service).

We will deal with the establishment of nurses’ relationships with the users in their work contexts, particularly the way nurses have perceived these relationships, in the section on skills and professional knowledge. In fact, this axis turned out to be essential in the analysis when talking about professional knowledge.
4.3 Professional knowledge at work

For analysis purposes, we will deal with professional knowledge and the way it is affected by the contexts of practice from the nurses’ views on what it means being a nurse and on what their sphere of action is.

Firstly, all the three nurses admit and evaluate the importance of the work they do mainly in terms of the relational area and of contact with the clients, rather than as a bunch of technical activities that they have to fulfil.

Secondly, there’s a clear recognition that what they used to regard as essential in nursing before entering the course or at the beginning of their professional activity has changed through time and professional practice. A change only made possible through confrontation with the realities of the settings where they develop their profession.

Well, maybe the concept I had was common sense: all that nurses do is give injections, clean and bandage wounds and that’s about it. (Alexandra)

The beginner nurse who participated in the group interview mentions the same idea.

“Being a nurse is... is...being a nurse is a lot different from what people think, people who have no contact with nursing; that is, common sense of... of people from outside the profession” (Focus Group: 23 years-old nurse, 1 year in the profession).

As her professional experience is still brief, Alexandra recalls the periods of clinical learning during the course to illustrate that what matters the most in her profession is not the performance of a variety of techniques that nurses must fulfil.

But I think that concept of... of nurse has been changing. Nowadays, ... it’s like this, I think that it is an amazing profession, as regards relationship, we manage, perhaps, to have that type of relationship with other people that is complicated in other professions, not even doctors manage that. We spend 24 hours (...) with the patients and ... we end up being that family that they don’t have in here (...) Then, there’s that relationship of real trust and many professionals don’t manage to have that which we are able to get and... (Alexandra)

Before entering the nursing course, Paula had no clear idea of what it meant being a nurse. It is only after entering the course that she realizes that there is some negative social connotation of the nurses’ image.

As mentioned above, she felt that she lost an essential part of being a nurse when due to service needs she became a key element in the daily management of the nurses’ activities. She says that she feels fulfilled as a “bedside nurse”.

When I moved into the administrative area, management, whatever you name it, as... I missed that part... that part of professional fulfilment which was... that inpatient direct care (...) But many patients who die or have died... what they feel or what they express here is that they feel they are loved, or they feel they are supported or... I think that is very important and it is... it is... that justifies our complete existence here. (Paula)

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95 Nursing courses in Portugal devote more than 50% of their time to learning in the context of practice.
Being close to retirement, Ana places the relationship with the users and the type of relationship established with them at the centre of her professional performance. The change in the interest focus of the nurses’ professional performance - both at discourse level and at the level of the expression of factors related to motivation for professional practice – has been analysed and investigated according to the dichotomy of nursing models: the biomedical model vs. the care or holistic model. The first one is focused on the development and fulfilment of routines and of physical care, under a scrupulous and punctual fulfilment of tasks. According to the second paradigm, the value, at least as regards discourse and conceptualisation, lies in taking care of someone from a holistic, integral point of view. The emphasis is shifted from the domain of doing into the domain of professional care for a person who, due to a health problem, needs some sort of help. This change in the conceptualisation of what is specific of nursing and the resulting re-appreciation and re-conceptualisation of practice have to do with the reinforcement of nursing education and particularly with the control nurses have gained over their own education. That control (a reality that emerged in the 60’s) made it possible for nurses to promote and explore a more autonomous field of action with a reinforcement of conceptualisation skills to the detriment of a historical posture of submission to an organizational medical power, based on the performance of a predominantly instrumental job.

Even tough the discourse and the motivation of nurses for their job seems to lie, in fact, on these assumptions, they are hardly immediately visible, or, to be more precise, predominantly visible on observing their daily performance. In fact, these areas highly valued in discourse and regarded as the core of the profession are time consuming and therefore go against the established regulations, current practice and the lack of social recognition of that field regarded as their own.

Ana’s path can illustrate this change in professional awareness.

Ana spent the most significant part of her initial work years, by the end of the 70’s, working as a nurse at a private analyses laboratory. In that context, all that was demanded from her was technical competence for punctures. One cannot consider that her role as a nurse was clearly defined in her working place:

*So, I started working at the lab, only collecting samples for analysis. But, I also didn’t feel very fulfilled simply collecting samples. (...) I got to collect a hundred and many samples on my own, a hundred and so. He placed maximum trust in me and, then, he liked me to carry out blood tests in the afternoon. And I said: but, Doctor, I don’t know anything about blood tests, doctor I’m not a technician, a lab technician; I am a nurse. – Well, but I know that nurse Caldas is a very interested person, an intelligent person. (...) and I used to do the sedimentation rate and keep the accounts and I think that was enough, wasn’t it? (laughter). In case he needed...; I don’t know, sometimes, I worked at ... the reception desk, if there was no attendant, I also used to do that, if necessary. (Ana)*

Her fulfilment as a nurse takes place when she is admitted into her present hospital. The relationship with the patients is the most valued aspect when considering what it means being a nurse. This is observable in the fact that not only she values that dimension explicitly but she also undervalues her present job in terms of effective nursing work.

*I felt more nurse-like in the day care unit, I felt more nurse-like. Here, it’s the type of job that, that can be done by a technician, isn’t that so? It is so, collections... can be made by a technician (...) I’ve never enjoyed it, I’ve never enjoyed working in consultations, in outpatient care. I think that there a nurse’s job is very limited in scope, she’s almost a medical practice assistant, I have never enjoyed it. (Ana)*

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96 After 1960 nursing schools came to be run by nurses who define and teach the curricular contents.
This type of comment made by Ana leads us to the second issue of analysis that we identified in the interviewed nurses and which was also observed in the two contexts in various degrees. It is not the mere contact with people, conceived as an instrumental dimension of work, together with the relational dimension that model or define the knowledge regarded as crucial in nursing. It is, rather, a kind of trust relationship strengthened by personal proximity and continuity of presence that expresses itself through an attitude of mediation between the patient and the institution.

This relationship seems to be achieved according to some identified assumptions: proximity, continuity and trust. It is a non-theoretical concept of professional commitment towards “their users” and it seems to be the driving force of those nurses (particularly as these feel that this way they are recognised, as confirmed by the feedback they get).

A: Most of... I believe that the nurse is a pillow adviser
I: A pillow adviser?
A: The one who is always going to be there next to the patient, the one he talks to, who is at the patient's bedside, who goes there! (Alexandra)

I think that the patients, at this moment, regard nurses as their life buoy, I think that ... (...) Indeed, I think nurses are the ones that they trust the most. That's the impression I have, you see? ... Because we spend practically 24 hours by his side, we are the ones, we are not the ones who are going to heal him neither do we make miracles, isn't that so? (...) And I think that the nurses are the ones they confide in, you see? (Ana)

But we’ll be there all the same and all that beats us as people, obviously. But I think that beyond that exhaustion, it’s very... it’s a very important role; that’s what I use to say and it is written as well, isn’t it? Our doctors get frustrated when they don’t cure, and we also get very frustrated when they don’t heal but I, sometimes, right? (...) The thing is, for us it can never be frustrating because according to what I believe in, that is, caring in full, I take care of him till he leaves. So, my role is always, my (role) nurse... is there in caring till life comes to an end, in that if I don’t have, if I don’t have any hope to offer him, I have kindness, I have support, I have pain and suffering soothing. You name it, many things. This is my idea of nursing, of nurse. (Paula)

This commitment to be present, which is not limited to healing therapy attempts, is one of the aspects that may illustrate the specific domain of nursing and which may also contribute to make the interest focus of the profession externally explicit.

Those aspects that nurses consider crucial don’t seem to be taken into account as regards service distribution, are hard to categorize and don’t seem to be recognised in institutional terms.

You have these specificities, it’s something... little things, things no one, I think, understands, but... (Paula)

The husband, a young woman was saying, I used to go home and sleep peacefully because I knew he would be alright... that’s the message, it’s very... (Paula)

Recognition resulting from the gestures and perceptions of the assisted clients and their relatives is a source of motivation for work. The motivation and the satisfaction of nurses regarding their work and the profession is more dependant on these factors than on the concrete and instrumental day-to-day gestures that are the most visible face of their daily life at work.
All the nurses interviewed in the group interview acknowledged this change in the emphasis and in the specific interest focus of the nurses.

(... I was not taught to value the techniques, I was taught to value the human side much more, the relationships, knowing how to be, how to behave, and not that much knowing how to do. (Focus Group: 43 years-old nurse, 19 years in the profession)

I have nothing to do with the... with that nurse who graduated 19 years ago. All I wanted was to make a bandage and I used to feel very fulfilled when he stayed there for a long time. (Focus Group: 43 years-old nurse, 19 years in the profession).

It was already mentioned here, so, really, we were very much into techniques, we did not value the patient as a person and I think that, nowadays the great change... and, I think that, well, it seems that 20 years is a long time, but, all things considered, in order for such a big change of culture to happen in a profession, I think that it was a rapid evolution... no longer regarding the patient only as that little bit, what we treated, rather caring for a patient... let’s say, a patient as a whole. I think that the nursing profession, and that was the big change, became much more person-oriented than biomedical. (Focus Group: 45 years-old nurse, 23 years in the profession).

The change in focus was characterised by a global movement of intervention by the nursing education institutions and influenced the way they conceive and above all the way they value different dimensions of daily work. This change is proved by a discourse that values the same dimension no matter the context of performance or the age and educational background of the nurses.

One of the professional performance issues valued in the performance of this role deeply inscribed in the relationship with the users is the decoding role. This mediating function takes place in the decoding of the institution, the symbols and the daily routines and it has been changing at the workplace as a result of rapid and massive access to information. Due to the Internet, the relationships in that mediation process have changed rapidly; this leads to some readjustments in the work (mainly in the way information is conveyed), to new contact forms, and also to nurses’ updating regarding the use of that technology. It is no longer a matter of decoding technical language that the clients hear from professionals or doubts on the diagnosis, treatment and prescription after a consultation with the doctor.

There’s the Internet and we must pay attention to it. Because when they arrive here, they already bring with them the burden of a diagnostic, terrified, sort of ‘it’s the end of the world’, it’s just the way it used to be, except that now they bring a lot more information from the Internet and the internet families, and the internet friends and a lot from the Internet and books (...) we see families in a state of shock, (...) but ... because they went to the Internet and they don’t understand the things they picked there, they don’t make a selection because they are not qualified for that. (Paula)

During the observation performed, we confirmed that many of the patients are young people and their laptops equipped with wireless instant access to the Internet are among the personal objects that keep them company during the long stays. That way, they are connected to their net of relationships outside the hospital and to a whole fast world of information.

Easy access to information, a mouse click away in any Internet browser, demanded a quick answer. Information becomes briefer and validation of the users’ knowledge is as important as giving information. Helping to distinguish between essential and superfluous, reliable and unreliable does this.
4.4 Professional status

In the previous section, it was mentioned that, no matter their age or educational background, nurses considered unanimously that the relationship with the users was a central axis of their interest and a source of their motivation.

In this section, we will try to understand more clearly what the weight of that focus on their daily performance is and to what extent that type of performance is valued among the multi-professional teams, at the work institutions and in the society.

During the observation periods at the two work settings of the nurses who participated in the study, it was obvious that they had sole responsibility for the daily management of their work. On the other hand, all the tasks involving therapy administration, collection of blood donations and of specimens for analysis require medical prescription. Also, inpatients are linked to a doctor who is the one with clinical responsibility over them, whereas as regards nursing assistance that responsibility is attributed to the team. These two factors contribute to hide the aspects nurses value in nursing care. It is at this level that Ana reflects about the degree of nurses’ autonomy in her service. Nurses worked autonomously in the service, they received the clients who would donate blood or initiated and monitored the whole process of transfusion therapy. Besides this, they were responsible for the spaces they used as regards both their organization and the selection of the material needed. However, when inquired about the issue of autonomy, nurse Ana considers that her service doesn’t promote the nurses’ autonomy at all.

She admits that it is in the tasks of monitoring the patients who get transfusions that they have more room for autonomy. But even then, the decision on whether to make a transfusion in the physical conditions available in the service or to send the patient elsewhere is no longer hers.

(... we cannot send a patient back if he is in bad shape and we don’t have a place to put him (... I don’t do anything without talking to the service director, to the chief of service, I don’t do a thing. (Ana)

There is some room for decision as regards the organization of the areas that they use.

Well, when, when the transfusions room opened I was the one who organized everything, I was the one who organized the ... the... that room, I was the one who organized it. At that time I found it, I found it very small and the.... But then I wasn’t the one who decided to open the service, it was the service director and I found it small. (Ana)

Taking into consideration the main purpose of the service where she works – the promotion of blood donations – Ana sees her action sphere reduced. Her room for decision-making on the crucial issues and objectives of the service is limited to the way they organize and supervise work.

That feeling of being unable to take part in the crucial decisions at service and to give visibility to a more autonomous work, even in areas they regard as their own, is shared by other nurses in the service.

In another context different from the service of Alexandra and Paula, the continuous presence of inpatients in close touch with the nurses and the occasional presence of doctors in the services for limited time periods (usually in the morning) seem to allow for a different concept and exercise of autonomy.
I believe that as regards the patients’ daily life activities we manage to get considerable autonomy. If we mean medication and all, that is not so. But as regards the rest, we enjoy considerable autonomy. (Alexandra)

There is a clear theoretical perception of the independent action sphere of nurses on work autonomy; that concept is based on current legislation. In 1996, the publishing of REPE\textsuperscript{97} (which clarified in legal terms concepts that support nursing practice within other health professions) determines that nurses develop autonomous and interdependent activities. Autonomous activities are the ones prescribed by the nurse, performed under his responsibility and resulting from a nursing diagnosis; interdependent activities are the ones developed in collaboration with other health professionals where the nurses’ action is inscribed in global action plans or protocols.

Together with this legislative measures, the re-conceptualisation of nursing autonomous practice and the resulting rise in professional and academic value lead to the selection of holistic patient care as a specific intervention focus. This type of care is characterized by an evaluation of the users’ help needs regarding the performance of their daily routines and by the compensation or replacement of the diagnosed deficit (whether at the level of their ability to feed themselves, to move, to ensure their hygiene, to defecate properly, to communicate or at the ability to fulfil themselves, among other things). In that process of being with a patient/user, of doing something for him that he cannot do himself, of stimulating a patient to attain a satisfactory level again or even of keeping him company at a terminal stage, the interpersonal relationship is the competency at play in professional performance. Interpersonal relationship is regarded as crucial to the profession, not because it is the intervention area in itself, but rather because it allows for a meaningful development of the intervention focus that nurses value the most professionally. Also in that matter, there can be a diverse understanding of the two services observed as regards both the level of autonomy perception presented by the nurses and the level of satisfaction with the content of the work they do.

At Ana’s service, nurses’ activities are restricted to the instrumental domain and reduced contact time with the clients does not favour a professionally meaningful intervention of nursing, whereas at Alexandra and Paula’s service nurses not only have a continuous time span for the establishment of a relationship with the users/families that they assist but also face needs of help, support and replacement – in areas that go far beyond specimens collection and therapy administration – triggered by serious health problems.

As regards Alexandra, even though she presents a quick conceptual distinction at discourse level, while specifying examples of her autonomy exercise, she presents mainly examples from activities that consist in formally or tacitly standardized sets of procedures. She admits, however, that she belongs to a team where she is free to decide and act:

\textit{But I don’t feel that we would need to ask anyone’s permission to do something. We, very often, by ourselves, take the initiative of doing something and only afterwards do we tell the doctor or ... well, whoever it is, what we have done, and we are not reproached for that.} (Alexandra)

Paula has a different perspective; without making any theoretical considerations, she regards the nurses’ sphere of action for autonomous intervention from a pragmatic standpoint, related to service management, (including the management of the inpatients’ needs during the 24 hours \textit{continuum}) and limited by the dichotomy presence \textit{vs.} sporadic contact.

\textsuperscript{97} Regulation on the Professional Exercise of Nurses (DLn°161/96)
the nursing staff keeps on running the service, always respecting... or never disrespects...
the other part, or the doctors also have authority, don’t they? (...) the truth is that
the nursing staff is the one who notices much more the problems, isn’t it? The doctors
also notice them, but the nursing staff is the one who is there 24 hours long, isn’t it? It’s
different and we always had a lot to run, a lot... all this. (Paula)

Paula leaves the issues of therapeutic decisions unquestionably to the medical part. The nurses’
role is centred on the definition of the remaining strategies that have to be implemented in the
process of a patient’s recovery or of his stay at the service.

Of course they are the doctors, they are the ones who have to prescribe treatment, I don’t
know, define the strategy, or else, if they have to prescribe a patient’s treatment, but we,
the nursing staff define the remaining strategy, how to get there... (...) Even, sometimes,
when we have to give bad news, or good news, good news are always easy to give, bad
news... because... the doctor goes there and breaks the news, as it’s going to happen
today. It’s a hard task indeed, but we are the ones who play the rest of the role, which
means being there by his side and supporting him while he keeps crying forever. (Paula)

The strategies mentioned by Paula are a part of her autonomous decision-making sphere of
action and consist of teaching patients and families the measures to take when they have low
immunity, defining and supervising contacts with the visitors, adjusting diets, informing and
enlightening patients and relatives about everything involved in hospital stay and in the
therapeutic process, meeting with various patients with similar problems and discussing
therapeutic options for the group, choosing and distributing beds according to the room mates’
characteristics as observed during the service observation periods.

As regards the expectations towards the profession, Alexandra says that she is disappointed; to
be more precise, she mentions that she was enchanted at the profession and got disenchanted
with the legislation. She feels that the things she values, which she graduated for and which she
works for are not properly recognised.

In every term, in terms of recognition, in terms of work, in monetary terms, in every term,
there’s no recognition at all. (Alexandra)

Being one of the younger nurses, Alexandra is the result of a political context and of a national
structure that contributed to a strong appeal for the profession: beyond the fact that nursing was a
profession that posed no problems in terms of the job market, one witnessed a promotion of the
social image of nurses. From an external point of view that favourable situation consisted, for
example, in the transition of initial education into a licentiate’s degree course (1998) and in the
establishment of a nurses’ Association (1998) aiming at regulating the exercise of nursing and at
validating access to the profession. Soon nursing education courses appeared in many private
schools besides the traditional schools in the country. A few years later the results are visible.
The number of nurses enrolled in the Nurses Association registered a huge rise: in the year 2000
37 487 were enrolled, whereas by the end of 2005\textsuperscript{98} there were 48 296 nurses enrolled.

The rapid growth in the number of professionals and the admission of many new licentiates in
the context of practice led to some lack of adjustment. The new professionals who had attended a
licentiate’s degree course as basic nursing education, in which competition to be admitted in the
course according to secondary school graduation grades is meaningful, feel a lack of adjustment
between the expectations they developed regarding professional performance and the effective
recognition of their work. Alexandra thinks that the historical weight of the profession still
influences the image of nurses in society.

\textsuperscript{98} Nurses’ Association (2006) Statistics 2000-2005
Some were caretakers and, suddenly, they would become nurses, because… I don’t know, I don’t know how this process was led, but I think that we are seen as someone a bit, sort of, outsiders. (Alexandra)

This is something that doesn’t happen, in fact, since 1944, by which time it became necessary to have a diploma to get the title of nurse. There was, however, a low admissions qualification for the nursing course, as the 9th grade was enough (or the 6th for the auxiliary staff course). Ana reflects that evolution. It is funny that Alexandra, nowadays, mentions those paths as hindrances to a greater social recognition, when trying to explain this aspect.

A huge difference. We were truly extremely ill-prepared, at that time, we couldn’t go beyond the trivial tasks, the nurse, which were (...) evaluation, a bandage, and not much further, right? (...) It was only after... I don’t know... after... after... 80, 81 that I really thought that... I started to develop as... as a nurse. I, I believe that I started to develop as a nurse because at that time I ... honestly was ill prepared as a nurse, I think so. (Ana)

Ana thinks that the major developments in the nursing career took place in the 80’s, which coincides not only with the integration of Nursing Education in the Portuguese Higher Education System, through a three-year bachelor’s degree, but also with the Establishment of the National Health System.

It is interesting that Ana mentions that her development and recognition as a nurse and a personal landmark have to do with moving from private to public service.

Then there were many years in which I didn’t get any on-the-job training because in private institutions one didn’t get it, there was no such thing, then I moved into the laboratory and I didn’t get almost any training, I couldn’t even miss work, could I? (Ana)

Through the establishment of the National Health Service, which integrated various healthcare structures in the same system and which aimed at fulfilling one of the principles of the Portuguese Republic Constitution that determined the right to health through universal, general and free care, the majority of the nurses became civil servants. Therefore they came under specific career legislation that ruled all the Health Ministry institutions regardless their sphere of action (this included both Primary Healthcare and Hospital nurses). Besides determining ways for horizontal progression (which was attained through time at work) and for vertical progression (which implied changes in functions and could be attained through additional education and application), the career also entitled all the professionals to equal rights in terms of access to on-the-job training. That same career insisted on control of the nurses’ work by the nurses themselves making it clear that only their peers could evaluate them and making sure that each institution developed a functional hierarchy independent from the other (medical and administrative) careers.

In general terms that model has remain unchanged. The Hospital Administration Boards consist of an Administration Board President, a clinical director (a doctor), a nursing director and an administrator and are appointed by the political power. This is so, whether in EPE Hospitals or in SPA (Public Administrative Sector) Hospitals. Between the years 1996 and 2002 technical directors were elected among peers (nurses and doctors). Paula regards the fact that, unlike previously, it is no longer possible to take part in choosing the nursing directions as a step backwards. It is not that Paula is the least interested in taking part in that sort of management, but only because it gave nurses the possibility to participate. Paula reveals an explicit lack of interest
in the issues of strategic management. Her concerns are focused on the pragmatic management of her unit and on the service that she provides her patients; she calls it her “little world”.

Neither is she very familiar with the issues that determined the change of the Hospital Status into SA and later into EPE. All the other nurses involved in daily patient care share this characteristic. They do not seem to know, neither to be interested in the political changes introduced in the management of the health units, provided these do not directly affect their daily performance.

(... there is more instability, because the Board changes, they change the... they change the directors, change the director nurses, some instability, but the work... is... is exactly the same. (...) I think that those things sometimes cause, sort of, certain instability, but the day-by-day work is exactly the same. (...) In my... here... honestly, I didn’t, I didn’t, I’m used to perform my duties, I didn’t notice any difference, you see? (Ana)

The changes introduced in the specific context of services are not very visible whenever one analyses them from the point of view of the nurses’ work. Nevertheless, the most visible face of these changes as far as nurses are concerned has to do with the new ways of managing human resources. On the other hand, since most of the professionals are still civil servants, these effects are felt in the new contracts closed and in the way the different types of contract have to be managed at the different services (as mentioned above). Although Paula is not under the new determination and is, thus, not directly affected by this, she mentions the informal atmosphere of the conversations among peers, which reveal a feeling of instability never felt before. The new forms of management, together with the present availability of workforce, make it easier to hire new nurses while reducing their stability at the institution. It’s an urban institution very attractive for human resources around which there are many nursing education institutions.

... are you quitting? That’s okay; you don’t want it? Okay. There will always be someone to replace you. (...) There are loads of nurses willing to work here. (...) This is no proper way to deal with nurses and to keep the nurses satisfied and I feel somewhat frustrated myself due to that, to ...that way of putting things. (Paula)

I think there are too many vacancies for nurses at the moment (as regards education)” and that there’s already unemployment and I believe this has to do with the Association, too. If they can’t stand up for us, they should have taken a much stronger stand. (Alexandra)

As regards the establishment of a Nurses’ Association, a long cherished aspiration, which has been recognised as a landmark for social recognition and for nurses’ consolidation as professionals, in the contexts of practice observed, there’s the same withdrawal as the one observed regarding the political structural changes.

“(...) I think that it is important for nurses, if they get a degree, I think that they must have an Association, just like the others... the... the other higher education courses. (...) Since I am already at a final stage, I had to... I had to enrol in the Association because it was compulsory, you see? (...) No, I didn’t notice any intervention from the Association... no, I didn’t, I... didn’t, honestly. Some other people may have noticed it, honestly, no, I didn’t notice any...(Ana)

In practical terms, I didn’t notice anything (...) I don’t feel that the order stands up for any of the nurses’ rights, I don’t feel that public opinion has changed due to the fact that we have a Nurses’ Association, I don’t feel that the Association comes out in favour of or against anything or... taking a stand, I don’t feel nothing of the kind (...) (Paula)
The nurses who took part in the group discussion consider unanimously that the establishment of a professional association and the existence of REPE are crucial landmarks in order to achieve a more balanced role within the health teams. They believe, however, (and so do all the other interviewees) that regarding field intervention the role of the Nurses’ Association is not visible enough; they even introduce a new axis of analysis: responsibility for the promotion of a truly autonomous performance depends a lot on the nurses own performance; a fact which is not cherished by all the professionals.

Not all of us are autonomous nurses (...) however, it is not everyone’s attitude, because it is an attitude that requires a lot of responsibility. From the moment on that we take decisions... we have to take responsibility for them... it’s... well, the obligation to... keep... it’s our, isn’t it? (Focus Group: 43 years-old nurse, 19 years in the profession)

There are things that, really, as it is changing, because it is much more comfortable, it gives you much less work being a performer of some things that they tell us to do than having to think and... than really being... (because it’s hard, says a colleague) exactly, but I believe that... nowadays, I watch it more and more often in my work area, ...in practical terms we are only performers of the therapy administration, all the rest is our responsibility... and... we don’t grab more things because... sometimes, maybe, we don’t want to, and there’s always an excuse for it, that we are overloaded with work, or whatever... (Focus Group: 45 years-old nurse, 23 years in the profession)

In the discussion that took place during the group interview it was, once again, underlined that nurses withdraw from the different settings of organizational decision-making that take place at a higher level than that of their own sphere of action within the specific service where they practice.

When it gets to the upper echelons it’s very difficult, it’s very difficult (...) but things are... are very difficult because then it interferes with health politics, it interferes with the health centre objectives, it interferes with a lot of things, already, with personnel changes, very often with different priorities and things, then, are not that easy (Focus Group: 43 years-old nurse, 19 years in the profession)

A little bit, we have to be politicians as well, I think that we leave it to all the others and then, I think that things get a little bit out of our way due to that... (Focus Group: 47 years-old nurse, 23 years in the profession)

We are still a little bit quiet in our profession, our profession is still a little bit quiet... but I believe that little by little it conquers some room and people take more and more notice of our importance (Focus Group: 45 years-old nurse, 23 years in the profession).

The nurses’ professional status seems to be marked by the following guidelines: a higher education professional education; a recent history of academic background and social image reinforcement; action divided between a sphere named as their own and an interdependent one; a lack of interest in decision-making beyond the limited areas of care taking and the difficulty in getting their autonomous sphere of action recognised both in terms of income and in terms of external recognition.

Despite the current situation, and even though none of the participants has chosen the course out of vocation, all of them are fulfilled and committed to the profession.
My enrichment as a person has always been associated to my profession, always. And to everything I experience and have experienced up to this day. (Paula)

No, I have never regretted being a nurse, there were some times … but, maybe, as in any other profession, that’s exactly the same. I used to think that the schedule was a bit hard, right? (...) I think that, I think that today, if I had to take another course, I believe I would take nursing…(Ana)

5 Conclusions

In an attempt to systematize the information collected and the analysis performed, in this section we present the main conclusions we’ve drawn, identifying the most significant issues and relationships in terms of the general objectives of the PROFKNOW project.

It is important to highlight that the major themes that emerged more frequently were, on the one hand, the ones related to the nurses’ education level and its influence on the social status of the profession, and, on the other hand, the issues concerning the specific sphere of action for nursing practice, the exercise of their autonomy, and the appreciation of that role. Taking into account the methods used in this study, the conclusions here presented naturally relate directly to the context of research as well as to its participants. The differences between generations identified during the presentation of the conclusions will be highlighted.

The evolution of educational paths is the most meaningful structural change in the development of the profession. The rise in the qualifications to enter the profession – a licentiate’s degree – has introduced change factors into the teams. The co-existence in the services of nurses with diverse qualifications leads to the expression of some tensions. Nurses who are not qualified through a licentiate’s degree but who, nevertheless, hold the power, the responsibility and the knowledge acquired at the work context, or nurses who obtained a licentiate’s degree through additional education (many of them under pressure of context and not of their own free will) vs. nurses who have attended a licentiate’s degree course from the beginning. These differences seem to play an important part in accounting for the role of academic education as a professional recognition strategy vs. the role of practice supported professional education. The lack of economic or professional rewards (at present, a licentiate’s degree doesn’t imply any change in the functional content of the nurses’ tasks or in their income) is the issue that seems to cause the most widespread discontent among the participants: the education effort was not met with changes in income or with a new functional recognition. This context has also contributed for the withdrawal or lack of interest in that type of qualification by the older nurse, close to retirement age.

There’s a lack of adjustment between the existing official recognition mechanisms and the true recognition of the profession. Under the current legislation, nurses are entitled to an autonomous sphere of action defined by law and in terms of functional control. Initial nurse education, as mentioned above, grants a licentiate’s degree. The state recognises the nurses’ suitability for self-regulation through the establishment of a Professional College. However, in practice, participants in the study still feel that there’s some lack of social recognition, not only by society but also by the institutions where they work. The history of submission to medical power, competition at work between autonomous/interdependent activities, the area of visibility that each type of activity manages to get, as well as some inability of nurses to convey to the public the importance and specificity of their practice may help us understand this paradoxical lack of adjustment.
The space for construction of professional autonomy is mediated by personal history and by the action contexts where nurses work. In practice, the exploitation of an autonomous sphere of action for participants seems to be demarcated: i) by their personal experiences (while socialized as a nurse acting within a specific model) and of the others, while working with nurses and recognizing them within a submission or a cooperation model; by the type of activities performed and the quality of the contact established with the clients.

The existence of a context that allows the development of an autonomous field of action is as important as having one’s own sphere of action and being willing to take it. The issue of the definition of a specific sphere of action becomes relevant through confrontation with the activities that they perform more often and which get more visibility. The areas of their work with which they identify themselves the most are not properly recognized within the multi-professional or institutional team, even if the institution guarantees the existence of a functional hierarchy for nurses, which is independent from the other careers.

Interpersonal relationships are regarded as the dimension that nurses value the most. Apparently, there are no differences among different generations regarding the importance of relationships in the participants’ professional performance. The relationships dimension and the type of relationship established with the users are regarded as critical axes to distinguish clearly between what is truly essential and what is secondary in nursing. The ability to develop that type of relationship with professional meaning is the sort of professional knowledge that it is only regarded as valid when it has been developed through practice. It is admitted, by participants, that in academic context these contents are taught and valued, but also that only professional experience can support a deeper understanding of its true meaning. This sort of knowledge is regarded as professional and developed through professional practice. It is, however, a type of knowledge that nurses find difficult to express clearly as they view it as something that is sensed (and shared among peers) rather than theoretical.

The quality of the interpersonal relationship with professional meaning in nursing is increased not only through proximity (based on presence) and continuity of care giving but also through the amount of help that the users need to manage their daily activities regarding their health problems. These two characteristics are crucial both for getting satisfaction at work and for autonomous and externally recognizable professional practice.

Among nurses there’s a culture of collaboration at work. Information sharing about the group of users assisted, global definition of each one’s responsibilities through a daily work plan, professional integration in the different action areas, professional performance in an open space (permanently observing and being observed) promote a culture of collaboration. The daily distribution of activities/responsibilities doesn’t inhibit cooperation. Cooperation results not only in mutual support attitudes in instrumental and routine activities (as it is assumed that the responsibility for the action decisions lies with the one officially in charge for a specific area), but also in the establishment of an informal “plan” for the monitoring and supervision of less experienced nurses.

The mediating and decoding function of nurses towards the users has been changed under the pressure of information technologies. The nurses that participated in the study indentified that the use of new information technologies forced some professional readjustments and self-education procedures. In the area of information supply, the relationship used to be asymmetrically supported on two poles: those who didn’t know and the ones who possessed and decoded information. This situation changed rapidly. The integration of new information technologies led to the change of those roles. More than transmitting information to many clients, the nurses’ role is to mediate between the huge amount of information available to these and its suitability for specific concrete situations.
There’s a big withdrawal as regards interest for strategic management. Maybe it doesn’t make sense to say that nurses lack interest for strategic management and for a global knowledge of the institution functioning regarding the structural political orientations. In fact, there are nurses in the administration boards of health institutions and these have responsibilities in institutional strategic management. It makes sense, however, to say that these nurses who are directly involved in care-taking, revealed a reduced interest in management, political or professional regulation issues provided that these didn’t interfere directly with their specific work area. By specific work area we don’t mean the institution but the service where they exercise their profession.

References


CHAPTER 6
Case Study Report Life Histories – Nurses Spain
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1 Introduction

1.1 Research Process

The carrying out of the Spanish case studies followed the objectives set out by the Technical Annex, the guidelines provided by the Finnish partners and the agreements reached at project meetings. The overall aim consisted in getting a better understanding of the intricate relationships between structural changes on the level of the welfare state (restructuring) and its repercussions in nurses’ lives, working conditions, professional knowledge and professionalization. More specifically, the objectives of WP5 read:

- to gain a deep understanding of nurses’ personal experience of work life changes and professional expertise at present as well over time
- to compare work life experiences and notions of expertise between generations or nurses in European contexts
- present ethnographic descriptions and analysis of health care work and life in different European contexts in order to understand practical professional knowledge at work
- to contextualize nurses’ life stories relative to histories of the profession, restructuring of health, and social changes in Europe in order to achieve life histories of nurses in Europe

With the help of the interview guidelines and later the guidelines for Life History analysis provided by the Finish partner these general objectives were transformed into a work-plan.

The hospital where fieldwork was conducted was chosen on grounds of personal contact with the head of quality control in nursing. After a primary visit from our part in order to present the project to the whole department of nursing control, the department selected three nurses to participate, corresponding to the age requirements (5, 15, 30 years) set out by us. A formal contract – ethical agreement – was signed between the University and each nurse, documenting the mutual responsibilities during the research. Contrary to other countries, we did not have to pass any ethical commission and research could start by the end of November in 2005 with a first round of interviews and finished in March 2006 with the second wave of interviews. During this 5 month period, three days of observations with each nurse were held.

Actual fieldwork started in early November 2005. The first round of interviews was held by two researchers in a semi-structured manner following the thematic guidelines distributed in the Consortium by the Finnish colleagues. Jörg Müller was present in all first interviews with a second researcher who would then do the ethnographic observations and the second round of interviews. The interviews were transcribed and edited by the researchers and mutually proof-read. After that they were returned to the nurses for their consent and feedback. As agreed by the Consortium, the first interviews were also translated into English, all being roughly between 90 and 120 minutes in duration, and occupying between 13 and 17 pages when transcribed. All six interviews for the nurses occupy a total of 77 pages.

The interviews and ethnographic studies with three nurses were analyzed according to the approved 12 themes of life-history analysis. The structural changes of the welfare state already discussed in WP1/2 will be handled in the context of the professional careers of the nurses,
especially those changes that connect to the experiences of nurses. In a similar fashion, a formal, decontextualized description of the tasks of nurses was avoided. Instead, task descriptions where inserted when related to points of interest such as professional knowledge or level of autonomy in relation to doctors. The generational aspect of the WP objectives will be treated in the final section being visible throughout the whole report as we draw on the three case studies. In addition we should mention that the discrepancy between interview guidelines and analytical themes accounts for the relative lack of data concerning the private, personal, family life and childhood of nurses. From the guidelines it was apparent that the interviews would have their focus on the current work situation of the nurses. Our clear emphasis during fieldwork, analysis and report was on working conditions, social relations at work, and knowledge/professionalization.

Finally, in October 2006 we carried on a focus group with 4 nurses, 2 of them involved in nurse training. It lasted for an hour and a half and it was structured around those issues of the report that we found more relevant or in need of deeper discussion.

1.2 Researchers’ conceptual position

Since our background as researchers is in education and none of the members of the research team had been involved in qualitative research with nurses before, we did not bring to the field such clear cut themes as listed in our WP4 report on teachers. However, previous work packages did establish a general conceptual ground for carrying the study.

First of all, there is restructuring. In a general sense, we understand it as the reorganization of capitalism during the last 30 years, linked to the transition from fordism to postfordism, from the welfare state to the flexible state, connected with an intensification of globalization and interconnectedness. However, such a broad conception has limited power for understanding what happens at the level of the hospital. Or more exactly, we have to find ways of localizing the global (Latour, 2005) in order to turn restructuring into a useful concept. We’ve tried to do so “following traces” and “making connections” (ibid.) more than attributing causes to consequences. If we take contractual agreements as an example, one of the key measures of working conditions, we need to relate them, first of all, to the flexible management of public health centres recently introduced at the local level. These new strategies are inevitable linked to the liberalization, privatization, and flexibilization of the National Health System carried on during the last 15 years. And this reform was conceived pretty much in line with the WHO criteria. The rationale has been creating a more efficient system –modernizing it while expending less. With these kind of methodological strategies we’ve tried to connect restructuring with our local site of study, trying to generate a deeper understanding of phenomena observed. In this case, restructuring explains part of the working conditions and puts them in relation with a general trend: the introduction of private-enterprise criteria in the management of public sector services.

We’ve also tried to put finding in relation to other key concept, generations. Following the example, data collected suggest a limited impact of these contractual changes in older workers (who had already succeeded in getting a permanent position) and a widespread precarity among young workers —the group more affected by the new, flexible, scenario. Precarity (coming from précarité in French and precariedad in Spanish), is a concept being increasingly used to describe the situation and we’ve found it useful. It defines worsening living conditions, generalized uncertainly, exclusion, and it’s a global category that aims at tracing relationships between work, life, housing, etc. rather than describing work conditions. That’s why it’s been deployable when trying to grasp work-life balance, above all for younger workers.
Professionalization was also part of the conceptual apparatus developed in previous workpackages and present in this report. In a few words, we understand it as the process by which a profession accedes to recognition within a formal structure in relation to claims about the particular practices and knowledges of that group. It is a process of establishing a status and a more developed and coherent sense of group, frequently in relation or opposition to other groups. In the case of nurses in Spain, it has meant the process of breaking with the philanthropic/religious/vocational past of the profession and the establishment of a “professional definition”, that is, a definition based on technical and educational criteria and a complex relation with other groups such as doctors. It is a claim for identity and territory.

Lastly, there is knowledge. And we certainly have to admit the lack of a defined position of our own regarding it. We seem to have been happy using nurses’ position on it: a concept defining two very different levels of expertise: the technical and the personal. When it comes to professional knowledge, they talk of the two levels, only to highlight the latter as the key—that which not everybody has. We think that a deeper discussion of this concept is required and probably should have been had before. We want to acknowledge the existence of this lack of a coherent positioning on our part.

2 The Research Context

2.1 Catalonia within the Spanish Health System

The information on the Spanish Health System that encloses the Catalonian Health System summarizes the main findings from WP1/2. Again, the available material cautions us from hasty generalizations. The situation is very fragmented, what is lacking is coherent, continuous provision of quality data on the national level. “Critical information such as staff and utilization levels in primary care, size of patients’ lists, patterns of utilization by age and social class, coverage of the new primary care network, waiting times, or the cost profiles of each hospital is not generally available in Spain on a nation-wide basis...”

Before describing the Catalonian Health System in more detail it may be worth recalling the historical and national context. First, the legacy of the Franco period can be summarized in three main points: coverage was not universal, coordination between the different networks was poor, and primary health care was clearly underdeveloped. Only with the solid majority the Socialist Party had gained in the elections in 1982, a fundamental reform of the health system could start. The 1980s saw the transition from a Social Security model to a National Health Service based on universal access and tax-based financing. The General Health Care Act of 1986 (14/1986 Act) provided the legal cornerstone for a new National Health System up to the year 2000. In line with WHO ideas, health promotion and illness prevention came to supplant a cure-based approach and were defined as the base of the system. This paradigm change was meant to imply the horizontalization of relations between health professionals undermining the primacy of doctors and their biomedical discourse (health promotion requiring a much broader spectrum of professionals); and it implied a shift away from the cure oriented hospitals to more Health Centres (Centro de Salud) as the main primary care structure.

The 1990s were dominated by the trend toward cost-control. It saw the publication of the Informe Abril that pleads for a ‘synchronization’ of the health system with the general trend towards ‘new management formulas.’ The necessary reform of the system would rely on ‘excellence’, ‘cost-control’, ‘management strategies’ and ‘adjustment to users’ expectations.

99 See D01 and D02 of Profknow project also for bibliographic references.
100 EOHCS, 2000: 126-127.
101 Irigoyen, 1996
The planned reform also opened the way for ‘collaboration’ with the private sector (outsourcing) and introduced the idea of competition between services’ suppliers to raise quality, scope, and price of provisions. Its main features are therefore: flexibility, decentralization and internal competition. The Informe caused strong opposition but influenced to different degrees the health policies of the Autonomous Communities (see below).

The most recent trend in the Spanish health care system gravitates around notions of “equity, quality and participation.” The Act of Cohesion and Quality of the National Health System of 2003 undertakes a mayor reform of the 1986 Act and identifies the new challenges of the National Health System such as orientation to results, empowerment of users, professional involvement, and integration of sanitary and socio-sanitary attention.

The first Autonomous Community to gain control over its public health system was Catalonia, in 1981. Andalusia followed in 1984, the Basque Country and Valencia in 1988, Navarra and Galicia in 1991 and the Canary Islands in 1994. The rest of regions remained under the control of the state’s general administration until 2002.

According to Navarro (2003), health expenditure decreased in Catalonia from 5.6% of GPD in 1993 to a 4.9% in 1999. This percentage is considerable lower that the UE-15 average (7.1%) and the Spanish average of 5.7%. This means that Catalonia is one of the European regions with the lowest health expenditure. At the same time, pharmaceutical expenditure is extremely high (20%), resulting in a total non-pharmaceutical health expenditure of 3.92% of GPD, the lowest in Europe. Besides these general data, reforms have not been able to reduce waiting lists, or to actually implement the primary health care reform: more than 20 years after it was sanctioned, between 30% and 50% of population continues to be attended in old ambulatories.

Catalonia adopted the National Act of 1986 in 1990, with the Llei d'Ordenació Sanitàri de Catalunya (LOSC). Its more important points regulated the separation between financing and buying from provision of health services and it insisted on the diversification of health provision institutions and a stronger competition between them. The Catalanian case therefore took a leading role in implementing the neo-liberal ideas planted in the Informe Abril and that the conservative government from 1996 onwards rescued and revived on a national level. In subsequent modifications of the LOSC (1995, 2003), the main trend is towards further diversification of health service providers, the decentralization of the administrative structure combined with the integration of health and socio-sanitary plans.

It should also be noted that the Catalanian health system has a more complex structure than other regions of Spain because there exists a double network of public and public/private services. In contrast to other regions there are fewer civil servants and more staff on a contractual basis.

2.2 The Hospital within Catalonia

Within the Spanish context, Catalonia has to be seen as the spearhead in terms of neo-liberal tendencies in the re-organization of the public health service. And within Catalonia, the hospital were our research was carried on holds a similar role. The Hospital del Mar is situated in Barcelona close to the Olympic port. It pertains to the municipality while being at the same time bound into wider administrative contexts such as the Catalanian Health Administration (CatSalut). Before getting confused by the organizational details, however, it is important to emphasize the unique status: the Hospital del Mar is considered an exemplary case in terms of

102 Freire, 2003: 302
103 Data varies according to Freire (2003) or Navarro (2003).
restructuring and the introduction of managerial aspects in a public health institution. It has been the model institution for “combining quality public health service with economic efficiency.”

This provides of course a very interesting setting for exploring the central questions of “knowledge at work” since the relations between macro-processes and individual life-experiences is much more pointed that in our educational research context.

Although the history of the Hospital del Mar can be traced back to 1905, the crucial event in its more recent history is the creation of the Institut Municipal d'Assistència Sanitària (IMAS) in 1983. The IMAS was founded by the town council in an effort to unify its health service provision and administration. It is the enclosing organization for a whole series of health centres including the Hospital del Mar and constitutes the central health service provider on the city level. It has an autonomous juridical status independent from the local Government. The directors’ board of IMAS is composed 60% by the municipality105 and 40% by the Generalitat de Catalunya. In addition, the IMAS is associated to the Consorci Sanitari de Barcelona where the Catalan government holds the majority of 60% vs. 40% of the municipality. Practically this means that the IMAS gets to administer some institutions that officially pertain to the local Government and “enjoy” a still more relaxed atmosphere in terms of working conditions (as will become clear from the personal accounts of one of the nurses).

The central innovation linked to the creation of the IMAS was a business plan. Singular in Catalonia and even Spain, its first version covered the years 1984-87 and introduced economic efficacy, control of spending, and profits as central arguments in the work of the hospital. Joan Clos, mayor of Barcelona, worked at the hospital as coordinator and describes the changes during the 80's as an improvement because they allowed unifying the previously dispersed centres of the town into a single administrative structure. This involved for example the unification of contracts, unification of informational flows, and a coherent planning of the strategies for the future, including research and lecturing of its staff. The latter passed from being a civil servant employed directly by the public administration to private and temporal contracts. The whole discourse on the creation of the IMAS as promoted by Clos follows a neo-liberal rhetoric where the provision of quality health care is achieved by adopting economic measures for grinding off the inefficiencies of the previous public administration.

The next decisive event for the IMAS and the Hospital del Mar more specifically was the Olympic Games of 92. The hospital was elected as the official service provider for the Olympic family which caused large scale investments in infrastructure and additional services (analysis of doping for example). Already in 1991 when Spain saw the publication of the Informe Abril, the IMAS actually considered itself as pertaining to the avant-garde of public health care, describing itself as 10 years ahead of the goals of this influential document. However, the post-Olympic period was marked by a certain recession as economic investments did not flow as strongly as previously. This lack of capital and further expansion apparently was countered by a process of restructuring with the objective to unify/specialize the health centres pertaining to IMAS (that lasted from 1993-1997). The Hospital del Mar was confirmed as a general hospital; the structurally very similar Hospital de l'Esperança however specialized in surgery with all other services migrating to the Hospital del Mar.

In its most recent period, starting from 1998 to 2003 a key aspect of the hospital is the implication of its professionals. These concerns mirror national tendencies as set out in the Act of Cohesion and Quality of the National Health System in 2003. The hospital lays strong emphasis on continuing education and the professional career and aligns its discourse towards “user
centred” quality health provision. Furthermore, since 1973 and renewed since 1990 and 2001 the hospital is associated to the *Universitat Autonoma de Barcelona* playing an important role in the initial education of nurses and doctors. In the year 2001, there were about 1000 students enrolled in the different educational centres pertaining to the IMAS. Given its relative small size in relation to other centres of Spain, its research and scientific production are among the most relevant in the country.\(^{107}\) Our nurses all were involved in either tutoring or lecturing activities.

The *Hospital del Mar* has 418 beds, 18 for intensive care; 10 surgery units, 15 units of hospitalization and attends a population of about 260,000 people in the districts *Ciutat Vella* and *Sant Martí*. The period from 1983 to 1993 was a strong period of growth where the hospital increased its capacity from 18,000 to 23,000 patients per year.

This local context in which our research on the nursing profession has to be situated is very likely to produce different results than our research on teachers. There exists a clearly articulated political agenda in relation to the *Hospital del Mar*, something which is missing on equal scale for our school. Although we heard more than once that the administration of the hospital is quite remote to the daily concerns of nurses, the problematic that emerged during our field work allow us to draw some explicit relations between restructuring and the work experience of the nurses. However, it has to be noted that this restructuring works primarily on the local and city level in instead of national level. Nevertheless, as the brochure of the IMAS indicates, the Hospital in this sense is 10 years ahead in terms of flexibility, decentralization and internal competition.

### 3 Collaborator’s Lives Courses

In order to assure the anonymity of the nurses, we have introduced pseudonyms for them.

*Maite* is the nurse with 5 years of experience. Initially Maite wanted to become a doctor but changed to nursing after getting into contact with some of the “hardcore” subjects such as anatomical pathology. She quit medicine and started to study nursing without being totally certain to have chosen the right profession. Only now when looking back she affirms that it was the right choice because she likes what she is doing. She received her initial education in the nursing university associated with the *Hospital del Mar* (*Universitat Autònoma de Barcelona*) and was offered a job soon after completing her degree. For five years she only got temporary contracts to work as a substitute, so she frequently changed between different services (neurology, orthopaedic surgery, heart surgery, etc.) without having the chance to get to know any of them more profoundly. During part of that period she also worked in another hospital at the Intensive Care Unit, which inspired her to do a postgraduate course on the subject. Although she completed the course, she wasn’t offered the job she expected and didn’t continue working in this unit. She’s currently working in the *Hospital del Mar* in a post-surgery ward. Currently, Maite has an interim contract of 21 hours (three days – Friday, Saturday, Sunday – 7 hour shifts) in the hospital after having worked during 5 years with temporary contracts. Her work is also more stable now being assigned a specific, post-surgery unit. But because she only works three days she needs additional jobs. During the period of our research she worked for a laboratory to do blood-extractions in different companies throughout Catalonia. She had to have her own car for this. Later, she was contracted by another institute pertaining to the IMAS, the IMIM\(^{108}\), for conducting clinical tests. Because it pertains to the IMAS like the *Hospital del Mar*, she does not have two contracts but an extension of her first contract in terms of hours: now she works 6 days, 3 on ward and 3 in the laboratory. She has one contract which specifies two very different tasks.

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107 It counts to the three leading university hospitals in Catalonia, in terms of scientific production in relation to number of professionals.

108 Instituto Municipal de Investigaciones Médicas (IMIM) is the Medical Research center of the municipality. Its basic objective is research and education in Biomedicine, Health and Life Sciences.
Maite’s initial five years of work experience have been characterized by a high instability in terms of contractual arrangements but also in terms of work contexts. The changes between services have not allowed for a continuous, planned professional career. Where and when to work has been determined by the last-minute necessities of the hospital and not by Maite’s knowledge or professional ambitions.

Flor is the nurse with 15 years of experience. Right from the beginning, the special status of Flor should be emphasized. Although she had been working in contact with patients most of the time of her career (as required by the Profknow project), just when our research started she accepted a more administrative position. This proved to be an advantage in the end because it allowed us to get a more profound knowledge of the current administrative tasks distributed between the local government and the municipality and the dimensions involved on this level of institutional restructuring. Flor started her studies in 1979. Since nursing studies entered the University in 1977 she was one of the first cohorts of the new generation of nurses with a University degree. Evaluating this change in the profession, she states that this has resulted in a higher intellectual level in the nursing collective but fails to translate into any direct effects such as higher salary or higher professional status. After having finished her studies, she specialized in psychiatry with an additional two year course. Because she started her studies later than usual and entered the profession coming from a different field (she had been working in a computer company), it was not easy to find a permanent job as a nurse at the Public Health System. She worked in a small hospital and later for an insurance company before getting into the Hospital del Mar, where she has been working ever since. As she says, she has passed through almost all services in the hospital. On the one hand because she likes to change and find new challenges, but also because the hospital moves the nurses around in function of its necessities. She had been working in neurology, in post-surgery, and intensive care among others. For 10 years she worked in the operating room as an instrument assistant. Although she had a special formation in psychiatry and although she asked her superiors at several occasions to work in this area, she had to wait until 2002 (?) for an offer from the Hospital. In 2002 she switched to participate in the creation of a day care unit in psychiatry (mental health), collaborating with a psychiatrist, psychologist during three years. Just shortly before our research started (Nov. 2005), the Hospital asked her to participate in the organization and coordination of several Mental Health Care centres in the city. This last position does not involve a direct contact with patients. It is an administrative position. In terms of decision making, autonomy, creative implication her career has clearly advanced. From being part of an operating team serving instruments she came to coordinate a day care unit and now several mental health care centres which as we will see involves delicate political negotiations between the implied institutions and their representatives and staff. However, it remains to be seen to which this professional autonomy produces a higher professional status in relation to her employers, that is, the IMAS.

Jenny is the nurse with 30 years of experience. Jenny's professional career allows tracing some relations between larger changes in the Spanish Health System and her work experiences. She finished her nursing studies in 1979 at the age of 21. After having completed her studies, Jenny started to work in a village together with a doctor. She described these initial years of her career as a key experience because she saw that there were other forms of working apart from the biomedical, cure-based paradigm she got to know in the hospital during her education. The project they initiated was a larger one, taking care of the people in the village on a more personal basis. In collaboration with the doctor she understood their work in a more holistic manner as encompassing health care that revolves around the patient at its centre. Although Jenny does not use these words, it is clear from her whole discourse that she put to practice ideas that would become central to the mayor national reform of 1986 and onwards (health care, teamwork). Later on, already in Barcelona, she worked during six years in psychiatry, a period she recalls as the “best professional experience” of her career because it laid the foundations (as we will see in terms of “care” and nurse-patient relationship) for her subsequent working contexts. After having
spent one intermediate year in nephrology (which she didn't like too much because it was too technical) she was offered to coordinate a unit of primary care where the emphasis was on teamwork between different professionals. Later she worked in a more administrative position coordinating the discharge information for patients in primary care units. Jenny started to work in her current position about 8 years ago. Together with other nurses and doctors she has build up a unit of day surgery where nursing again has its specific weight. In addition she is lecturing in the university in an online environment. Jenny's professional career can be seen in close relation to the central ideas that moved the reforms of the Spanish Health Care System. Her emphasis lies on team work and patient oriented health prevention and care. The coordinating positions and experimental work she was involved throughout her career indicate the new and more influential role nursing was able to acquire. Far from simply applying certain techniques, Jenny's activities included strategic planning, building up nursing services, exploring new terrains for nursing that previously did not exist (such as the primary care centre for example). She was involved in the creative extension of her work, acquiring autonomy in relation to other health professionals. However, this high professionalism from her side has not really translated into advances on the career ladder. She still is after 27 years of work experience on the same level in terms of professional status as when she started. Although the changes associated with the reforms in Spain translated into a real professional challenge for her, eventual benefits in terms of professionalization are missing.

4 Thematic Analysis

4.1 Working conditions

When discussing working conditions, a line should be drawn between public and private centres. According to the nurses we talked to, private centres offer more opportunities for stable contracts, worse payment and less possibilities for in-practice learning. All the nurses that collaborated in the study worked in public centres (even though the concept of “public” is increasingly problematic in the case of Hospital del Mar, as we saw) so we turned our discussion to them from now on.

Working conditions are usually described as being precarious. There are three types of contracts: temporary, interinaje, and permanent contracts. Temporary contracts cover usually very short periods of time -contracts for one day are not unusual. They can be substitutions in case of emergency, sick-leave, holidays, etc. There are also temporary contracts of a second type specifically for vacant positions. Meanwhile a given position is not officially published for being covered with a permanent contract, it is occupied by an interinola who will have an interim contract that is more stable than a temporary one, but offers less security than a permanent one. As Maite explains, interinajes are not uncommon, since many nurses with permanent contracts take sick-leaves or ask for transfers to other shifts. Permanent contracts finally provide more stable work relations and economic security. They have no temporal limit. They offer a status similar of that of a civil servant and are only accessible after a public call and examination.

The average trajectory for nurses is to live on temporary contracts for about 5 years. That is, being available for work anytime, any day for a last-minute call. After this stage it’s possible to accede to an interinaje, which means a fixed schedule and certain stability –until the position is officially called for. Some nurses are able, after being interim, to get a permanent contract. There are few exemptions to this rule. It is extremely difficult to get a permanent position without having been an interim first; it is difficult to be an interim without having worked under a temporary contract first.
These three types of contracts are standard contracts in the Hospital del Mar. It should be noted that there is no staff with civil servant status as it was formerly the case in public health institutions. One reason for the creation of the IMAS in 1983 consisted precisely in eliminating the status of civil servants for health professionals that pertained directly to the municipality and having greater flexibility in the management of worker’s contracts. Adding to these three categories, there are also four different contracts regarding the number of hours (excluding substitutions, which are absolutely flexible). Therefore, there can be temporary, interim and permanent contracts of 14 (weekends), 21 (weekends plus Monday or Friday), 35 and 40 hours per week. Temporary contracts are slightly better paid by hour (because they are subject to fewer taxes). Average earnings are: 560 € for a 14 hours contract; 800 € for 21 hours; 1250 € for 35 hours, and 1500 € for 40€. The actual final amount is however difficult to estimate, since there are many bonus payments: working on a bank holidays, night shift, or risky position, among others. Permanent personnel are eligible for trienios, a special bonus for every three-year period worked.

Nurses receive 12 payments plus 2 extra ones in July and December. In addition, in the Hospital del Mar they have a third payment in April depending on their punctuality and attendance. After having worked for 25 years, nurses receive one extra month of vacations. With 30 years one gets an extra week of vacations or the pay check that corresponds to this week. There also exists a regulation which allows nurses from 60 years of age onwards to take partial retirement, which means that they can work less hours by earning the same. All these conditions are related to collective agreements, which are signed between each hospital (or group of hospitals managed by the same institution) and the different parts, with the approval of the union trades. It is precisely the decentralization of agreements that allows very different working conditions within the Spanish Health Care System (and between public and private centres).

As we’ve seen, temporary contracts characterize above all the beginning of the working experience of the nurses. The precarious conditions they impose become apparent when considering that contracts are made from one day to the next. Nurses often do not know if they will work the next day or not. This implies that they have to organize their live around those contracts, always pending to receive a call from the hospital.

“Because when you start they don’t give you a contract for a whole year, but give you a series of short contracts as a substitute. And so you probably go home one day, and you finish your contract and you say to yourself, ‘I wonder when…?’ And tomorrow morning they call you, ‘please come’ they say. The worst thing is the type of contracts. It’s horrific at the beginning, because there are one-day contracts, two-day contracts, three-day contracts, or contracts where they only call you for the weekends, but they call you on Friday. Or they call you to come immediately. You can’t have a life like that. On the other hand, what you want to do is work, but you don’t have a life because you are always hanging about wondering whether they are going to call you or not. Of course if you say you can’t and you say that you can’t a lot of times, then they stop calling you.” (Maite)

Those temporary contracts leave little room and stability when it comes to planning private life. In addition, the contract has its negative effects on professionalism. As already mentioned in the description of their professional careers, the nurses rotate very frequently between the different services, where the hospital needs them.

“So today you are in neurology and tomorrow in gynaecology and the next day in general surgery... Of course you are the Jack of all trades and master of none: in other words, you know a little bit about everything, but you don’t really know anything. You can’t work with much security...” (Maite)
The frequent changes between services prevented her from providing a quality service to patients. Seeing a patient more holistically apart from a certain physical cure is impossible.

"The worst thing is when you go from here to there you don’t get to know any patient. The thing about the patients –they are very clever– and when they have never seen you then you are new. You are always new. So naturally, they don’t trust you. Sometimes they trust more in what another person tells them that they have seen three days running than you, who are new, who they have just seen." (Maite)

The temporary contracts are often tied to be a “shift runner,” where a nurse has to help out across all services of the hospital where someone is needed, changing even between several units in one day. Participants in the focus group pointed at the non-sense of the situation: shift runners are the most experienced and valued workers in other countries, whereas here it seems to be a kind of punishment of rite of passage. Quality of attention, they said, is highly compromised by putting inexperienced nurses in such a stressful and difficult position. A similar kind of highly dynamic situation was observed during our stay with Jenny, where the secretary and the assistant nurse continuously changed between attending patients in the waiting room, doing administrative work in the operating theatre, working with a medical team or helping Jenny. Without being able to establish more stable relations neither to patients nor to the work itself Maite felt physically and psychologically exhausted. She had no sense of belonging, she felt alienated from work and disoriented in relation to its goals.

"Of course, you get lumbered with all the hard jobs of all the departments, and you end up, well, apart from the physical exhaustion, psychologically you don’t know whether you are in Paediatric, if you have gone up there yet, if whoever told you whatever they told you, whether the surgeon... Of course, you reach a moment when... I was six months doing this and I asked to them take me out of there because I was going mad." (Maite)

Although the work situation is quite precarious as she described it, Maite is not really unhappy or dissatisfied, even though it is hard for her to work on weekends because it practically leaves no room for being with her family when the rest have more spare time. A positive consequence of the frequent changes between services that she mentioned was to get to know the whole staff of the hospital. And, more importantly, she has a positive attitude to her work because she really likes to do it. We will come back to that when discussing "professional ethics and goals."

These conditions were also commented by the participants in the focus group. The will to work, they said, was stronger than the concern about working conditions. Asked about the limits of the situation and dignity, they laughed. There seemed to be an reluctant or ironic acceptance of such a stage of precariousness. Other opinions were registered, though. Flor, for example, confirms to know many nurses who work on temporary interim contracts without considering it especially bad. Although Flor has a permanent contract now, she passed in the beginning of her career through many different services doing substitutions. And although it is stressful to jump without preparation right at very special tasks (she had to work in the operation room from one day to the next), she also positively notes that it gives you a very broad knowledge base.

"I came into the hospital, if I remember rightly, in a department that was called semi-intensive. It was an intermediate stage between intensive care and the general hospital ward, and from there I went to the ward, I was moving around for a time on substitute contracts and the like and well, I did a full tour that was good for me personally because I got a lot of training from it: I didn’t have a set post, but I was replacing nurses who had holidays or the odd day off and so they needed someone. So I went around different departments and different shifts and this gives you quite a wide-ranging knowledge base."
Which is quite typical of this hospital and I think a fairly accurate reflection of the health service in general.” (Flor)

Flor also gave the impression in the interview that the precarious contractual conditions have partially been assumed as normal for the profession reflecting just the standard labour situation outside nursing.

“... the labour market is very tough, and we should not forget that there exist nurses that have had for 17 years I don’t know temporary contracts or interim contracts, they don’t have a permanent contract, that’s true, but it’s not necessarily worse than in other professional collectives.” (Flor)

Certainly, these conditions are not exclusive to nursery. When it comes to working conditions, flexibility, uncertainty and precarity are the general situation. The rate of temporary contracts in Spain is the highest of the UE (+90% and with a clear tendency to grow in the last 5 years (INEM, 2006)).

During the three day observations with Jenny this was partially confirmed. On the second day, an assistant nurse was substituting the sick colleague of Jenny. Drawing the discussion on her work conditions the assistant qualified herself as "lucky" because she only had to do 3 years on temporary contracts, whereas some of her colleagues have 7 or more years without being offered a more stable contract. Jenny rejects this situation on the grounds that permanent contracts were the norm when she started to work. It is remarkable that in her account no temporary contracts or rotations between services figured. She started her career in a fairly stable setting with the doctor in the village (see above). But for another colleague present at the discussion the reality of nurses has changed quite a bit in the last 30 years; it doesn't make sense to compare Jenny's career start with the contemporary situation in the hospital. Precarious work conditions are the norm when starting to work as nurse. The last 'chance' to start working with a permanent contract finished in 92 with the Olympic Games. As outlined in the introduction, the hospital experienced a period of strong growth where many nurses entered with permanent contracts. As Maite states, after the Olympic Games the worst contractual conditions developed following a general trend to liberalize the labour market. Currently, with the increase of the 14/21 hours modality, more nurses can have access to a permanent contract –which nonetheless obliges them to look for second and third jobs to earn a living wage.

Permanent contracts of the type Jenny and Flor have in combination with their years of working experience give them a more stable schedule. They get weekends and public holidays off. They can plan their holidays which is not the norm if a nurse is contracted as a substitute or interino, like Maite. The management has contracted one nurse which will substitute all nurses working three days a week when on vacation, so Maite will have to wait for her “turn” -easily two or three months later than the official period in July/August. Jenny or Flor are in a position where they don't have to cope with these inconveniences anymore.

We have to note, however, that the work conditions as described in the IMAS are not generalizable not even on the local level. They are specific for this employer. Compared to other public health service providers in Catalonia that pertain more directly to the CatSalut (e.g. the ICS), the IMAS can be characterized as leading a tighter regime. In the brochure celebrating the 20\textsuperscript{th} anniversary of the creation of IMAS, an administrative employee underscores the bewilderment that the installation of an attendance recorder (clock) caused among the workers of the Hospital del Mar when the IMAS took control.\textsuperscript{109} It makes clear that this type of control is far from being usual and accepted.

\hfill \textsuperscript{109} IMAS (2003), p.11
This tighter regime of the IMAS now surfaces in the work of Flor. Her new responsibilities to coordinate different mental health centres which in part belong to another entity, namely the Institut Català de la Salut (ICS) underscore the differences between a public institute and the “optimized” management exercised in the IMAS. Flor explains that normally health professionals are contracted for 37.5 hours / week. In the centres that pertain to the ICS, nurses only work 30 hours. In her opinion, the ICS which belongs directly to the local government allows this type of non-attendance resulting in a missing shift. Flor, coming from the IMAS which has a tighter regulation aims to remedy those nuisances as well as other “bad habits” that apparently have been converted into “acquired rights” in the institutes that belong to the ICS, such as coming late, leave early, taking half hour breaks. This was confirmed, and quite celebrated, by one of the participants of the focus group, who lived the transition. Now, she said, they are real workers, having to deal with discipline: no more shopping in working ours, arriving 1 hour late etc. She said that changes in management also meant that they had to justify every expense, so they took consciousness of how much their work costs. This, according to her, has resulted in a much more efficient management. However, the group couldn’t decide whether this resulted in a better service provision.

Apart from the contractual situations that substantially frame the working conditions of the nurses, how do we have to describe their general work setting? What are the recurring problems, difficulties, necessities? The overall situation may be related to the very recent crisis of the Health Department of the Catalanian Government (CatSalut) linked to the working conditions of doctors in public centres and Centros Concertados. During May 2006 the trade union of the Catalanian Doctors called a strike of 7 days to claim, among other things, better working conditions, more resources, reduction of 48 hour wards, higher wages, and improvement of quality at work. The strike was supported by the national Spanish trade union of nurses, the SATSE. In a similar, parallel struggle the trade union of nurses in Catalonia, through their local platform operating within the ICS, tried to reach consent for the partial early retirement with same wages, increase of staff, better payment, and reduction of working days per year. The claims of the doctors are similar to the problems that emerge from the material of our research with nurses. Working under time pressure is routine; there is no time to care for the patient beyond technical cure; no time for continuing education; there are no teams of properly skilled health professionals that could guarantee a quality service; the human and technical resources have not increased in the same way that work has. Jenny makes the point especially for the latter problem:

“Yes, they want to promote this unit but how are they going to do it? We continue to work with the same people in the same physical space which is claustrophobic. [...] This is how things always are done. Let’s increase, let’s increase numbers and later we will talk about the additional staff and space required. And this burns you out. It burns you out because to work this way is very stressing.” (Jenny)

Her work has come under increasing time pressure because more and more patients are put through her unit. This makes it impossible to actually execute her work as she would like to: she has no time to care for her patients.

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110 The Catalan Institute of Health is the biggest public health service provider on the level of Catalonia. It includes 8 hospitals and more than 32.000 professionals and the three strategic lines of health care, research, teaching.

111 Health institutions that are funded by a mix of public/private money are called concertada.

112 As a success of the strike, a professional council of doctors was created that will debate issues related to work directly with the administration and management. The Health Department of the local government also accepted that the higher wages of doctors working in centers with mix financing (public/private – concertada) will also become effective in the public centers, managed by the ICS.
“That's what I really enjoy to be able to talk to the family of the patient when he or she comes out of surgery and explain them how he or she is, that they see each other and later go home. And this you cannot do. Or if you do, you go against the rest of the team taking time from doing other things. And this, honestly is very frustrating, this frustrates me a lot.” (Jenny)

Although Maite is not as explicit as Jenny about deteriorating working conditions she also testifies to the enormous amount of work she and her colleagues have to manage. Normally, each ward has 3 nurses assigned to 40 patients. In her ward, however, there are four beds for patients which require special treatment (and which belong to another specialty) and have their special nurse assigned. Although there are 3 nurses on her ward, effectively only 2 nurses have to cope with 36 patients. As long as the head of nursery and administration approve the situation, there is not much she can do but to try to get the job done. Apart from the negative consequences Jenny already described, Maite underscored the fact that this work situation makes it impossible to put to practice new knowledge. As she states:

“Yes, you cannot take advantage because our workload is impossible. That's the truth, impossible! Just a while ago a colleague of mine went to do a course on “disfagia problemas de reducion” and said 'This was ideal because you had a room and they brought you the patients, they sat down the patients, you'd run the tests, and then they would take them away again... this was it.' Working like this, calmly running all your tests, this one has “disfagia”, this one has, this one not. Here, this would be impossible. You have to run your tests whenever you can and if you can't do it today then you'll do them tomorrow, because meanwhile they share out breakfast you have to do another 50 things... Our workload is enormous, all the more in this ward, I can tell you, in the end of the day your legs hurt you can't even imagine.” (Maite)

From our observations with Maite it became clear that there is a lot of “mechanical” work involved in her activities. Time for “caring” in the sense of treating a patient holistically is a luxury given all the “basic” tasks that have to be accomplished first. In the case of Jenny, the observation confirmed the very flexible nature of the working environment and team. She qualified her two days as “chaotic” but not “stressful”; not too many patients were operated during our stay but because of sick-leaves there was steady coming and going of different professionals. However, getting to know her work context it became clear that she is bound to other schedules (booking of the operating theatre) that could make it easily impossible to follow the rhythm she would consider ideal for “caring” for her patients.

Participants in the focus group, however, argued that it was not time the big issue here, but professional culture. Two of them were involved in nurse training and in a patient-centred philosophy of work. It was the lack of such conception, together with a desperate seek of recognition by patients and doctors what made it so stressful for most nurses. Under certain conditions, one of them said, it is better that they don't have more time –they wouldn't know what to do with it.

Social Relations at Work

Without considering social relations at work, the working experience of nurses could not be captured adequately. Already Maite and Flor emphasized that a nurse essentially is the interconnecting node between a whole series of health professionals, the patient and the family. With the Health Reform of 1986 this role of nurses was officially confirmed by aligning the health system with a preventive paradigm that distributed the responsibilities between a team of health professionals. At the same time, the precarious work conditions that figure in the preceding paragraphs suggest that the relations between nurses or between nurses and doctors are
likely to be submitted to extreme tensions and pressure. However, no clear-cut generalizations could summarize the situation of the three nurses. Each one has a very specific social configuration at work that wouldn't even converge in their relation to doctors which often figures as the most dominant aspect.

**Nurse – Doctor**

All nurses were confident about having their own autonomous sphere independent of doctors. Although the traditional image of the nurse as assistant to the doctor is still strong in the profession according to Jenny, it is in decline. Flor states that their territory and their own sphere are won on a daily basis through small struggles.

> “Do I make myself clear? “I’ll go and get your medical records if necessary, I don’t mind. I’ll do what has to be done and I don’t mind doing any job. Now, because you are the doctor doesn’t mean you can tell me to look for the records for you, because I won’t go and get them, that’s for sure.” They visit the patients, bring all the records and leave them on the table for you. And you think, “And that?” “They are for filing”. Ah, I pick up the records and put them on their desk and they say: “These records, what are they doing here?” I say: “They are for filing”. I’ve given you this example because a lot of the terrain we are gaining is won in this way. Making them see that everyone has their post, that everyone has their own job.” (Flor)

For Flor, nurses have improved their status little by little. Doctors have started to realize that nurses have their sphere of influence and knowledge and they have theirs with the mutual goal to serve the needs of the patient. However, this complementary role rarely happens on the level of practice where seldom doctors would ask nurses for advice or their opinion. What clearly difficults this professional emancipation is the high percentage of women in nursing vs. a high percentage of men being doctors. The professional subordination gets thus reinscribed and reinforced by the classical hierarchy between men and women in gender relations. The fact that doctors can keep their casual cloth below the white coat and nurses don’t is a visual marker for the different professional roles.

But as Maite tells us, the relation with doctors is not necessarily framed by the status protocol. Equally important is age and personal affinities with some doctors in contrast to others. She gets along better with doctors her age than others. Even though personal approximations may exist between individual nurses and doctors, the norm between the two professional groups is cordial without entering too much into each others domain. For being a team, there is remarkable little official space for working together, as our observations show:

> “From the nurses' viewpoint, the relation with the doctors is very limited. Theoretically they form part of the work team, but their routines never coincide. Their paths cross in the corridor, but they never visit a patient together. There is no sign of tension, rather their relations are affective but always maintaining a certain distance. In the words of Maite 'they mind their business and we ours.' We should remember that they neither have breaks together nor do the doctors enter into the room where nurses have their break.” (Field Notes)

What is more, Maite and her colleagues usually take their break when the doctors make their visit on the ward. She also considers that weekends are better for working since almost no doctors are around. From this description, it follows that nurses' work functions relatively autonomously without direct influence or supervision from doctors. As Flor stated, they have their own area of knowledge and field of action. Although doctors define for example the medication and treatment of a patient, the execution of it falls under the responsibilities of nurses, without the doctor even knowing how a certain cure is applied in detail. And it depends
on the self-esteem and self-confidence of each nurse for taking advantage of this autonomy or in contrast, informing the doctor about every step she takes or irregularity that occurs.

This autonomy may include the interpretation of patient behaviour in relation to medication, or making arrangements for commissioning a medical analysis which has to be signed by the doctor. Flor already demonstrated that this autonomy in professional terms often has to be conquered in small steps. Maite gave us an example to what extremes this can go when refusing a doctors request to put further injections to a coma patient. In her opinion, the moment had come where disconnecting this patient should be seriously considered. Although the doctor got furious, she maintained her position and professional ethics. She is unsure what would have happened if another nurse wouldn’t have done the job; but the fact that there were no consequences for her whatsoever shows that her professional autonomy and decision taking has a wide and not clearly defined reserve.

Further examples of this dynamic were provided by the participants in the focus group. One of them explained how after several conflicts, nurses at her unit (psychiatry) had struggle –and managed- to have a say on patients’ process of discharge. She acknowledged the importance of the Nurses Supervisor, who supported the struggle and made it hers. This example, she said, was a sign of how times are changing. Other, similar, examples were discussed. And they all agreed in the importance of having a supporting Supervisor, who after all is the person in charge of these kind of negotiations.

_Nurse – Nurse_

Whereas the different professional roles between nurse and doctor and the associated, historical power relations define their relation at work, within the nursing collective social demarcations are drawn based on professional ideals. Interestingly, Jenny re-qualifies the relation nurse-doctor on the grounds of her difficult if not devastating working relation with her colleague.

“What is the concept of nursing? It is one or another model. It is the maternal authority or not, and that’s it. Or we are professionals and we get involved and fight to be professionals… and nothing else. So I have never had problems with doctors. Absolutely never! Not here or in psychiatry. Never! Problems with nursing, yes. A doctor has never laughed if I have tried to look up something on the Internet that we have been talking about. In the nursing staff they have… The nursing group is very, very complicated. At least it is here in Spain I think.” (Jenny)

In her service she shares the work with one more colleague. She cannot work with her because their professional ethics is diametrical opposed: where Jenny puts the patient at the centre of her work, her colleague’s own concern is to get the job done, the faster the better. That’s the line Jenny but also Maite draws: between the groups of colleagues that are good professionals that integrate medical knowledge, technical nursing knowledge and care; and those that just apply instrumental nursing knowledge without bothering much about anything else.

As mentioned, doctors do not control the work of nurses. There is rather a high degree of auto-control between nurses. For all three nurses there was not a central authority that would specify the tasks and methodology to be accomplished. The nurses took the decisions themselves about how to organize their work. During our observations with Maite it emerged that the procedure for changing shifts is organized by the nurses themselves, guaranteeing the continuity of treatments besides the control of the work done. Although there are superiors at the work place, auto-regulation is the norm. Equally Jenny is very autonomous when it comes to exercise her work; her superior, although often present in the room never took the occasion to debate the organization of Jenny's work (or to criticize or to praise it).
The autonomy when it comes to organize and evaluate work then results in a complex social microcosms between the nurses. They have to arrange themselves with each other, get along with each other and find ways to negotiate the distribution of the work and deal with contingencies. During the observation of Jenny, for example, a former colleague of her came to help out in her service because she knew that staff was missing. This happened not because she was officially assigned this task but because of personal solidarity and friendship. Equally on Maite's ward a complex system of rotation between the nurses is in place. It is based on personal “good will” and solidarity to distribute the work load evenly –even though not infrequently it breaks down giving rise to conflicts.

The picture resulting from the focus group was shadier. The two of them working in nurse training talked about a serious lack of will to conquest a strong sense of autonomy. Nurses lack power mainly because they don’t want it, they said, because they don’t support each other. Maite’s story can be telling in this respect: her enrolment in the research project aforementioned had generated gossiping and resentment among other nurses, that didn’t understand “why her, being new in the unit”. The situation was similar to another participant in the focus group, who was participating in a research project on diabetes. She didn’t have any kind of support by her colleagues, even though her supervisor seemed to be happy about it. However, she didn’t quite agree with the idea of bad relations among nurses and tried to relativize it —“not all nurses are like that”. One of them in particular was participating in a research project on diabetes and was.

The one thing they all agreed upon was troubling: a great part of the difficulties in everyday work was related to the fact that “we are too many women”.

Nurse – Patient
The role of the patient will be described with greater detail under the topic of professional knowledge and professional ethics and motivation. It should be enough to point out that for all three nurses the patient as a human being is at the centre of their professional motivation. However, the work conditions essentially difficult this objective and threaten to undermine their professional identity, leaving little or no room for inter-personal relations with patients.

Another important aspect in the relation between nurse-patient is the role of the doctor. The subordination of nurses gets reflected in terms of a questioning of nursing knowledge and competencies by the patient or the family. The first address for the patient – even though the time share of nurses is much higher – is the doctor.

4.2 Professional Knowledge

The clear dividing line in terms of knowledge for the interviewed nurses runs between technical, task oriented knowledge on the one hand, and person centred caring knowledge on the other. The literature usually draws the same distinction in terms of explicit vs. tacit knowledge. All three nurses agree that instrumental, biomedical knowledge such as measuring blood pressure, handling injections, administrating medication, reading and writing medical documentation, down to the more sophisticated skills constitute the taken for granted medical base of nursing). It is well established in the scientific literature (they call it “techniques: that which everybody can learn”). On the other side, however, the real core of nursing does not reside in this biomedical knowledge but rather is constituted by an implicit knowledge of personalized, holistic care, a capacity to relate with the patient. This basic personal knowledge was defined in part as being unavailable to explicit forms of representation and management. On the contrary, it usually was understood as a personal attitude and pre-disposition, “something that one cannot learn”.

See overview of literature on professional knowledge WP1, p.17ff.
More specifically, this care-oriented tacit knowledge was described by Jenny as “practicing empathy towards the patient.” Explicitly she made the point that a nurse treats patients as individual persons being responsive especially towards their affective and psychological needs. This requires a high flexibility since each patient is different. It is a skill that cannot be learned:

“The personal relationship with the patient, the family and considering them is not in the text books and they don’t study this, and it’s something that I don’t know whether it is innate or it is education or… I don’t know what it is. But I do believe that it is basic, it is fundamental. And I have always worked in this way: it is not something that through experience I do more now. It is also true that psychiatry also taught me a lot about how to deal with the patient. And attending the patient,... in all its richness, this is brilliant isn’t it? With all their stress and their anxieties and suchlike. I think that nurses should spend some time in psychiatry compulsorily in order to understand how people suffer. And this is nothing to do with having a vocation. I believe that it is very basic... Communication, placing yourself in the situation of another person. ” (Jenny)

Communicative skills are implied in a non-instrumental notion of care. From the ethnographic material and the interviews it emerged that “caring” essentially means to respond to the emotional needs patients have when undergoing very stressful situations such as being treated in a hospital. It means to be responsive to their concerns and anxieties, to provide comfort by keeping them informed on what’s happening and ease their stay in the hospital. This preservation of a human touch in the face of a biomedical machinery represented by doctors cannot be learned. Equally the youngest nurse described that besides all the technical knowledge, there is the “heart”, the “personal attitude” at the centre of nursing which you cannot learn.

“You learn the techniques. The time comes when you have to inject, place tubes, make probes... all this is a technique which is like the person who knows how to do any manual thing, since you learn how to do it. But then you have to have what is really the heart, the genesis of nursing. And if you don’t have that inside you... There are people who have it and people who don’t. That’s something you cannot learn.” (Maite)

Surgeons in sharp contrast treat patients according to their impersonal, objectified, biomedical pathology. In contrast to nursing, the doctors can reduce the patient to their cure, treatment. Beyond the personal attitude and communicative skills, a nurse therefore needs a very broad knowledge base because she has to treat the patient more globally. All three nurse exemplify in this sense the reform of the Spanish Health Care system that initiated from the 70s onwards a turn towards health prevention strategy.

“You are not only going to give injections or take pressures, you have to do a job that is much broader. The work of a nurse is very wide-ranging. Wide-ranging because you have a patient before you with an illness, but added to this illness there is a series of problems that probably lie behind the illness which are work or social problems of all kinds. You have to have a very wide-ranging scope of knowledge.” (Flor)

Considering the three statements of the nurses one could circumscribe three types of “knowledge” implied. First, there is what Jenny or Maite have described the personal attitude and knowledge, the “heart” involved when treating patients. It is the skill, the human touch or tact when treating with patients in difficult, stressful situations. As such it has to do with your character, your communicative abilities that cannot be learned. In sharp contrast, there is the explicit biomedical knowledge and nursing techniques, the manual skills like putting an injection. But in-between those two extremes there is another type of knowledge that Flor has mentioned. Neither is it completely tacit nor instrumental but rather interdisciplinary. It is knowledge required to perceive the patient holistically, as part of wider relationships that cannot
be reduced to medical treatment nor “caring” treatment. As Maite defined herself, she is the interconnecting node between a whole network of health professionals and the patient (family). The nurse, as Flor also commented, is the person who provides a continuity of service by attending the patient 24 hours a day, 7 days a week. Being the centre where the different threads of the health services come together, a nurse has to know a little bit of all: the medical vocabulary and discourse of doctors, the world of the social workers that may be involved, the needs (psychological and even spiritual) of patients and family, the physiotherapist, the dietician, etc.

The observations of Jenny's work are quite telling in this respect. Part of her responsibilities involve not just the preparation of patients for surgical intervention and the monitoring of post-intervention recovery, but also to attend each of them in a special preparatory sessions. During those sessions it is her task to inform the patient of the general procedure of ambulant surgery and clarify their questions. But apart from those rather technical and administrative matters, she has to judge from the patient's medical history, social relations (family), and the “general appearance” if he/she and the patient's immediate environment are stable enough to undergo outpatient surgery. If a patient has no family that will take care of him/her after the operation, he/she needs to be admitted to the hospital instead. Jenny's work requires therefore not just solid medical and administrative knowledge but also a inter-personal sensitivity for addressing the anxieties of the patient (including family) that ranged from medical to existential concerns. Consequently, the oldest nurse saw a good part of her job as being a mediator between the world of the doctor (surgeons) and the patient. As she told us during the observations, she is continually translating between the expert medical discourse, the requirements of the hospital and the evidently limited understanding of the non-expert patient in order to contain the anxiety of the patient facing medical treatment. She has to “protect the patient from the doctor.”

This emphasis on the tacit, implicit knowledge at the heart of nursing does not mean that the taken for granted instrumental knowledge wouldn't cause problems. On the contrary: in the working life of the hospital both forms of knowledge are immersed in different types of struggles, conflicts and negotiations. For example, the will of a nurse to learn a new treatment or method does not mean that she will have the necessary resources to do so. Time and money issues arise and made worse by the lack of support by the management. Even the conditions given to apply the new knowledge in work practice aren’t especially favourable. Maite laid the most emphasis on the very difficult conditions that prevent her from learning and applying new knowledge. In order to visit a course or to participate in a conference she had to use her leisure time or ask for ‘free’ –non-paid- days. Besides, it is a sacrifice that could lead nowhere professionally. Her postgraduate studies turned out to be perfectly useless since the promised position never arrived:

“I haven’t done another postgraduate course since. Not even in surgery. I would like to do it, but... I’ll do it one day. It's a shame because you train yourself. And it is a sacrifice, both economic and physical. And all for nothing, because it has been of no use to me. And now I have lost everything that I learnt.” (Maite)

On the other hand it seems that precarious working conditions in terms of high flexibility and rotation between different services have resulted in the “internalization” of continuing education for nurses into the hospital. Instead of visiting certain courses, a nurse learns at work being instructed by other nurses at the job. Although, of course, external courses are available neither the youngest nor the oldest nurse perceived them as a real possibility for valid continuing education. Besides the bad quality as Maite commented, heavy rotation between services also prevents the planning ahead and scheduling of external course visits. Flor took more advantage

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114 In one case during the observation a patient hesitated to respond to Jenny’s question regarding the level of “pain” she has, out of fear of negative consequences from her insurance who might stop payment.
in this sense of external offers, but also insisted that frequently one has to learn at the job
directly. For substitutes or new nurses, this is the normal condition because they frequently come
to fill in where they are needed and pass through a variety of nursing services. But it is also the
case for more profound changes, as when the middle nurse was assigned to work in intensive
care or the operating theatre from one day to the next. That's the way you learn, at work:

Nurse: “For example, I was some time in the ICU, I told you I have been in many
departments. So being in the ICU involved having to train myself up quickly. One day
they said to me: from Monday you have a contract in the ICU… It gave me a fright, I had
very little experience at that time. On the other hand everyone knows that we have the
most critical patients in the ICU, with the biggest problems: big problems because in the
majority of cases they are patients that are connected to machines. So this means you
have to know about a lot of machines, a lot of mechanical stuff.”

Interviewer: “Right.”

Nurse: “So you have to have your wits about you, you cannot be the daftest one there. I
was taught a lot in technical terms, about handling things and a great deal at a human
level. You go through very tough situations in the ICU, like having to tell a parent, not
just you, the whole team, that you must disconnect their son after having reached the
conclusion that he is brain dead. They are very, very hard situations. So all of that, in
human and relationship terms, teaches you a lot: any situation teaches you in fact. There
are more critical situations and they teach you, because you have to experience them
more intensely. I think I have learnt everywhere. When I went to surgery I didn’t know
anything. I didn’t know the difference between one instrument and another (laughter).
Nothing.” (Flor)

Maite explained that in contrast to private clinics where the responsibilities of nurses appear to
be more compartmentalized and restricted, the public institution holds a wide variety of different
activities for nurses and they have to know a lot:

“Because I think that here you can learn a lot more. Later we will all have time, like
those in the CAPs (local health centres), won’t we? Being a nurse in a CAP is just
measuring the blood pressure of the patients with hypertension. Which is a job just like
mine. But there you don’t learn anything, you simply monitor. Here, and above all in the
public health service, is where you learn the most, because it is where you have more
work to do. As I said to you, we do everything here. A girl told me she had worked in a
private clinic and she said, “Ooh, here you do electrocardiograms and blood cultures.
Not there: there we called and said ‘electrocardiogram’ and someone came with a trolley
to do it; ‘blood culture, they came up from the lab…” I say, “What a cushy number”.
Here we have to do everything ourselves.” (Maite)

Brought together, both Flor and Maite statements shed a special light on teamwork. It appears as
if teamwork between nurses – below the more general level between doctors, social workers and
nurses – is not conceived as functional collaboration, but rather a result of the instable working
conditions. You collaborate not as specialist among specialists but to get to know the current
local work context as when Flor was taught by her colleagues how to handle the instruments in
the operation theatre.

This learning at work on the other hand requires a high degree of autonomy in terms of
continuing, autodidactic knowledge acquisition and knowledge production. All three nurses
agreed that there was a continuous need to stay informed, to personally investigate and keep up
to date. They all underscored the necessity to switch between services, to rotate in order to learn.
For Flor this learning at work however has to be complemented with self-study. When starting to work in surgery, she got herself a list of books to study the new medical vocabulary. Similarly, Maite voiced her constant inquietude and desire to try out new things in order to keep moving professionally. Or Jenny, who responds to the question of her sources for training and new knowledge:

“From yourself. In other words, self-training. When I began in psychiatry I got down to studying psychiatry. And from the work colleagues as well, of course. When I went to nephrology, the supervisor herself, and I think she was the best supervisor I ever had, who is no longer there, she gave me the bibliography and the books to learn from. And you teach yourself and from the people who have been working in the department.”

(Jenny)

But the nurses not only show a very high degree of autonomy when learning new skills, but also when producing knowledge. Jenny has built a unit for ambulatory surgery whereas Flor has just accepted to build up and coordinate different centres of mental health. They have been involved in activities of strategic planning, conceptualizing ICT services, doing nursing research, and extending their knowledge into questions of management that come up when conceiving new nursing services from scratch. What they were required to do thus goes well beyond the application of certain instrumental nursing knowledge and well beyond certain notions of “care.” However, it remains far from clear to which degree this knowledge and autonomy translates into a higher status for the profession.

**Professional Ethics and Professionalization**

Already in the previous section the professional values and motivation surfaced. Especially Maite and Jenny coincide in their main motivation: to treat a patient holistically attending his/her emotional, psychological, social needs as opposed to delivering a pure biomedical, instrumental, task oriented service. Their ideal profession gravitates around a “human touch.” That’s what distinguishes a true professional from a “nurse” just doing her job:

“There are two types. There is the good nurse who is concerned and there is the other type of nurse who is a technician. Only doing the techniques is not nursing.”

(Jenny)

Flor did not respond in a clear cut fashion as the other two. She defined her profession in very general terms as “Helping the patient”. However, she conceives this “caring” extends itself into other fields and disciplines. Already Maite made clear that nursing ideally signifies to see the wider necessities of the patient by providing the communicative node that draws together the different health professionals. For Flor, who just started to coordinate different mental health centres in rather deprived areas, “caring” entails to see the patient as forming part of a wider picture precisely involving his/her social context. In the same way that the nurses articulated different types of knowledge, we can now identify differences in their idea of their profession. Whereas Jenny concentrates on a personal, psychological oriented notion of care, Flor stresses the social dimensions of care.¹¹⁵ Maite mentions both aspects on equal grounds.

The inherent difficulty in providing this type of care, its emotional and thus often pre-verbal nature situates the core of their professional identity on the personal level. It is a personal attitude towards others that distinguishes a “good” form a “bad” professional. Just applying instrumental, biomedical knowledge has no special merit in itself; anybody can do it. However, to care and to respond to patients needs independent of one’s own emotional state requires a special, a strong character.

¹¹⁵ However, it is important to note that Flor “discovered” as she says, this more encompassing aspect of her profession only recently when assuming her new responsibilities for coordinating the health center network. In the hospital, she further says, work is more centered on the instrumental techniques than those holistic aspects of care.
“I always say that being a nurse is like being a nun. You have to have something inside you, because there are lots of times when you would chuck it in.” (Maite)

A special, unquestionable dedication to the patient. Flor understands her profession as involving a certain ability to sacrifice oneself.

“In nursing I think there are a lot of people working because they like doing it. It’s not simply a professional opportunity among others... Of course there are also people who just do that, but the big majority are people who believe in the profession and they like it, and they are motivated to do things. Actually most of the people I get in contact with, new people that arrive here, I honestly have to say that they surprise me; because of their education, their motivation to continue in education and because they have an ability to sacrifice themselves which is unfortunately required in our profession.” (Flor)

Jenny’s position on the core of the profession is interesting because it is marked by a certain ambiguity. She stressed, as did her colleagues, that not everybody can become a nurse. It requires a special attitude, certain social and communicative skills to put yourself in the skin of the other, the patient. At the same time, however, she was much more explicit when it came to distinguish this notion of care from the traditional stereotypes of nursing. Caring as defined by her has nothing to do with the traditional feminine role associated with the nurse. It has nothing to do with the nurse as mother. Equally, it has nothing to do with vocation. For her things will start to get better once a nurse recognizes that this “caring” can be established as the defining, legitimate core of her profession, leaving behind the traditionally associated metaphors of “sacrifice”, “mother”, “vocation.” She links this professional notion of nurse also to continuing, self-directed desire for knowledge.

“Look, I think that being a nurse is not just three years studying and that’s it. It’s not just one more salary for the family, pin money. From the moment the nurse thinks that she is a professional things go better. Nurses are not the doctor’s assistant, the side dish, the girl... From the moment you see yourself as a professional, learning things because you are interested, seeing as how you have to train yourself...” (Jenny)

The difficulty to understand nursing as an autonomous profession has to do on the one hand with the strong feminization which reinforces the maternal link of nursing. But on the other hand it also has to do a great deal with the head of the nursing department that underscores one model or the other of the nurse.

“Nurse: That the nursing group really believes that what it does is a proper job. I’m not sure if that is an answer. Look, with doctors this doesn’t happen. But the group of nurses is basically made up of women. The majority is married and the majority works for some more money to help the family economy. And I think that this is very... the philosophy is one that says this is not experienced as a job but as an economic support. It supports the home economy.

Interviewer: So it is more related at a personal level to the family?

Nurse: I think so. If you look at... well, no. There are lots and lots of nurses, who reach the hospital and call (she simulates a phone call) “The beans are in the fridge. Take them out as soon as you get home” (she hangs up). Half an hour later (she picks up the phone): “Listen, don’t forget the kid” (hangs up). The day we forget, the day we come here really as nurses and all that stuff from home ... Which is what the man and woman doctor do... So it’s not about being a woman. That is one aspect of it I think. Then the
nursing management should emphasise the fact that it is a profession. If there is a maternal model then we give it credence (she picks up the phone simulating the previous calls). The beans and the kid. Because at the end of the day what we do is a little bit of charity, isn’t it?” (Jenny)

As mentioned, Jenny's account is interesting because it leads us to a kind of ambiguity in relation to the nursing profession. On the one hand she states that nursing cannot be learned, that it is a trait of a person’s character, innate, pre-verbal, a skill not to be learned. But at the same time, she sees very clearly that nursing is in need of defining very precisely its professional boundaries to combat the subordinating stereotypes of the past. “Caring” would define the profession and provides the base from which the profession can claim its authority, its genuine contribution within the team of the other health professions. However, it seems that by maintaining this type of knowledge on a tacit, non-explicit level, by defining it as personal attitudes and situating it on the inter-personal level it is essentially antithetical to taking on a legitimizing function. Jenny's key work experiences are telling in this respect. She qualified them as a “key” because she learned that the whole status and knowledge associated with her position is not important. Precisely the status symbol – the white coat – is devalued in favour of the personal relation with the patient.

“And I learned that the white coat has no value whatsoever. Is the importance you give it as a professional but I shouldn't have this value. What I want to say is that there are other things. You can care and be with people without... and in psychiatry I didn't wear a white coat. And I was among them. I was more between you-and-you. The white coat for me is a hygienic thing and nothing more.” (Jenny)

It seems that for Jenny there is a sort of impossible dialectic at work: as soon as the profession would be able to claim its status, to make it visible on an organizational level and transform it into official power, it threatens to go against her professional ethics: to be with the patient on equal grounds. This might be just the first ambiguity of “emotional labour” as a professional service.

The focus group gave us more information about these issues. The confrontation between a quasi-vocational conception of nursing and a highly professionalized one was present. Three of them were extremely critical about the idea that there is a technical dimension (what you learn) and a emotional one (what you are). They convincingly argued that both dimensions are taught and learnt. One of them went even beyond, saying that she’s not a nurse, but works as a nurse. “If I were a nurse, I’d have to go around helping people”. For her nursing was a job with a schedule and a salary. Nothing else. It was interesting how the group questioned all the mythology surrounding the profession, the mother-nun referent was identified as an obstacle to the development of the profession in terms equivalent to other health professionals. They were very sceptical about the way the professional career is being re-design (they didn’t believe it was going to result in any kind of status increase) but they were even more critical with traditional ways of thinking about nursing.

Flor explained that nursing as profession has come a long way and that the discipline has its distinct corpus of knowledge that grants it a distinctive weight when compared to the neighbouring medical professions. However, without further detailing specifically this genuine nursing knowledge it was clear from the observations and the interviews that this knowledge not necessarily has succeeded in a greater professionalization of the discipline. Tacit knowledge is not acknowledged on the same grounds as biomedical, scientific knowledge. And even where nurses have produced clear-cut knowledge, they don’t have the authority or power to devise its usage and further application. The following two examples will help to illustrate the issue.
The first example concerns the “professional career”. Flor has been involved in the attempt to professionalize nursing. The Hospital del Mar was the third hospital in Barcelona which adopted in 1998 the implementation of professional careers. The main idea was to find a common and official formula to reinforce the profession, provide incentives for continuing education and to devise a manner to recognize and value the individual effort of each nurse (but also doctors). Before entering into details it should be stressed that the “professional career” despite its label actually doesn’t pertain to the profession but to the health provider! Neither there exists a professional career on the national level, nor even on the local level, but each company (IMAS, ICS) has its own model. As a consequence, when a nurse changes between those health providers her professional career will be invalidated; it is non-transferable between employers. Each health provider negotiates its own model of the professional career with representatives of the employees (nurses and doctors alike), trade-union members, and members of professional organizations. The specific philosophy agreed upon in the case of the IMAS is summarized in the following list:

- Participation is voluntary
- Irreversible (other places it is reversible; a nurse can be downgraded).
- Economic benefit
- Not automatic
- Results from a continuous evaluation during the whole career
- It is considered an instrument for professional development
- A way for learning from experience.
- An instrument to increase motivation of professionals
- An instrument for establishing a tighter linkage between professional organization and the objectives of the company. An instrument to consolidate the organizational culture and to extend it to all professionals.
- An instrument to modify the routine at work and that prevent accomplishment of quality work
- An instrument to reinforce the self-esteem of professionals.

It specifies four career levels and a nurse needs at least 23 years to reach level four, given she has a permanent contract. Each level is associated with a certain wage increase. To accede to a new level, a nurse undergoes a process of evaluation that corresponds to her specialty. Criteria for evaluation include the years in service, and:

- Documentary, administrative skills
- ICT usage
- Work scheduling and decision taking towards more efficiency
- Communicative skills with the patient and family
- Teamwork
- Technical nursing skills
- Being open to the requirements of the employer
- Assuming teaching responsibilities
- Continuing education and self-formation
- Participating in research

Those aspects will be evaluated by a team comprising the head of human resources, the head of nursing, the head of the ward or department, work colleagues and trade-union representatives (as

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116 This may also be the reason why there exists no official documentation. Each health service has its own model of professional career. Flor provided us with the internal documents of the IMAS.
A nurse will be evaluated horizontally (by her work colleagues), vertically (by her superiors) and by herself.

Jenny’s reaction to the professional career was quite sceptical. As she states, the main player from her point of view, the patient, is left out of the picture.

“I am doing it but the fact is this idea of the professional career is a bit of a trick. You see, there is the curriculum part and the other part which is where you don’t really know what they are evaluating. The teamwork, you don’t know who is evaluating you, your knowledge and the projects with your colleagues that you don’t know how they are evaluated. There is a whole series of things that mean that... Let’s take the curriculum. You know how to count, so therefore you know if you have a curriculum or not. And the other aspect is something highly subjective. You don’t know who evaluates you, or how. No, I don’t believe in all this stuff about the professional career. Apart from the colleagues and the curriculum, I think the clients should be asked.” (Jenny)

Although there are quite clear criteria of what is evaluated and although you know who will be evaluating you (as it is stated in the document), the subjective, personal qualities obviously do not have the importance in the evaluation scheme they are supposed to have – given the centrality they enjoy in the professional ethics of Jenny. Her experience is that what defines a good nurse slips through the raster and is generally not acknowledged.117

For Maite the problem with the professional career resides on another level. Although the main objective is to incite continuing education, for her it is not practicable out of the already mentioned working conditions. There is no support, no money, no encouragement to do these things: go to congresses, do courses, etc. Participation in research only happens upon invitation by doctors but support for own initiative is basically non-existent. Maite participated in a two day work exchange with Belgium which sure would give her points in the professional career, but:

“I think that there should be time and that there should be someone behind supporting you, saying, “OK, go on the, you do this... You need people? We need cash? Well here they are, get going”. But of course, otherwise... if you have to ask for a day of your holidays to go wherever. Listen, I come back from Belgium on Saturday at 10 p.m. and so I don’t have to get up on Sunday at 7 in the morning after being 2 days there I have to take a day out of my holidays. So instead of saying... I don’t know. I took a day from my holidays because I thought, “I am going to get back exhausted after two days shut in there”. Things like that, you see?” (Maite)

For Maite, doing research or going to congresses means to do more things which in the end do not really pay in return.

The gap that exists between the personal accounts of the nurses of their professional identity and the professionalization attempts also became apparent by the case of Jenny. As mentioned, she formed part of team to build up a unit of outpatient surgery. A crucial question for this unit was the time period necessary for patient recovery. In order to avoid risks, patients spend in the beginning a large amount of time in the unity before it was considered safe to send them home. With experience accumulating over the years made possible by Jenny’s documentary system, the

117 Another indicator could be the value assigned to knowing second languages. For Jenny, this would be utterly important; to be able to communicate with a patient in another language would greatly improve the service. During our observation we could witness the actual difficulties she encountered with immigrants that did not speak Spanish or Catalan. But knowing a second language apart from Catalan adds the same amount of points (0.2) to your “professional career” as getting the official certificate for Catalan level B.
time period could significantly be reduced. She, as head of the unit therefore produced very valuable knowledge. However, the problem is who has authority over this knowledge and to which ends it will be applied. She as a nurse understood the time reduction essentially as a caring aspect: the less time a patient has to spend at the hospital the better. However, even though she did produce that knowledge, she has no authority over it since the patient throughput is decided by the administration according to economic criteria and not by her according to her ideal of care. In this sense, "her" knowledge is now exploited by the administration to increase the number of patients treated a day contrary to the ideals she associated with it. This difference can also confirmed by observing that knowledge is ignored when it only concerns improving the service. As part of the outpatient surgery unit, she designed a database for documenting the operation(s) of the unit. From her perspective, there is wealth of data accumulated which could help to provide for example more specific care for the immigrant population. But it doesn't interest anybody according to her because it is uninteresting in economic terms. In other words, the knowledge of care, even when it can be articulated in precise terms beyond personal attitudes or sacrifice, is not acknowledged as such and has no effect in the sense of professionalization. Jenny makes here a perfect case for what Beach has analyzed – following Willis (1999). She exemplifies the tension between knowledge at the service of socially useful labour vs. its productive value in economic exchange.\footnote{See D02, p.255} She feels burned out. She thinks that her employer does not recognize the professional career she has accomplished. Despite the challenges and high autonomy all nurses exhibited during our research, their skills and broad knowledge, true professional power is still missing.

4.3 Social position

No particular data was gathered around this issue during either interviews or observations. This item was not present in previous guidelines and did not emerge spontaneously. Earnings were discussed above, when discussing working conditions.

4.4 Work-life balance

This aspect was already discussed above, when considering working conditions.

5 Concluding Remarks

This last section will summarize the main themes as they emerge out of our research material. It will also stress generational differences to the degree that they are apparent at all. Finally, some tentative ideas relating the status of “emotional labour” will be put forward. If we had to summarize the relation between restructuring and work experiences, one could say that the Hospital of our research aligned its discourse to official rhetoric of improved quality and service, to efficiency and cost control; that nurses have been part of very challenging and inspiring work situations but that they are not able to enjoy the results of their effort.

A fundamental aspect to characterize the nurses' personal experience of work life is their working conditions. Especially for the youngest nurse, the actual contractual conditions and their consequences are quite severe. Comparing Maite's situation with Jenny's there has been a huge change in terms of flexibilization of contractual arrangements and work to be done. Although Maite sees the negative consequences, she assumes this situation as somehow the normal condition (at least for beginners in the profession), as Flor does. Moreover, these contractual
arrangements have a clear impact in work-life balance. All nurses entering the labour market should expect to spend around five years of contractual uncertainty – the kind of uncertainty that permeates all spheres of one’s life and that we could call “precarity of existence”.

Apart from the contractual arrangements, everyday working dynamic is equally important. Whereas Maite assumes an immense workload as “normal,” or at least she doesn’t see it as a reason not to like the profession or think about a change, for Jenny it has passed a critical threshold. She cannot work the way she would like to. She perceives the change, the increased importance of efficiency and economic criteria as a deterioration of her working conditions; she feels burnt out.

For professional knowledge there are no apparent generational differences. All three nurses stressed the importance of auto-didactic learning as essential. Whereas Flor valued external courses, Jenny or Maite showed more scepticism towards their real professional profit. There is no interest from the administration of nursing to foster knowledge acquisition or research. It is the burden of the nurse, a personal effort drawing on resources that are outside of the work context (personal time, vacations). In addition, all nurses agreed that nursing cannot be reduced to its instrumental, biomedical knowledge.

When asked specifically about differences among generations regarding the sense of the profession, participants in the focus group couldn’t agree – or more exactly agreed that there was no clear-cut dynamic. They thought that personal trajectories (at work and education) were more important in developing one sense or another of the profession than the generational variable.

During interviews, independently of their age, nurses experienced their profession as caught in a struggle to establish and defend their territory against the biomedical discourse of doctors. The rejection to define their profession based on instrumental knowledge also served to distinguish a true professional. Their ethics on holistic care involving psychological as well as social aspects was very palpable during the whole research. But it was equally apparent that neither health administration, nor patients, nor doctors did actually value and recognize this knowledge – that was the case also within sectors of the nursing collective itself. Therefore, it does not lead to a higher professionalization: all these practices and knowledge being produced (and which they conceive as a terrain of autonomy and authority), does not enter the official discourse on nursing.

In a similar direction the very concept of professional knowledge as caring (on a psychological or social level) should guide a re-reading of the previous work packages. The question is whether our conceptual framework elaborated during previous sessions is sufficient for capturing the themes and concerns that have emerged from the nurses’ accounts. Our approach as outlined in WP1/2 to restructuring and its effects on the professions and professional knowledge concentrates on the production, representation, management and exploitation of explicit forms of knowledge. In this sense, the role of higher education in relation to the professions is analyzed in WP2. The public universities lost ground in defining professions, being replaced by private certification institutions. Equally, a mayor trend of commercialization of education was detected, where lifelong learning as knowledge transfer and skill updates are increasingly seen as the necessary condition to just stay in the job (but without actually translating into a professional benefit at work!). In this sense our analysis was framed towards the increasing
commercialization of explicit, scientific knowledge and its insertion into the capital system. However, there may be another type of analysis which centres not so much on the profit extractable from a knowledge product but on how capitalism may feed off the very structures that generate this knowledge in the first place. It might be worth to reflect on the ambiguities or paradoxes involved when “care” intersects with knowledge, when “emotion” becomes “labour.”

Our case study suggest the existence of series of profound gaps: between the process of professionalization and the sense of profession; between the official corpus of knowledge that defines the profession and the nurses’ everyday practices and insights; and between the aforementioned trend of exploitation of knowledge and the disregard that the management shows for different kind of knowledges being produced by nurses. These gaps point at a relevant space between some of the frameworks for the study of restructuring and the evidence collected. They all seem to coincide in signalling a split between everyday processes and official-institutional dynamics. The nurses that we have studied are working in an environment defined by trends of flexibilization and privatization, but their quotidian practices, inexplicable without that setting, is not however fully explained by it. By pointing at these points of tension we highlight the need for a more complex understanding of restructuring. There seems to be an important layer of practice and expertise that escapes the mayor trends identified in previous WPs. The management of the hospital—the micro-site of restructuring—, however flexible and brutal, cannot hold it all. There are many particles of everyday practices that exist and develop on their own—in a much more flexible and liquid way.

6 References


CHAPTER 7

Nurses’ Life Histories: the Swedish Case

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1 Introduction

This report deals with issues of restructuring of the health care as a welfare state institution, and Swedish nurses’ professional knowledge at work, situated between state and citizens. In accordance with the PROFKNOW workpackage 5, the aim is to:

- get a deep understanding of nurses’ personal experiences of work life changes and of professional expertise in the present as well as over time
- compare work life experiences and notions of expertise between generations of nurses
- present ethnographic descriptions and analyses of health care work and life in order to understand professional knowledge at work
- contextualise nurses life histories relative histories of the profession, restructuring of health care, and social changes

In this paper I will address these aims from the point of view of three nurse portraits, each is a result of life-histories and observations and each is written with a hope to help future elaboration of relations between work life changes and nurses’ professional expertise.

Planned changes in governing of public institutions described in terms of marketization including clients’ freedom of choice, decentralisation, and deregulation etc are often characterized as restructuring. In this paper the focus is on such measures that effect nurses’ daily work and on the dynamics that appear when they are in use within a nurses’ community of practise, but also how they effect individual nurse’s life.

In order to understand work life changes, the analysis has started with a focus on what the nurses regard as important aspects of their work and on what they try to accomplish in their meeting with patients. What characterises a “normal” work process? Another question is about ‘things’ that can be related to restructuring measures, where do they appear and how? Such measures can sometimes be difficult to observe, they very soon become a part of an ongoing stream of mundane events. A point of departure here is that such changing measures can appear as disturbing and difficult situations. Therefore the analysis also has focused on disturbances and other difficulties nurses face in relation to what they try to accomplish in their meeting with clients/patients. Individual and collective strategies including tools available for the nurses to handle “normal” and “disturbing” situations have been another important aspect of the analysis. In short, what do the nurses struggle with in order to do their work and which tools are involved? Some of these tools could be of an infrastructural nature. Others could be used for particular purposes. Also learning strategies and formal education are included here.

Three nurses who work in an urban multicultural area have been interviewed twice and shadowed. In the first interview the question to the nurses was: can you tell me about your life as nurse? The second interview was used to clarify aspects from shadowing and the first interview, and to deepen themes.

I told the nurses that I was interested in their story, not an official one that would look good. I also asked them not to avoid telling me problems they have encountered, and that I would not value what they say in terms of bad or good. They could talk rather freely about what they regarded as
important. The three nurses have got their own transcription of the first interview to read and comment.

The first interview was made between December 2005 and January 2006 and the shadowing took place between January and April 2006. I have followed the nurses in total nine workdays, but often on a half day basis to be able to keep full attention. My attention was directed towards typical and problematic situations as expressed by the nurses in the first interview and related to meetings with patients and to demands “from above”. Organisation of work and infrastructural conditions, tasks, interplay with clients, colleagues and others, and resources used by the actors has been an important focus of the shadowing. A main focus was on use of tools and possibilities to handle the problematic issues. During the shadowing I also had opportunities to small talks with the shadowed nurses and their colleagues. Situations from the shadowing are mainly nurses meeting with patients in the waiting room and scheduled meetings. I also participated in the nurses’ formal meetings. The second round of interviews was carried out in January and March 2006. I have also participated in three formal nurse meetings. All meetings should have taken place even if I was not there. I had the possibility to ask questions to the participants, before, during and after the meetings, and so I did.

I have given the nurses names on N: Nina with around 15 years as a nurse and four years as a primary health care nurse, Nancy with 31 years as nurse, and Nora, with 38 years as nurse. Nina was the youngest nurse at the health care centre which also illustrates that most nurses who work in health care centres have rather long experience; this is commonly not a first job. Work at a health care centre also requires specialist education. This is the reason why the condition of choosing three nurses with different length of experience, as defined by the PROFKNOW-project, could not be met. There was no nurse with short work experience at the chosen health care centre. It is reasonable to believe that the situation would have been the same at other health care centres.

A group interview with nurses at the same health care centre was also carried out. Four primary health care nurses between the ages of 44 and 59 years participated. They graduated from nurse education 1982, 1985, and 1990 respectively. The focus was on themes developed in the analyses of the individual interviews and the shadowing. The group interview took place in October 2006.

2 National and local context, a brief introduction

This section gives a brief introduction the Swedish health care and some major reforms of importance for nurses’ work. The studied primary health care centre has here got the name the Haglunda’s Health Care Centre, here referred to as the Haglunda Centre, and is situated in Göteborg, the second largest city in Sweden. The section also introduces the city and the Haglunda Centre, with their official presentations as a point of departure.

2.1 The health care system

The Swedish health care of today is often depicted as an organisation comprising three levels:

- regional hospitals
- central county hospitals and district county hospitals
- primary care

119 No data about the oldest nurse, she presented herself as a nurse with long experience of the occupation.
The division is made by for example taking the patients’ need of hospital care, the nature, and the difficulty and the complexity of the visiting patients’ health related problems as points of departure. This is also a picture of a vertical hierarchy related to specialisation and qualifications. Primary care is described as the basic level. People can turn to health care centres (outpatient clinics) with their health related problems. Expectant mothers and children under school-age can follow programmes for preventive care with regular check-ups (almost all of them do so). Primary care also includes long term care of elderly, long term psychiatric care, and care of physically and mentally disabled. This kind of care often takes place in the patient’s home but also in nursing homes or group dwellings, not in acute hospitals. The county hospitals and the county district hospitals are for conditions that require (inpatient and outpatient) specialist hospital care. The most advanced, and highly specialised, care is delivered at the nine regional hospitals.

In the following some major health care reforms are listed:

1. 1982 – The Health and Medical Services Act of 1982 (SFS 1982:763) defined the health care activity as to prevent, search for, diagnose and treat illnesses and injuries. A supplement to the act in 1985 also introduced prevention of ill-health and the importance of health promotion and disease prevention.

2. 1985 – A new patient-record act (SFS 1985: 562) states that all licensed health care professionals must document the care of patients. This is a new obligation for nurses. All reports must be personally signed. In 1993 ‘Provisions and general advice’ from the National Board of Health and Welfare (SOSFS 1993:20) particularly points out that nursing care must be documented and that this is a nurse responsibility.

3. 1992 – 1995 The ÄDEL-reform (care of long-term patients), the Handicap reform, and the Psychiatry reforms. The care of long-term patients and the handicapped was transferred from hospitals, provided by the county councils, to the municipalities.

2.2 The city

This study is carried out in a health care centre situated in one of the largest municipalities in Sweden, the city of Göteborg with around 485 000 inhabitants.

Göteborg is often officially described as has been dominated by trade and shipping ever since the city was founded in 1621. Industrialisation, another aspect of stories about the city, was started in mid 19th century, first dominated by textile industry but later also shipyards and engineering industry. Some of the companies that were started in the beginning of the 20th century soon became world leading, for example SKF, a somewhat later example is Hasselblad. In the official homepage of Göteborg, the city of today is presented as “a city of industry and expertise, with two universities and many service companies” (www.goteborg.se).

Presentations of Göteborg are often given an international context. Early Göteborg was build by Dutchmen, and Swedish, Dutch, English, and German were official languages in Göteborg during the 17th century. In the 18th century the Swedish East India Company began trading with China. Scottish businessmen came to Göteborg and were a part of the early industrialisation. Some of them became very rich.

If we leave the historical Göteborg and take a step to Göteborg of today we could still attribute an international context to the city. The Haglunda Centre is situated in a city district with the
same name, Haglunda, where many people have their origin from another country than Sweden. It took me about 15 minutes to reach the health care centre by tram from the city centre. My impression was that this short trip took me to almost another world. It was not that the buildings or the nature were different in Haglunda. On the contrary, the building style was typical Swedish 1950s and 1960s apartment buildings, the nature was very Swedish, and in my eyes many areas in the city district looked very nice. But the language spoken on the tram was different. Or, I should say, all the different languages that were spoken. And it was like the tram tour changed character near the big shopping centre in the centre of the city. Before the city centre the Swedish language dominated, after the city centre the Swedish language became a minority.

In official documents, the international context of today is presented differently in comparison with descriptions of the immigrants of the glorious past. For example, the annual report of 2005 from the city board (www.goteborg.se) says that there are big differences between Göteborg’s 21 city districts regarding the citizens’ social well-being. In comparison with average Göteborg, Haglunda is an area with more people who are unemployed, get compensation from Social Insurance Board and receive social security. People who live here also have less income and lower education than people in average Göteborg. Therefore Haglunda sometimes is described as a heavy area.

The Haglunda Centre is one of 26 health care centres in Göteborg, run by the regional council, a political decision-making body mainly with responsibility for health care. The centre is chosen because it meets the demands defined by the project: an urban, multicultural area.

2.3 The health care centre

The Haglunda Centre is rather large with more than 60 employees. In total around ten of them are nurses. Other categories employed at the health care centre are doctors, assistant nurses in the little laboratory, midwives, psychologists, physiotherapists, occupational therapists, etc.

The supervisor and the assistant supervisor of the centre both have a background as primary health care nurses. They are not only supervisors for the nurses but for all staff at the centre, including doctors. The supervisors report to the health care area manager, who also is a nurse. The health care area manager reports to one of the eight county council managers. This also illustrates that the line of authority is related to positions and not to professions. A nurse who becomes a manager leaves nursing so to say, and becomes a manager.

The Haglunda Centre belongs to the public health care system and the Region Västra Götaland. However, many health care centers are run by private owners, who often are doctors and/or nurses, but publicly funded in relation to a purchasing procedure. Also the public health care centers are part of this procedure defining the agreed achievements and the reimbursement. In this aspect there are no big differences between public and private providers. A public provider has the same efficiency demands as the private provider.

3. The Nurses

This section introduces the three nurses, their family background, why they decided to become nurses and their way to nurse education. The three nurses have all different nurse educations in relation to reforms of the nurse education in the 1970ies and 1980ies. They also have specialised in different ways after graduation from nurse education. Nina talked about herself as a primary health care nurse, and Nancy and Nora as nurses. However, they are all here referred to as
nurses. Nina is referred to as primary health care nurse only when important for the described situation.

3.1 Nina

Nina works as a primary health care nurse. She is 36 years old, unmarried and has around 15 years of experience as registered nurse. In 2001 she graduated from her specialist education to primary health care nurse. Nina lives alone and has no children. She says that she works a lot, sometimes too much, and that she is very interested in her job.

Her parents are both compulsory comprehensive school teachers, the mother at the junior level and the father at the senior level. Nina’s sisters are also nurses. She tells me that her mother wanted to become a nurse and worked in a hospital when she met Nina’s father but was convinced by him to become a teacher. Nina says that her mother has not tried to persuade her to become a nurse but also that her mother is very happy about her choice of occupation.

Nina says that she knew early in life that she wanted to become a nurse. After the 9 years compulsory school, she took the two years Care line at the upper secondary school. A couple of years later she was accepted at the nurse education (two years long) in Uddevalla. In 1991 she got her license as a nurse.

About nine years later she entered a specialist education to become a primary health care nurse (two and a half semesters) and finished in 2001. Before she could enter the specialist education she had to complement her nurse education with a course in research methodology (one semester). Nurse education had been extended to three years, in relation to the 1993 higher education reform and among other things to meet requirements from the EU. Nina’s nurse education from the 1980ies did not give her the qualifications to enter the specialist education.

Before entering the specialist education, Nina has also taken a course in “prescription right”. This course was also a part of the primary health care nurse education so Nina later got a repetition. The course gave her possibility to prescribe some defined medicine and some tools, e.g. for patients with diabetes or incontinence. She has also a couple of shorter university courses in nutrition (5 weeks) and diabetes (5 weeks).

Nina had different jobs as assistant nurse in geriatric care and at a health care centre before she entered nurse education. The nursing line at the upper secondary school gave her this qualification. At this time, the nursing line was an entrance requirement also to nurse education. Students with other backgrounds had to take a complementary course to enter nurse education. Therefore Nina’s way to nurse education could be described as straightforward, even if she later in life had to complement her nurse education to get access to nurse specialist education.

Nina’s first job as a nurse was in the acute care and an orthopedic department. It was a permanent position and she worked in different teams of nurses and assistant nurses, and in two different wards, wherever she was needed. She liked the job very much but after six months the position was withdrawn because the hospital should save money. She got a permanent job in the geriatric care (nursing home) and became employed by the municipality, the political level with responsibility for long term care. Nina stayed there for six years but describes the job as heavy and psychologically pressing. As the patients were old, many of them needed terminal care and she also had to support relatives. After that she worked as a consultancy nurse in the municipality. She visited handicapped people who lived in special homes and elderly people in their own homes. She also kept this job during her specialist education to primary health care nurse.
You visited the patients when they needed care. Not the caring part but more like a consultant, I came and dressed their wounds, they called for me if someone didn’t feel well, medicine, insulin, follow up of diabetes patients, blood sugar and such things. It was a consultancy within the municipality, in one of the city districts, I started in 1997 and stayed until I became graduated as a primary health care nurse in 2001.

We had a car and visited them in their homes, and a cell phone so they could contact us. Security (emergency) duty.

Some of her colleagues were primary health care nurses. “It was natural for me to enter (the primary health care nurse education)” she says, because of this job but also in relation to her phase in life:

And it was at the security (emergency) duty I got the idea to become a primary health care nurse, because I had colleagues that already were primary health care nurses. It was natural for me to enter. And it also was right in relation to my phase in life, to get a break. I had been working for ten years as a nurse, and it felt natural to get a break, yes to get a repetition concerning diseases and so on. And I also got the prescription right, and got a repetition of pharmacology, medical treatments. I think the primary health care nurse education was almost one of the better educations I’ve ever entered.

After the primary health care nurse education she worked at another health care centre that was closed down after a while. Then she came to The Haglunda Centre, for no other reasons than that they offered her a job. But she also says that she likes her present job very much.

3.2 Nancy

Nancy is 56 years old and works as a nurse. Her father was an engineer and her mother was a housewife. She has two grown up children.

When she was a child, Nancy’s dream was to become an architect. At the upper secondary school she took the three years natural sciences line. Nurse education was not in her mind at that time, she says. First time she applied to the architect education at Chalmers she was not accepted. Later she started another education at Chalmers. During a summer holyday she worked in the home help service. She liked the job and was appreciated by the patients. Next year she applied both to the architect education and nurse education. She was accepted at the nurse education in Borås and started, but about one and a half month later she was accepted at the architect education too. However, she continued with the nurse education:

During a summer holiday I had a job within the home-help service. And it was a patient, a lady she was around ninety, she said, sister are so capable, I think you should become a nurse. Yes I said, this is worth to consider, then there was nothing more. And one more year passed, and I applied to architect education and to nurse education. Maybe there was a growing feeling, a longing to care. Because it was great fun that summer I thought. And when I was accepted in Borås I started there, but after one and a half month I was accepted at Chalmers and architect education. No, I thought, it wasn’t the meaning that I should start there, because I liked it very much in Borås now.

Nancy’s education was five semester long. She started in 1972 and graduated in 1974. She also says that she has never regretted her choice of profession.
Her first specialist education was a six months course in medical and surgical nursing. More or less she took the course to get away from a bad work situation, but also because she was interested in the subject. Her second specialist education is intensive care nursing (one year). After that she also took a 10 weeks long university course for nurses in cardiac insufficiency. She says about the course that:

*That’s absolutely the most enjoyable I’ve ever done, yes the best regarding education. I was so terribly good.*

After that she also took a couple of five weeks university courses in cardiac nursing. Her latest university courses are a couple of courses of 5 weeks each in lung health care.

Nancy’s first job as a nurse was at Sahlgrenska hospital and a haematological ward. She stayed there for six months and then came to another medical ward. Next job, after she had got her children, was a nursing home. After her first specialist education she worked with medical care in Alingsås, and after her second specialist education with heart intensive care in Borås.

Her husband got seriously ill and she returned to Alingsås where they lived. She now divided her working hours between a medical ward and a heart outpatient clinic. During her period in Alingsås she also studied cardiac nursing, in total 20 weeks (three university courses). She also worked as a nurse manager for a time. Her husband died, she moved to Göteborg and came to The Haglund Centre in 2001.

*I moved to Göteborg together with my son. And I just took a job, any job. It was the most unplanned thing I’ve ever done. I just saw a job in the newspaper, a vacancy. Well yes, I call them and ask if I could come. Yes they said, you can come. In other words, it was insane, so without thought and unplanned. And I went to an interview with our supervisor, and she asked me if I could test the job, so here I am now. 2001. I had had no thoughts about a job at a health care centre, I just ended up here because my life was chaos and everything was upside down. I said to myself that I’ll start there and then I’ll see. But I’m here still. That’s the way it is.*

Nancy has around three years of different specialist educations after graduation from nurse education. Perhaps this does not make her an average nurse. But she tells me that nurses who work at health care centres most often have longer specialist educations of different kinds. Nancy is also not a primary health nurse like Nina. As we will see later this position, being a nurse but not a primary health care nurse, is also organising her workdays at the Haglund Centre.

### 3.3 Nora

Nora is 60 years old and works as a nurse. She was born outside a middle-sized Swedish town. Her occupational career has taken her to several other Swedish towns but also to Afghanistan and Tanzania. Her mother was a housewife but worked also as a cook. Her father was an engine-man and also took care of the heating in an aircraft workshop. A very heavy job she says. He was also very interested in politics. She describes him as a dedicated socialist, very active and ahead of his time. Today she lives together with her husband in Göteborg. She has two children, born 1973 and 1976.

Nora’s educational background is the former Girls’ school and she entered nurse education in 1964, in Norrköping, at the former The State’s school of Nursing. The application process was different from today when admission mainly is based on marks from upper secondary school:
It was one of those courses where the applicants were tested. They no longer had a one month long test period for those who wanted to become a nurse. But we had to take a two-days test instead. We were interviewed and tested by a psychologist.

When I ask her why she wanted to become a nurse, the answer is that she has no memory of a particular wish to become a nurse. It was a good middle occupation, caring. “But I could have been a teacher also, maybe” she says and refers to her generation and people with non-academic background.

Her education was three years long and included a specialist education. Nora’s choice of specialist education was psychiatry, but children’s health care was another option for her:

*I had never thought of psychiatry as an alternative but I had a period of practical work at an old mental hospital in Östergötland called Birgitta hospital. And I became very interested in this, the care they gave, but still I wasn’t sure.*

The specialist part was in the end of the nurse education and took Nora to another Swedish town where she got her education. But she also took a shorter period of practical work at an intensive care unit:

*bearing in mind that I should meet patients who have made attempts to commit suicide.*

After registration as a nurse she has taken several courses: Preparatory courses for work in developing countries including English and studies of Islam (in England), specialist education in medical and surgical nursing (one semester), specialist education in intensive care nursing (two semesters), shorter courses such as health care in developing countries, tropical medicine (at St Göran’s hospital in Stockholm), catastrophe medicine (at the National Rescue Services Agency), and management courses (organised by county council with assistant unit managers as target group).

Nora’s list of employments is long:

- First job after graduation in a psychiatric hospital. Stayed there for two years.
- Work in an intensive care unit. She says that she was afraid of loosing knowledge in somatic care.
- Moved to another town, work in a medicine outpatient clinic. There was no job to get in the intensive care unit.
- Night shifts in the intensive care unit, after a parental leave of about six months.
- Work in Afghanistan. She came to Afghanistan in the summer 1978 together with her husband who had got a job at an eyes hospital, and their small children. Her plan was to work with world travellers and the problem with drugs. However, the war broke out and all drug addicts disappeared from Kabul. The war escalated and the foreign nurses were asked to help the state hospitals to take care of wounded by war. In the following lengthy quote Nora tells about the situation she was facing:

*Gun-Britt: How long did you stay?*  
*Nora: Two years. We had a five year contract that we had to break because of the war. I helped them at the hospital and I had contacts with people around, yes it was hard experiences, I never thought I would be in a war, but yes that was how it turned out. And then, after the invasion we went to India for a while, we had a holiday. We then went back to the country and continued to work. It was not decided whether we should be evacuated or not. But we lived in a evacuation plan. From level one to four one can say. One was to stay inside and four was evacuation. It changed between these. A curfew was imposed in the*
evening. But anyhow, I have had good use of this experience when I later have met refuges. And here at the health care centre we have many wounded by war and traumatic experiences. And I can put myself in their place even if my stay was voluntary and many things are different from my experience. But I know a little, I have tasted how it is to be scared. But there are so many hard experiences but most of all a fascinating country and a fascinating people and rich experiences.

The employment list continues:

- The war was escalating and Nora and her family were sent home in 1980.
- Nora and her family took a new job in Tanzania and stayed there for two years. Nora describes her work in the intensive care unit, a situation very different from the Swedish hospitals:

  Nora: /.../ It was gunshot injuries, traffic accidents, the cars were in a very bad condition and there were not so many traffic rules. Burn injuries, they make food over open fire and the children fall into the fire. So it was real intensive care patients. A guy had been bitten by a crocodile, among other things, big thorax injuries. So it was a new experience to work with so seriously wounded and with so little resources. And this was a good hospital in comparison with the rest of the country. There were only two cloths at the entire ward and they were used to all the patients.
  Gun-Britt: To all the patients?
  Nora: Yes to all the patients. And for other things to. Even for cleaning. And when I asked why it was like this the manager looked at me and laughed and said that if there are more clothes they will disappear. That is, they cannot have one cloth for each patient because they disappear. An incredible problematic situation and I, as a foreign nurse, spend much effort to make ten clothes and mark them with name and so on. And the patients were lying directly on the mattresses without sheets because there were no sheets. And yes, it is unbelievable, people are bleeding, defecation, they wet themselves on the bare mattresses. Unbelievable experiences of poorness and misery.

The employment list continues:

- 1982, back in Sweden, worked a shorter period in a surgical ward.
- Emergency care unit.
- Surgical outpatient clinic.

In February 2006, short after our second interview, Nora takes a time limited position at a hospital church as a lay worker. She needed a break from the job at the health care centre she says.

4 Organising work

The three nurses talk about a division concerning work tasks between primary health care nurses and nurses. As mentioned, Nina is primary health care nurse and Nancy and Nora are nurses with other specialist educations.

Every morning the four nurses, who not are primary health care nurses, at the centre assign themselves to one of the three main nurse tasks: One nurse takes care of the sorting of waiting room patients, one is a so called acute nurse
and the two others answer the telephone. Together with a doctor the acute nurse takes care of the patients with breathing difficulties, chest pain and such things, that is patients who cannot wait for treatment. Answering the telephone is referred to as Tele Q, a computer based queue system that controls and orders the phone calls from patients seeking an appointment. The Tele Q work is similar to waiting room work in that it also is about sorting of patients. Every morning when I arrived I could read on a white board in the so called telephone room. 

Besides these three tasks, the nurses have consultancy hours when they see patients with different kinds of problems, and in accord with their nurse specialist education. Nancy’s specialty is long term follow ups of patients with lung diseases such as asthma/KOL, Nora’s is newly arrived refugees who need a medical examination. The other nurses do long term follow ups of hypertension and diabetes.

The primary health care nurses were not included in the assignment system. They mostly see patients as booked consultancies but every morning they spend one hour answering the Tele Q. During the group interview the primary health care nurses said that their work has changed.

> Earlier we did more house calls. We used to do the house calls in the morning, and after that patients could come and see us. The consulting hours were open so the patients could just come and see us. It is not like this any more.

During the shadowing I followed Nina when she was on a house call. She told me that this was almost an extraordinary situation; it was not so common that she had to visit patients in their home. The reason was that the patient needed a wound dressed after surgery but had difficulties to come to the Haglunda centre.

During the interviews all nurses expressed an interest in health promotion and to include this aspect in their meeting with patients. I also noticed during the shadowing that patients’ way of life was a recurrent theme in the nurses talks with patients.

### 4.1 “Professional ideals”

What do the nurses talk about as important aspects of their work? The question can be answered by including aspects that are regarded as a problematic. In focus are the relation to patients and between nurses and other health care occupations. Nancy talks about her first job as a nurse in the beginning of the mid 1970ies in terms of hierarchy, and an authoritarian head nurse. She also had very little contact with the doctors as well as with the assistant nurses. Besides, the patients were very ill.

> The nurse really was under the head nurse, she was a real boss in the ward, with a cap on her head. Everything she said was law. /.../ It was really awful, a very bad start of my career. I neither had contact with her nor with the doctors. It was such a long distance between everybody. I had contact with my colleagues, but very little with the assistant nurses, with the auxiliary nurses. They were on there own. And the patients were very ill. Many of them had leukaemia and at that time they couldn’t get helped as they can today. It was to depressing I thought, I had no support at all, it was just awful /.../.

Nancy soon left and got another job at a nursing home. Also here Nancy talks about boarders between nurses and assistant nurses. She also describes a job with lack of contact between the caring staff and the patients.

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121 The room where the nurses used Tele Q and had their meetings. The primary care nurses did not use this room.
The job was not patient centred. The idea was to carry out your work as quickly as possible and then have some coffee. Maybe it often was like that before, I don’t know. But what I saw there I have never seen so much since. And maybe it was because the work with old people is heavy, I don’t know. But I didn’t feel at home, the staff was watching each other.

Nina talks about the earlier job she had at the nursing home and the relation between her as a registered nurse and the assistant nurses. They worked in teams she says, but also that the assistant nurses had no understanding for her job as a nurse.

It was a heavy job, you were a part of a team, and yes, if I should be unkind, one could say that the more patients you helped with their morning toilet or such tasks, the better nurse. After that you had all your nurse duties left. The drugs, dress wounds, check the patients’ well-being or if something happened, reporting to the staff were the nurses tasks. This meant a strong tension.

The quotations above illustrate a health care with different groups and that the nurses talk about themselves as belonging to a specific group, nurses. Nurses are different from doctors and assistant nurses.

The nurses also talk about the relation to patients. In the second quote Nancy in particular points out that her job should be good for patients. The relations with patients should have certain qualities. When they talk about their current work at the health care centre the nurses in particular mention continuity, meaning that the patients should see the same nurse or doctor if they have continual visits at the Haglunda centre. Nurses should also not take over the initiative from the patients, but teach them so they can handle their disease by themselves. The nurses also talk about a focus on the patient’s whole situation instead of ”task oriented” nursing.

Perhaps the later is a common way of talking when nurses describe their work. The preferred overall view against the bad task orientation. A talk about the patient’s whole situation can of course not be interpreted as an exclusion of biomedical matters. And likewise, task-oriented can also refer to other aspects of nurses work than biomedical aspects. To my view, such division in nurses’ work is difficult to make here. A main point could instead be that nurses’ relation to patients is a tricky one and easy to dehumanize. It is also reasonable to believe that the same counts for other health care occupations as well.

Another main point in relation to the stories told by the nurses is that continuity is not self-evident. It is even quite possible that a patient sees different nurses or doctors from time to time. And who defines the patients need of care and in relation to what? Will teaching of patients imply that the patient’s do not have to visit the Haglunda centre any more? Probably not. But perhaps the daily life of a person with a chronic illness will go easier.

People who are in need of care should get care, be taken care of as patients and not be refused. However, the nurses must refuse people partly because some of them do not need medical care but partly also because there are not enough appointment times to see a doctor.

* Nora: /…/ We prioritise, we make an assessment of people who come to the health care centre because there are not enough appointment times to see a doctor. And I don’t know if I can stand up for that assessment, maybe we have appointment times for around sixty percent of the patients who are in need of care.
* Gun-Britt: But how do you know which patients to give an appointment time to see a doctor?
* Nora: Yes that’s my responsibility as a nurse.
Gun-Britt: And you must say no to some of them?
Nora: Yes.
Gun-Britt: But if some of them?
Nora: Yes this is so scary. I must know how to ask the right questions and all the time read between the lines. Because there are not appointment times to all who see us and all of them should not have an appointment time. Many people see us for small things that they can take care of by self-care. And our task is to give them an appointment time or not give them an appointment time, give advice, sometimes tell them to come back for a follow up, we can book visits to the primary health care nurses, and in cases of emergency to the psychologist, or social worker, for example if the patient express suicidal tendencies. We usually send these patients to an acute psychiatric clinic but sometimes you don’t dare to do that, because you have a feeling that the patient has serious suicidal thoughts. It’s the same with chest pain, we must take care of them even if we don’t have appointment times.

Some of the patients’ relation with this health care community can be described in terms of continuity. Continuity is related to patients that make visits rather often and most commonly for the same problem. One way the nurses can make continuity is to arrange meetings for the patient with the same primary health care nurse or doctor. But this is impossible if the health care centre has to send the patient to a private provider for a first and acute visit. The following is from a nurse’s waiting room work, where she decides if patients should get an appointment to see a doctor or not. She has access to a computer with the booking system and the patients’ medical record.

(from field notes)
9.07. Pushes the bottom to the queue system. Patient number four comes to the counter window. Asks for ID, search for the patient’s data in the computer. Asks questions to find out about the problems and what have been done. The husband interprets. Tells the patient that there are no times left today and also that she will need a longer appointment time with the doctor for examination. If she needs a time very soon she can call tomorrow at 7.45.

The patient wants a time booked for tomorrow. But the nurse says that she is not allowed to make a reservation for tomorrow. She has to tell the patient to come back early next morning or preferably contact the health care centre by phone. The patient is not satisfied with this. The nurse suggests them to visit a private care giver close to the centre but the patient want a long term contact.

The nurse tells me that she didn’t want to make a 15 minutes reservation, that it is not fair to the doctor to make a 15 minutes appointment. The situation will be too stressful for the doctor and the patients don’t understand why they don’t get the help they need. “I am more and more convinced that this is the way we must work”, she says. The patient needs a real examination of her problems and a long term contact with the same doctor.

9.30 Another nurse enters the room to substitute the first nurse, it’s time for coffee break. Still many patients in the waiting room.

The nurse tries to bring about a long term contact between the patient and a doctor. It is not quite easy. The booking system in her computer regulates what is possible to do. There are no appointment times left and the people who work at Haglunda centre have decided rules for the booking system. The nurse can therefore not give an appointment time the next day, she must ask the patient to see another provider or to come back early next morning. During my shadowing I noticed that the nurses’ encounter with people in the waiting room often was very problematic in
relation to what they wanted to be able to accomplish, what they regarded as the need of the patients and what was possible for them to do.

But the nurses do not only determine patients need of care and who are in need of continuity. They also see patients who already have got a diagnosis and prescribed treatment by a doctor. In the following Nina, the primary health care nurse, sees a patient with diabetes:

(notes from fieldwork)

Nina sits on a chair at her desk, the patient on a chair facing her. I sit on a chair beside the patient. The patient has given me permission to participate.

Nina: How are you?
Patient: I feel fine, but I think that you will say that I don’t.
The patient has been prescribed visits to a leisure centre (for physical exercise, something Swedish primary care nurses and doctors can prescribe) and tells Nina that this has not turned out well. But has now started to exercise again.
Patient: My values are not so good.
Nina: Okay.
Patient: /.../ I think about it all the time, the food. But it is difficult. The blood sugar has been around 11 in the mornings. I don’t know why it’s so high in the mornings.
Nina: Do you eat in the evenings?
Patient: I try not to eat after eight o’clock, but it’s difficult. I’m so hungry in the evenings.
Nina explains the connection between eating in the evenings and high morning blood sugar.
Patient: At least I think about it.
Nina: If you eat regularly during the day you probably will be feel so peckish in the evenings.
Patient: I need appointments to you all the time, then I would shape up.
/.../
Nina asks the patient to lay down on the bed. Takes a blood test from the fingertip. Leaves the patient. Takes the blood sample and the little bottle of urine the women had brought with her, goes to a analysis machine in a room near Nina’s consultancy room/office. Analyses the blood sample. Takes the urine sample to the lab, analyses. She tells me that the values are too high. Goes back to the women.

Nina: Let’s hope the tests will be better next time.
The patient: I drink aloes, maybe I shouldn’t do that?
/.../
Nina: Bring the declaration of contents (refers to aloes) next time so can we read it together. Have you brought your diary?
Patient: No, I haven’t used the diary so much.
/.../
Gives the women advice about food.
/.../

Nina tries to get a picture of the patient’s wellbeing in relation to the test values and the patient’s described way of living.

To summarise, the nurse community of practise works here as a gatekeeper and a controller. Is the patient qualified to enter the health care centre as a patient? And regarding qualified patients that already have got a diagnosis and treatment prescribed by a doctor: Have the prescribed treatment and the patients way of living had enough effect?
A characteristic was that even if many of the patients were well known for the nurses, their meetings with patients were short, from a couple of minutes in the telephone up to one hour during nurses’ consultancies. The patient-record also works as tool to make the health care professionals work public and thereby also exchangeable. However, the nurses do not have access to a support system providing them with the right questions when facing patients in the waiting room or in the Tele Q system.

The next section mainly concerns the gate keeping aspect.

4.2 Organising patients

The health care centre is situated on the 4th floor in a community building. But the nurses cannot just open the door to the health care centre and let the patients grab the first nurse or doctor they see. Therefore the centre has a waiting room for patients and this space is the first a person meets who enter the door. The waiting room has several quite comfortable chairs and an inbuilt glass room with two counter windows. A queue ticket machine is placed just in front of the door. By help of the queue tickets starts a sorting of patients. There are two kinds of queue tickets depending of the purpose of your visit. If you already have an appointment with a doctor or a nurse you are supposed to take a ticket to the counter window where you can pay your fee to the secretary. Then you are asked to go to one of the waiting rooms inside the centre, outside your doctor’s or the nurse’s room. Your doctor or your nurse will call you up. Most likely you will not have anything to do with the nurse who sits in the other counter window. But if you are ill and do not have an appointment time you are supposed to choose the queue ticket to her, like in the example above. She will decide if you need to see a doctor or a primary health care nurse/acute nurse, and if so she will try to give you an appointment time. If you get an appointment time you have to take a ticket to the other queue, pay your fee, and see the doctor or the primary health care nurse. A sign also created a third category of patients who did not need a queue ticket: patients with breathing difficulties and/or chest pain. To let them wait could be life threatening.

The nurses start their work at eight in the morning but open the doors to the waiting room 15 minutes earlier. When I arrived around eight it was always full of patients, some mornings I counted to 30.

The computer based booking system is an important tool to handle the logistics of patients and communication between the nurses, primary health care nurses, doctors, and assistant nurses in the little laboratory. The computer gives the nurses access to for example:

- The actual patients name, national registration number, and address
- List of the actual patients visits to the health care centre
- List of prescribed drugs to the actual patient
- The doctors’ patient-record
- The nurses’ patient-record
- A “note-book” where the nurses can communicate with others at the centre, for example send messages to a specific doctor regarding the patients that have got an appointment time
- Access to en intranet with e-mail, information about access to other health care providers, interpreters services etc
- The appointment schedules to doctors, nurses, and primary health care nurses

The booking system divides the day in 15 minutes periods. A normal visit to a doctor is decided to take 15 minutes. The schedule is marked in different colours, differencing different kinds of
15 minutes periods: A) emergency visits, B) planned visits to doctors/nurses to be booked by nurses, C) planned visits to doctors to be booked by doctors, D) doctors’ prescription time (time to write prescription - with or without patients), E) administration, F) coffee and lunch.

Notes from field work, waiting room.

8.07 The nurse looks up the patient’s list of visits to the health care centre, generated by the computer system. Maybe the patient has seen a district nurse? Asks question to find out about the patient’s problem. The patient has an appointment time to a district nurse today at 10. Rebooks to an acute time to see a doctor at 10.30. /…/

8.10 The younger man also wants an appointment time for his little sister. Her knee hurts. The nurse documents the first patient in the computer. She blocks a time to a doctor, if the sister should need it she says. Asks the sister, the brother, the girl to follow her to a small room /…/ I ask the brother if I can follow, it’s okay. The nurse examines the knee, it hurts says the sister. The mother says that the girl cries because it hurts. The nurse gives them the appointment time to see a doctor.

8.17 The computer says that the actual doctor has got an emergency patient. Tells the family that they have to wait a little longer than expected, even the father. /…/

8.42 All acute times are fully booked, There was one left but a patient had so big problems that three quarters were booked. Now the anxiety starts says the nurse (referring to all the patients in the waiting room). /…/

The rules decided by the health care centre staff says that emergency visits only can be booked the same day. The system did not accept that the nurses scheduled patients the next day on a ‘15 minutes’ marked as emergency visits. Other visits could only be booked one month in advance. Every day the system opened one new day for new bookings, one month ahead. Therefore the nurses often only could give the patient an appointment time the same day or after one month. Of course they could have given the patients a planned visit earlier if there had been windows in the schedule, but there was not any. This created a pedagogical dilemma for nurses encountering the patients, but also often an ideological dilemma when they had to refuse patients in need of care.

Gun-Britt: What would happen if you opened up your booking system for the next six months to come?

Nancy: All the times for appointments would very soon be fully booked. It’s no problem to fill the schedule. But it wouldn’t help. We had two blocked weeks and the pressure from the patients was so high that the two weeks were opened up in pure desperation. It was a very tough period. But it was only help for the moment, for that day. For the people who were there that day it was comfortable. But next day the problems were even worse. Because it’s hard for a patient to hear that there are no more appointments times until a month ahead.

The temptation to open the schedule is of no help. To handle the encounter with patients in waiting room, the nurses often break the rules they had created in the booking system. The pressure from patients was sometimes too difficult. Then they had to negotiate with the doctors.

They could use doctor’s prescription time, like for example a nurse did during my shadowing:

Notes from shadowing January 12th.
The booking list shows that there are no doctors’ “acute time” left this day. Earlier a patient with difficulties in breathing came to the centre and Nora had made a reservation of one quarter in addition to the already booked quarter, to make the situation tolerable for the doctor. Now she can see that this reservation is “taken” by one of the primary health care nurses. Maybe it’s another patient with difficulties in breathing she says. She tells me that she will ask a doctor with “prescription time” if he can see the patient. Nora goes to the doctor. The nurse comes back. Tells me when the patient has left that the doctor will see the patient besides the prescription work, that he had got three minutes to examine the patient.

The following situation concerns a patient who needs an appointment to get an extended doctor’s certificate of illness. But there are no windows in the booking system to the patient’s doctor.

Notes from shadowing January 12th.

11.51 The nurse says to me that she understands that the patients are worried about not getting an appointment in time.
11.58 The nurse can see in the booking system that there is an untaken appointment time to the actual doctor in February 8th, its eight day after the time limit of the first certificate. She knows that this doctor don’t want to write a retrospective certificate. I wouldn’t hesitate if it was the same doctor (as had written the first certificate).

The nurse goes to talk to the doctor and ask him if he can accept the date and a retrospective certificate.
12.01. The answer was no.
The nurse: I was allowed to give the patient a “planned visit booked by doctors”, marked with green colour in the booking system.

Also the doctors could handle the booking system in the favour of the patients:

Notes from shadowing January 25th.

8.20. The nurse tells me that the doctor knew he was the acute doctor this day. Therefore he had asked the patient to come back and book an appointment. He was not allowed to book the acute times one week in advance, they can only be booked the same day, but wanted to see the patient again after a week.

The patient who has got an appointment time gets a little piece of paper with the appointment time as a reminder to the patient to be there in time. Then the patient followed the stream laid out in the booking system. Pay the bill in the right counter window, go to the right waiting room, the nurse/doctor sees in the computer that the patient has arrived and paid the bill. Of course the doctors and the nurses talked to each other during the day but the most communication about patients took place by help of the computer and the patients’ record.

5 Accountability

5.1 Collaboration with colleagues and documentation

The booking system in the computer is a powerful tool in the ordering of patients. But it is also a tool that makes nurses’ work public.
When the staff start the computer they log in with their name and everything they write about patients in the records are stored with a signature. All the staff at the centre have access to the patient-record in their work with this patient, even after a long period.

The nurses’ documentation follows the so called VIPS model, a standardized model for nurses’ documentation. Other staff categories can read the text and utilize it as facts about the patients, but it is only the nurses who write the VIPS records.

Nora: /…/ we documented earlier too, we wrote a lot in the intensive care unit, everything we made with the patients, reports to the nurse on night duty, what had happened to the patients. But it was rather arbitrary with our own words and so on. The documentation became more precise, what do you refer to when you use that word? So it could be used internationally in a report, so we all know what we referred to when we used a word, that everybody referred to the same thing. And that is very good.

GW: Internationally, you mean
Nora: Yes in the different models that were growing. The VIPS model, you got search terms and so on.
GW: Do you still have this?
Nora: Yes we have models, caring models that we follow. It’s a part of the education today. The nurse education. How to do the documentation. It is very well developed in comparison to the sixties seventies when we wrote by hand, stories. The problem was that we didn’t know if we were referring to the same thing, no, personal valuation. It’s strange but it worked, it turned out well. No one can say that things happened because of the careless documentation. Or maybe it is so that one can do that, but I don’t know. Many of the questions of responsibility are related to insufficient documentation. There had been no time for documentation. But I think it is important, I try to teach my students how to do the documentation. And not because you must protect yourself but that it’s important for the patient, medical security.

The short contact, the continuity and the fact that people cannot remember everything about a patient from time to time if they see them only one hour every sixth months for example, make this public communication necessary. If a nurse leaves her position another nurse quite easy should be able to control the patient with diabetes, lung disease, high blood pressure etc. The work at the health care centre would not work without tools that make nurses exchangeable. Continuity is therefore not necessarily connected to a one and only person but created by help of collaboration with colleagues and public documentation.

But the documentation is not only of value for the patients and the nurses. The health care centre gets reimbursement from the region (Västra Götaland) depending on how the meeting with the patient is documented. The patient-record and the booking system are directly connected to the economy system.

5.2 Achievements – “sticks” and Tele Q

The result of the health care centre is among other things measured in relation to the number of visits by patients to doctors and primary health care nurses. However the doctors see fewer patients than they should. There is no lack of people who are willing to be a patient at the Haglunda centre. On the contrary, the waiting room is full and many are refused because there are no appointment times.

The economy system reports a visit by a patient as ‘a stick’. The reporting goes directly from the patient-record to the economy system. As indicated in the interview with the primary health care
nurse Nina, the ‘achievement is also measured per every individual. For Nina this is no problem, she does more ‘sticks’ than the agreement says. However, this is no help for the result of the centre.

*Gun-Britt:* Your performances are measured, can one say so?
*Nina:* Yes in a way yes, we have a calendar with booked appointments for the patients, we have no open activity. They call and get time for an appointment or I give them a new time when they are here to see me. We should do, what is it now, 2700 visits a year.

*Gun-Britt:* 2700.
*Nina:* Every primary health care nurse in this area, it’s a heavy district, around ten, fifteen visits a day. But educations, planning days, other meetings, telephone hours, are not included in this, we should answer a certain amount of phone calls per hour.

*Gun-Britt:* So it’s registered?
*Nina:* Yes everything is registered, all visits are documented, and all phone calls, in the patients record.

*Gun-Britt:* What happen with all this information?
*Nina:* Our economy department reads sometimes.

*Gun-Britt:* Un-identified?
*Nina:* Yes yes, they don’t get Sven Andersson has been here, they get a stick as we say.

*Gun-Britt:* Do you get feedback?
*Nina:* Yes we get monthly and quarterly reports.

*Gun-Britt:* How are you doing?
*Nina:* Very good, almost too good because we have been understaffed.

All care must be purchased by the region. This also means that the primary health care nurses, or anybody else employed at the health care centre, cannot start up new kinds of activities without a purchasing procedure. Time is measured during the working day, i.e. every appointment with patients gives a certain amount of money, up to a certain number of patients. If the health care centre staff sees fewer patients they get less reimbursement and if they see more patients than the agreement says, they got no reimbursement for the extra patients. Also visits to the primary health care nurse are purchased by the region and so are the nurses’ consultancies.122

But Nina also says that the pressure from management on the doctor is harder than it is on her. Her normal appointment time is 20 minutes (doctors 15 minutes), but for example, the diabetes patients can get 1 hour.

*Nina:* /…/ But the purchasing is so limited, and the resources are so limited, so we have to give up health promotion (describes health promotion as her main interest).

*Gun-Britt:* It is so?
*Nina:* mm. The primary health care nurses from this city district meet once a month and we discuss how to increase this aspect. Next Thursday the top manager from the primary health care participates. It will be a lot about home health care but also health promotion. As it is now we integrate health promotion in almost all our meetings with patients. But the patients are already ill when they see us. But we want to turn it in another direction, and meet the problem outside the health care centre so to say. A health promoting activity, community information.

/…/

*Gun-Britt:* Everything you do must be sanctioned, so you can count it as hours in your calendar.
*Nina:* Yes.

*Gun-Britt:* You can’t control your day in that sense.

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122 The patient also pays 60 SEK to the region when they see Nina and her primary health care nurse colleagues or have a consultancy appointment with a nurse. A visit to a doctor costs around 120 SEK.
Nina: No not basically, I can control if I should do administration or see patients. But the direction is fixed and of course I want to see more health promotion.

Nina tells me that that she can plan her day but she cannot introduce new activities outside the purchasing process. This does not stop her and her colleagues to discuss matters they think should be included in their undertakings with the primary health care manager.

The nurses that not are primary health care nurses, are not measured by ‘sticks’. Instead their performance is measured by availability. All patients should get an appointment the same day if they need one and 100 percent of all phone calls to the centre should be answered.

Every morning two or three nurses answer telephone calls from patients. As has been mentioned the telephone system has got the name ‘Tele Q’:

Nurse: /…/ (refers to Tele Q) the programme tells me which number to call, or if the patient does not have a press-button telephone which messages I should listen to. We can adjust how many phone calls we can manage per hour, it’s about eight per hour. And there we sit chained.
Gun-Britt: How many hours do you do with Tele Q?
Nurse: It depends which day in the week, but Monday morning if I don’t have (the waiting room) or is acute nurse, I sit there between 8 and 9, coffee break between 9 and 9.30 and the telephone again until 12.

The telephone is connected to a computer and the nurses can easily see on the screen how many phone calls they have been able to answer, different bar charts give them immediate response on their work. Nancy says that:

Nancy /…/ they (the primary health care nurses) answer the telephone between 8 and 9. This is new since two weeks. The politicians want to increase the availability and we try this way to do it. The patients should reach us by phone. Now it is so that about sixty percent of all phone calls don’t reach us, they are thrown out of the system.
Gun-Britt: Do they measure this?
/…/
Nancy: Mm, but we will be able to decrease the share I think.
Gun-Britt: How come?
Nancy: Last Tuesday on a network meeting we were told that we can adjust the number of calls you accept per hour. If you increase the numbers you open the queue. And that means that people don’t have to call again. Because we don’t know if it’s the same persons who call several time.
Gun-Britt: Yes.
Nancy: We have the network meetings (nurses from district Hisingen meet regularly) so we could share tips and advice. Those who had longer experience from Tele Q had noticed a decreased pressure in the afternoons when they opened up the queue. We were afraid not to handle so many phone calls, 40 per hour, we have therefore accepted a lower number to be able to answer them. But now we have tried the other way and it has turned out well.

The nurses can manipulate the Tele Q system and thereby also effect the outcome of their work measured as number of phone calls.

The primary health care nurses in the group interview say that they are accountable for the result of the health care centre and that this has created a situation where they have to leave the health promotion. During the interview they talk about themselves as an occupational group not
necessarily belonging to a health care centre, that their work could be organised separated from the centre.

*Nurse 2: The work of a primary health care nurse should have a preventive purpose, this is in our mission. But today we only work with ill patients one can say /.../ we do very little preventive work. Because there is no time left and the health promotion is left aside in a way. And now they are going to employ health coaches in every health care centre to do this job. But this is really the mission of the primary health care nurse, but we haven’t got any time for this /.../

Nurse 1: But the district nurse is more involved with serving the doctors and answering the telephone. When I started to work in the primary health care the district nurse could see patients rather free but now we have to adjust to appointment times and give service on the telephone. Be available in a different way, for the health care centre. And this is not why I took my education, to give service to a health care centre. But it was this (the prevention work) that attracted me. /.../ They take the primary health care nurse to the Tele Q and to the waiting room work. But a district nurse should not work like that.

The district nurses say that health coaches, a new occupational group, will take over the health promotion. They also say that they have to help the nurses to improve the availability of the health care centre.

The nurses continue by talking about the ‘sticks’.

*Nurse 2: To fulfil your achievements, this is what counts /.../ You must do a certain number of sticks every year. A diabetes patient takes one hour. An injection, you can carry out three injections in an hour, which is the same as three sticks. A diabetes patient gives one stick for that hour /.../ it’s no selection. /.../. One stick each.

The nurses say that ‘sticks’ is an imprecise device to measure achievements. But they also say that the there will be cut downs of staff if the health care centre do not fulfil the achievements agreed in the purchasing process.

6 Education and learning at work.

6.1 Specialist education and courses

All three nurses have years of specialist educations after their graduation as nurses, so have also the nurses that participated in the group interview. Some of them also had got their specialist education paid by the public employer. The later can indicate that specialist education is not only in the interest of the nurses, also the employer value the education. The paid education could also indicate a lack of nurses in certain areas during some periods.

Nora’s story about specialist education also reveals changes in the nurse education in relation to possibilities of employment. As mentioned, her nurse education from 1960ies included a specialist education in psychiatry. Since the late 1960ies, nurse education has been divided in two parts. A basic education is common for all nurses and leads to a legitimation as nurse. After basic education nurses most commonly also specialises. Nurses’ specialist education follows the medical division of health care areas, and thereby also the sub-specialization of medical sciences.

The length of nurse education has varied during the years. Nancy’s 2,5 years refers to 1960ies reform. The nurse education was again reformed in 1982. The entrance requirement was changed. The idea of recurrent education was emphasised in that the nurse education became a
second step, built on the Care line at the upper-secondary school level. The study programme in general nursing embraced two years and was leading to registration as a nurse. Like before, the education could be followed by a specialisation (0.5-1 year). This is Nina’s education. The nurse education was again changed to three years in 1993, and among other things introduced an own core subject, ‘nursing’ (omvårdnad) as a programme specific subject and a common base for all nurses, regardless of specialisation. The new education is three years and can like before be followed by specialist education.

Nora soon started to work with intensive care, a field that could be regarded as totally different from her specialisation in psychiatry. She tells me that she didn’t have to take a new specialist education. She only had to follow a more experienced nurse the first period. She also worked as a nurse anaesthetist interchangeably with the work in the intensive care unit without specialist education in this field.

_Gun-Britt:_ Did you have to take another specialist education in intensive care?
_Nora:_ You could just start and work beside a more experienced nurse, and get a good training, or yes, a learning period, and then I started to work.
_Gun-Britt:_ You worked together with a nurse?
_Nora:_ Yes, but that was not enough, we alternated between the anaesthetics and the intensive care unit. I worked as a nurse anaesthetist during long periods. I was an apprentice, and worked together with a nurse and administered anaesthetics to the patients. This was because you got to have up to date knowledge in both areas. But I was never alone, there were always people around, experienced nurse anaesthetists and anaesthetist doctors, so I was not alone. But I was allowed to do a lot.
_Gun-Britt:_ What you are saying, as I understand you, is that it was possible to work in different specialties?
_Nora:_ Yes, that is what I’m saying.
_Gun-Britt:_ And today, as a psychiatric nurse, would you be able to
_Nora:_ No, no.
_Gun-Britt:_ be a nurse anaesthetist?
_Nora:_ It’s unthinkable.

Until the end of the 1970ies, Nora’s education was sufficient. “This was a period when they said that five years of experience from practical work at an intensive care unit is the same as specialist education”, says Nora. But after that she had to do something about her specialist education. She could not get a permanent position in somatic care without a specialist education. Therefore Nora entered the specialist education medical and surgical care. This education was one semester and because her children still were small, this was easier for her than the one year intensive care education.

During the group interview the nurses talked about shorter (five to ten weeks) university courses for nurses. I asked them if it was important that it was university courses:

_Nurse 3:_ Yes that is what it should be.
_Gun-Britt:_ Who says so?
_Nurse 2:_ Our salaries are bad of course but this is.
_Nurse 1:_ Quality.
_Nurse 3:_ Quality, yes, but it is for negotiation of salaries.

When I asked them what they wanted to know more about the answer was to keep up to date with things. “What you learned three or four years ago can be out of date”.

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But the nurses at the Haglunda centre have also access to shorter courses. They get a certain amount of money every year and can on their own initiative participate in courses. Nora for example participates in a course in relation to a new project she is a part of about help to alcoholics.

All nurses at the Haglunda centre participate in regular formal meetings, both concerning management information and continuing education. However, the nurses and the primary health care nurses do not participate in the same meetings. The district nurses have their own formal meetings and their own network with other primary health care nurses in the city district. So have the nurses.

6.2 Analysing effects

A conclusion from the previous section is that formal education is an important aspect of nurses’ expertise. It is also interesting to notice that the nurses at the Haglunda centre emphasises their different specialist educations by having two different networks for continuing education.

The following illustrates a more evidence-based approach to knowledge production within a nurses’ community of practise. Evidence is here related to quite standardised procedures.

After her appointment with a diabetes patient Nina shows me a checklist she has made for follow ups of patients with this disease. She says that she uses it to show the patients their changing values over time and to help them change their habits regarding food and exercise. The check list is used by the other nurses too and contains the following: weight, Body Mass Index, blood sugar and result of other tests (related to the kidneys), blood pressure, information given regarding cost, exercise, smoking, alcohol, hyper- and hypoglycaemia, care of feet, inspections of feet and place for injections, patients own tests etc.

The check list works as a tool involved in the construction of a diabetes patient. It decides what aspects are regarded as most important for the nurse to pay attention to. The nurse analyses blood and urine and try to persuade the patient to change her behaviour so the values become normalised.

Another tool involved in the construction of the diabetes patient is the guidelines from the Diabetes Association with ‘normal blood sugar values’:

<table>
<thead>
<tr>
<th>Good</th>
<th>Limit</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before meal</td>
<td>5.0-7.0</td>
<td>7.1-9.0</td>
</tr>
<tr>
<td>After meal</td>
<td>6.2-9.0</td>
<td>9.1-11.2</td>
</tr>
</tbody>
</table>

If the test values are too bad Nina contacts the patient’s doctor, probably by writing a note to her/him in the computer. The test values are widely spread and used in many contexts. They are used by Nina as a controller of the patient’s diabetes. The same ‘normal values’ is of course also used by the doctor, but in relation to diagnosing and prescription of treatment. The same ‘normal values’ work differently in different systems of expertise. They can be regarded as a ‘boundary object’ (Star & Griesemer, 1989) in the communication between Nina, the patient and the doctor.

Nina says that she sometimes blames herself for not being good enough if the patients do not change their way of living in relation to their disease. Sometimes the patients do not understand because of language problems. She often uses an interpreter but this is not easy either. It takes time to learn how to communicate by help of an interpreter. It is easy to loose control over what is said during the talk. Does the interpreter really understand the message?
Maybe I have had a whole day with diabetes patients who don’t have looked after their health. I can feel that I have given everything but they have not been listening. I can have that feeling, and that is very tough. And you can often mistrust yourself. It must be something wrong in the way I say things, or is it that they don’t understand? There is much language confusion here, in all our work. I work a lot with interpreters. And this is also something I have learned. I rather work with a professional interpreter than a relative. Because relatives talk in a different way. And one thinks that the sentence I’ve just said shouldn’t be so long even if it is in that language.

During my visits at the health care centre I sometimes noticed angry patients who did not get what they wanted. Sometimes this probably was part of a language problem. If neither the patient nor an accompanying relative hardly understood but just a few Swedish words the situation could be tricky. The use of interpreters was often important both during the consultancies and in the sorting of waiting room patients.

Changing patients’ way of living is a quite complex task. If a person do not understand Swedish it can be tricky to rely on normal test values as a tool to communicate with patients. The use of interpreter also changes the speech situation. Nina says that she looses control. There are no standardised procedures or simple tools available. But the interpreter can also be regarded as a tool, mediating the situation. Other tools are the length of the sentences. When such tools are used by the individual nurses, the interpreting situation takes from.

7 Demands as described by nurses

As has been mentioned, the PROFKNOW project deals with knowledge at work, situated between state and citizens. This section deals with nurses’ stories about demands they have experienced in their meeting with the management and with pupils and parents.

7.1 Demands from management

The health care centre should fulfil the commitment regarding number of patients’ visits to doctors/primary health care nurses and thereby also keep the budget. The nurses’ handling of the logistics in the waiting room is, as mentioned, directly connected to the economy system. But the management also demands that the health care centre should give an appointment time the same day to all patients who need one. No patient should also meet an answering machine saying that all lines are busy, a nurse should answer.

Nancy and Nora talk about the end of 1980ies and beginning of 1990ies as a period when the management demands on nurses changed. Both of them worked as head nurses in an acute hospital at that period. Nancy says that:

The demands on the head nurse were high. Earlier it was a kind of retreat position for a tired nurse. If you had worked for a long time in a ward you sooner or later became a head nurse. And this is wrong. It should be the person fittest for job that should get it.

Nora says that the economic aspects that appeared in the 1980ies/1990ies were not only a change for the worse:

Nora: But of course it was good to be aware of this, it was quite comfortable in the 60ies and 70ies. You just did your job, and it was of course important to do a good job and you
got (your continuing) education from the doctors and so. But when you become aware of what things cost.

Gun-Britt: Become aware of? What happened?
Nora: How to say it, for example if something should be done, call the porter to change the oxygen cylinder, it was always like that, nobody knew nothing but everybody just came and did these tasks. And the lab came and took the tests, we had no idea of how much it cost to take tests and so on. But suddenly everybody was responsible for their own budget. We were not allowed to call the porter, we had to learn how to change the oxygen cylinders, and we had to learn how much it cost to take tests. We just cannot take a lot of tests if the tests are not motivated.

Nora: This was a new way of thinking for us in the health care. But it makes no harm, but sometimes maybe one could have wanted not so much focus on the economy, but this is what happened.

Both Nancy and Nora describe the current economic situation as very different from what they experienced earlier.

During an interview a nurse shows me a letter concerning strategic goals for the health care centres in the area. The letter is sent by e-mail to all employees and says that an economy in balance is the superior goal. The nurse is angry when she shows me the letter. She says that she has heard this before but never seen it in print before. She also says that the demands from the patients and the demands from above are conflicting.

The nurse: We are reimbursed in relation to how we do the documentation (shows me on the computer screen).

Gun-Britt: Someone is measuring your work? Because this must be connected to the economic system?
The nurse: Yes we are measured against how much money we generate and they can also see what we actually do by looking at our notes.

Gun-Britt: Do you get feedback?
The nurse: Hmm, do we get feedback? Not yet, I cannot answer this. We have just made a point of getting the money. But the demands from above and from the patients, they are incompatible. It’s impossible. I don’t know how a person should be like to handle this. You must have blinders on and a good fellowship within your work group and try to survive the day. And now we were told by our head district official that the economy should be prioritised before the patients. It’s clearly stated in the text.

Gun-Britt: It says?
The nurse: That the economy is more important than the patients. I’ve never seen this in print before. Now it is stated that the economy goes before the patient.

Gun-Britt: From the region?
The nurse: Mm.

Gun-Britt: What kind of text is it? Do you know that?
The nurse: It’s here in my e-mail. I’ve seen a lot. But never so harsh statements... strategic goals, could it be this one? Mm (opens the document).

Gun-Britt: Yes, strategic goals 2006, (reads from the document) there, “in the year 2006 two strategic goals are superior, namely an activity in balance regarding economy and increased accessibility but the economy is superior to everything else”.

Another nurse says that she never had a feeling there was a lack of resources during her previous work. There could be long waiting lists but they gave priorities to certain patients and asked others to wait.
But I never felt that we were not good (= have resources) enough. It is not an alternative at a health care centre to ask people to wait, they close every evening. But now we must be the police in an organisation we cannot influence, this is different. It’s not about economic consciousness, because this I think is good, it’s something else.

The nurses describe a contradictory situation in relation to demands from management, doctors and patients.

7.2 Demands from patients

When I ask her, the nurse says that her job is about meeting with patients. She tells me stories from her workday illustrating that these meetings can be difficult and they can be good.

A nurse describes a pressure from the patients, in particular related to her work with the sorting of patients in the waiting room and the Tele Q system. As has been described above, there are not enough appointment times to see a doctor for the patients who are in need of care. Daily she must tell the patients that they cannot see a doctor, even if they need to see one. The patients’ must try to get an appointment somewhere else. Many patients get angry.

The nurse: The hard thing is not the telephone but to treat the patients in a way that they feel satisfied, even if they have got nothing. That’s the trick of our job.
Gun-Britt: Yes I saw that, it was pretty tough (referring to shadowing).

The nurse: Mm, mm. Sometimes they get angry, regardless of what we say. It’s frantic here sometimes. The illness rate among women is high, the highest score in Göteborg. Many are reported sick, a lot of people from different countries, different cultures, and we as women should not tell men how to behave, they get mad at us, yes many things happen, many threats.

The patients can sometimes get so angry that they hurt the staff. Nancy tells a story about a (female) doctor who was attacked by a man. She used the alarm but the sound was so low that none of the other staff could hear it.

But Nancy also tells me many good stories about her meeting with patients and how fun it is to work in the health care centre.

You get many laughs here too. Yes we have great fun here. You meet relatives, the old women from Turkey, they have been in Sweden for a while now but they cannot speak Swedish. Their sons act as interpreters, and their daughters. You get in contact with the whole family, it’s exciting to see the interaction between the family members. I had a patient at my consultancy hours, a man around sixty. He was rather ill but he always worked, he loved his job even if he should have been granted an early retirement pension. He wanted to work and he loved life and was always in a good mood. He had his mother with him she also had bad lungs and often came on an acute visit to us for treatment. One morning I met him near the place where I live, he gave me a hug, and told me that I always was so kind. He should now visit his home country and asked me if I wanted something from his home country. Yes I said. Do you want plums or wine he asked. Flowers would be nice I answered. No I said plum brandy he said. So I said yes to plum brandy that morning, it was so funny. They are so generous, but it was so funny that I got it wrong. Yes they show their feelings, if they are angry they are angry. And that is good for me, because I feel that it is easier for me to get angry, and easier to be happy, to be the one I am. I’ve learned that from them. It’s very interesting, it’s like a new occupation.
Nina says that it sometimes can be difficult to meet men from other countries and to tell them how they should live.

*Gun-Britt: Did you know what it was like here when you came?*

*Nina: No I didn’t. I knew that many immigrants lived here but not the effect on my own work. I had practical work in Torslanda during my primary health care nurse education. That health care centre worked in a totally different way than we do here. It’s often difficult here when the men come as patients and I sit here as woman and give directives. Often I ask them to bring their wives and that could also be a trouble for them. I often ask them, who makes he food at home and who buys the food, and to do it that way. It can also be a problem when a woman needs care and to get the husband to understand that she needs her own appointment time. That she needs time for exercise, physiotherapy or what it may be. There are many cultural misunderstandings. But also interesting. I like it when I don’t have the answer ready all the time.*

All nurses say the work at the Haglunda centre could be rather tough sometimes but also that they like the job and that they do not want to change to a job at a health care centre in an “easier” city district. So does even Nora say, even if she decides to leave for another job. The nurses never complained about the patients, neither in the interviews, nor during the shadowing.

### 7.3 Demands from doctors

A nurse describes a terrible work situation for the doctors. Her actions affect the doctors’ work situation. She says that she tries to protect them and give them a better work situation but also that the pressure from the region is hard to increase the number of visits to see a doctor.

*The nurse: /…/ But you cannot go on so long here, to say no, say no and say no, it’s heavy for me, for the body and mind so to say. Even if I know that we do as good as we can, we actually do that. But we can change small things on the surface, like changing the booking system, different projects, as now we have the breakthrough method, how to become more effective.123*

*Gun-Britt: What is it?*

*The nurse: Yes they try, the region, they try to change our way of working with the appointment booking to see a doctor and the way we plan. How to plan emergency appointments in relation to next visit appointments. To make things more effective. But if you are a little unkind you can say that this is about whipping a dog that already lay down. But maybe this is not so serious, I don’t know. I don’t know, maybe it would work, because there are successful health care centres. But how to change from twelve, fifteen patients a day to 25, I don’t know how to do it.*

*Gun-Britt: A day?*

*The nurse: Yes, and I don’t know how to manage with this. They (refers to the doctors) are already tired with the number of patients they see today. But of course, some of the meetings, administration. Yes you must have administration. But how to make consultancy work more effective, that’s what it means.*

*Gun-Britt: So your job governs the doctors’ work situation too?*

*The nurse: Yes.*

But the pressure from doctors is also more direct. During my shadowing a nurse told me that she had made a booking she knew the doctor wouldn’t like. “Now we soon have Disa (the doctor) here she says. And Disa soon turned up. The nurse laughed and told Disa what she had said to

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123 Nora says that this method has not changed any routines yet and they have not got a report from the work group yet (a nurse, a doctor and the head of the centre are involved in the project).
me. Disa laughed too but also said that the patient wanted a doctors’ certificate of illness and that he was trying to deceive her. The social insurance office would soon complain and Disa could get a bad reputation if she writes certificates too easily, she argues. (The nurse’s argument was the patients’ high blood pressure).

But the situation contains more than the dispute about the appointment time. According to management demands every patient should only get 15 minutes appointments. During the shadowing I could notice that the nurses often booked 30 minutes. They knew that 15 minutes was too short for some patients. But Nora says that she has to think about the doctor too. It can be very difficult for a doctor to have too short time for a patient with multiple problems. Both Nancy and Nora said that the job turnover among doctors is high. If a doctor leaves, the situation will get worse with even less windows in the booking system. The nurses also worry about the doctors’ health; they say that some of them have been reported long term ill because of the pressure from workload.

One day, when I came to the centre to talk to the supervisor a doctor was in her room. The supervisor asked me to stay and listen to what the doctor had to say. She complained to the supervisor that the nurses gave only fifteen minutes to patients with for example depression. Sometimes it also takes fifteen minutes for an old patient to undress before the examination, she said. The supervisor also told me that the demands on her from management was to only give patients 15 minutes, never answer a patient that there are no appointment times to see a doctor left. This is the message she has to give the nurses – and the doctors.

7.4 Demands from actors outside the health care centre

A nurse says that she sees a new kind of patients in the primary health care, the acute care send them to primary care much earlier than they did before. Today, she says, the social insurance office more often deny people the right to be on the sick-list even if they are given a certificate from a doctor at the health care centre. Nurses have to face the patients when they come back and are angry. The doctors say that they cannot write more on the certificate than they know and the patients say that they cannot work. The nurse has to face the patients and this is often a very difficult situation to handle. She can do nothing because this is a question for the doctors. And, she adds, the doctors cannot do anything either, they have written everything they know.

The nurse: /.../ It could be nice to work here, and it is nice to work here, but it is so heavy because of the lack of resources. It affects my body and my mind, this is absolutely impossible to do with the available resources.
Gun-Britt: But the politicians often say that they want to develop the primary health care. Is that something you hear also?
The nurse: I think they talk a lot about preventive work and health care. We have a primary health care nurse with this orientation, and nurse consultants who talk about exercise and smoking and such things. But many things from the inpatient care are transferred to the primary health care. Much more than I am used to from before. Many doctors send the patients directly to the health care centre from surgery, without even starting a sick leave period, this is a shame I feel, and old doctors too, that they don’t start the sick leave period. Some doctors start the period but it happens that they send them to the primary health care instead. Then we have no idea about what has happened. They investigate the patients’ problem but they don’t want to give them a sick-leave. And they refer the patients to the health care centre for x-rays. This is an economic question. We have the responsibility for the patients, they are consultants, and please do these tests. The tests will then appear on our account. So, so much as possible to the primary
health care, and sick-lives that they don’t want should effect on their own statistics. Now I’m mean but.

Gun-Britt: What you say is that the acute care and the primary care try to cut costs, that the acute care...

The nurse: That’s my interpretation. I wish it was like before. When they did the investigation, the surgery, the patient got a sick-leave and was referred to primary care for follow up. But now we get involved in an earlier stage. It’s so much economic thinking in everything we do. But of course you can see it this way. We live in a big city. There are lots of clinics, you can see it that way too. They turn to the health care centre, we have a responsibility for the district, we should be able to take care of them but we can’t. The resources are limited, they must be sent to other clinics, there are private clinics all over the city, emergency departments, different kinds of clinics. But sometimes they cost and often the patients don’t want to, or can, pay.

But it is not only health care actors that put demands on the centre. In the local press the availability of the health care centres in the city is a recurrent topic. During the group interview a nurse said that:

Nurse 2: One gets furious when reading the newspapers saying that at this and this health care centre they manage (the achievements). And then I know about the populations there (not so many unemployed, unhealthy people, immigrants and refugees). You know, I get furious. /../ here you get the list /../ the debate is so untrustworthy

7.5 The professional “no”?

The nurses say that it is possible to make the correct priority regarding patients, but that it will not help. There are not enough appointment times to see a doctor.

Nora says that she wishes that the politicians would say that we do not have more resources instead of blaming the health care staff for not being good enough:

/../ And I can imagine that they will understand the day they become patients themselves. But it’s no use just to tell them because they have only the money they have, they have got a certain amount. I can understand that. But it would be interesting to know how they think, I think it would be fair if they said: this is the way it looks like in the primary health care. Then I would accept it. But they don’t, they try to convince us that it is better than it is. But it would be interesting to talk to them. /../

The nurses have meetings regularly with the supervisors. Thereby they follow the line of authority. Can they use this way to say ‘no’ if they do not accept the situation? Probably not. The supervisors are pressed also and have to follow up the economic incentives and to find out new methods to make the work more efficient. Nora says that:

We change and change and change all the time, I think this is typical, since I started here. One thing is tested, now we do like this, okay, and then it will work for two weeks. And then it falls. And that is a mystery that I don’t recognise from my earlier work. That the routines don’t work /../ all the time improvisations and urgent measures so that this whole apparatus don’t go to pieces.

But the nurses sometimes give the patients the time they decide the patient need, even if it is more that 15 minutes. This is also a professional ‘no’.
7.6 Life at home and life as a nurse

Nora describes the work as psychologically pressing, that she often is not able to give the patients the care they need, that she often has to say no to patients who need to see a doctor. The job is not hard and stressing in the way that we can fear that the patients should die or something she says, “but it’s the other thing, the lack of resources, that is stressful”.

I have never felt so inadequate, anywhere. And that is remarkable. Because it really is very nice to work in a health care centre, mixed ages, the panorama of diseases is wide. Only if we had the resources. Because this is a nice work.

Nora says during an interview that somebody should say that we do all we can with the resources we got. She has decided to leave the job.

Another strategy is expressed by nurses during a group meeting. They say that the job is okay. We do as well as we can and that is enough, and of no problem.

Nancy says that she tries to see the nice aspects of the work, even if she thinks that the conditions are bad.

Nina has got help from the supervisor to reduce her commitments. She is involvement in an EU project that occupied here even outside working hours. She also says that she have had difficulties to say no to patients. Nina is a health coach and also tries to influence the staff at the Haglunda centre. I could also notice that the lunches and coffee breaks were scheduled for nurses and doctors.

8 Concluding comments

8.1 What does restructuring mean?

The health care system in Sweden can easily be described as a complex web of specialisations related to diseases, organs, ages, gender, techniques, service functions, different providers, and different political levels etc. Different actors with their specific qualification provide measures ranging from general prevention to advanced acute surgery. All this is institutionally defined as health care.

In terms of specialisation, restructuring at the Haglunda centre means that a specific stream of patients is directed to a specific provider: the primary health care. Patients should not visit the expensive emergency units at the acute hospitals if their problems can be handled by the cheaper provider. No patient should be denied care and should only be referred to another provider if the centre is not qualified to give the care. The idea is that it must be easier for patients to visit the health care centre than the acute hospital emergency unit.

The incentives are economic and regulated by a purchasing procedure. The health care centre must reach the agreed achievements. If not, the threat on the health care centre is loss of resources and thereby also reduction of staff. Self-regulating tools such as measurements of ‘sticks’ or measurements of availability are introduced. This highly effect nurses and in particular the professional configuration of the primary health care nurses.
8.2 How is restructuring working

Restructuring is working in terms of measurements of achievements in relation to occupation:

The purchasing procedure decides what the health care centre should achieve. The nurses talk about the patients as ‘sticks’ in the economy system. Every time the doctors or the primary health care nurses see a patient the health care centre gets a ‘stick’. But only if they see patients for purposes that follow the agreement. The primary care nurses can for example not develop their interest in health promotion. This will not be reimbursed by the responsible political level.

The computer-based booking system, the patient-record, and the Tele Q are connected to the economy system. Thereby the actions taken by nurses, when documented, also are used for other purposes than for the benefit of patients or facilitating nurses’ work. The booking system, the patient-record, and Tele Q make it easier to organise the work when giving the patients appointment times or making notes of patients’ conditions. But Tele Q also generates lists of the availability. And the booking system and the patient-record also generate ‘sticks’. By measuring the ‘sticks’ and the availability the management controls the activity.

The division of labour between nurses and doctors concerning patients’ appointments, the rules connected to the booking system and the reimbursement from the region create strong tensions in relation to nurses’ work. Restructuring in terms of measurements of achievements thereby also creates a contradictory situation for the nurses when they work with waiting room patients or Tele Q:

The nurses’ actions effect the doctors’ work. If the doctors get to many patients, they do not cope with the situation and leave. With too few doctors the centre cannot fulfil the obligations as related to the purchasing procedure. If the doctors’ get fewer patients and thereby cope with the situation, the centre cannot fulfil its obligations. Whatever the nurses do when they sort the patients will be wrong, and the health care centre looses money. This contradiction is visible also in relation to patients. If the patients get the time they need the centre gets fewer ‘sticks’, looses money and risks a reduction of staff. It will most likely become more difficult to get an appointment then. If all patients get a 15 minutes appointment, most likely some of them will not get the care they need. The computer is a tool at work between patient and nurse and makes the patient a 15 minutes ‘stick’, a situation that is problematic for the nurses when they regard the patient as in need of a longer appointment with the doctor.

Restructuring is here also working in terms of a new occupation: the health coach. This will be discussed further under the next heading.

8.3 Professional configuration

The nurses say that health coach is a new occupational group that soon will take over health promotion. The nurses interviewed also talk about health promotion as the essence of the primary health care nurses’ work. The situation illustrates that health promotion issues are still regarded as important questions by their employer, which also follows what is pointed out by the Health and Medical Services Act of 1982.

However, the situation also illustrates a reconfiguration of the primary health care nurse.

The interviewed primary health care nurses talk about themselves as different from nurses, and that they not necessarily are a part of a health care centre. Health care centres were mainly established for doctors’ work and the nurses employed at a centre should give service to doctors.
The primary health care nurses’ work was described as different from nurses’ work. During the shadowing I could notice that the nurses and the primary health care nurses most commonly arrange their meetings for management information and continuing education separately from each other. If they have meetings together, other staff at the centre is involved as well. The primary health care nurses are not part of the nurses’ assignment system with help of the white board in the telephone room. Another thing that distinguishes the two nurse categories is that patients’ visits to a primary health care nurse generate ‘sticks’, but not visits to the nurses. However, the nurses also had responsibility for long term follow up of patients, just like the primary health care nurse.

Demands of availability now “forces” the primary health care nurses to carry out nurses (sic!) work like Tele Q work and sometimes also waiting room work. They become more involved in the health care centre as a total, including a responsibility for the economic achievements. They can neither just care about their own work with patients any more nor can they just care about their own achievements related to the purchasing procedure. This could indicate that the difference between primary health care nurses and nurses is decreasing.

However, the primary health care nurse can also be described as belonging to a primary health care team. We can then talk about a net of professions, or an internal care chain, where every profession contributes with specific competences to the overall care of the patients. The Swedish primary health care was developed during the 1970ies and 1980ies with the establishment of health care centres and the primary health care nurses got these new centres as their base. Earlier they most often had had their base at primary health care nurse centres and with responsibility for the population in a certain district. In smaller places the primary health care nurse centre often was the same as one nurse with responsibility for the whole family and their health related problems. The Ädel reform in the beginning of the 1990ies also meant that the municipalities now are responsible for care of the elderly that earlier was provided by the primary health care nurse. The former single nurse now becomes a node in a care chain of other occupations (internally at the health care centre) and providers of health care (for example, when acute hospitals send patients for follow up after surgery).

However, there are also tools in use here that strengthen the profession of nurses. For example the documentation system VIPS is a powerful global classification tool, not only to categorise patients or to use for economic purposes but also for stabilising a nurses’ community of practise by pointing out what nurses should pay attention to and what they should document. The system of documentation holds the profession together but also makes nurses exchangeable. Other nurses can read the patient’s record and take over the responsibility. The latter is important and is not something new for nurses, but maybe for the former primary health care nurse with responsibility for citizens in a district. Most nurse categories have always been exchangeable in relation to patients. This community of practise will not work without exchangeable nurses. They most often see patients very seldom. The patients are dependent on the care giver and they must also rely on the documentation system to get the care they need.

Another characteristic of nurses’ work is that they most commonly see single patients and rarely patients as a group.

Also guidelines, for example from the Diabetes Association, work as stabilising tools when used by nurses. They are involved in nurses’ interventions in relation to work with patients.

8.4 Professional strategies
Nina’s story is about her occupational development. A turning point is when she decided to become a primary health care nurse and got the job at the Haglunda centre. Her work today engages much of her time also outside working hours. She participates in a development project financed by the European Union, she develops tools for control of patients with diabetes, she makes food lists etc. Her supervisor has helped her to cut down her commitments. Nina is also interested in health promotion and wants to develop this aspect of her work. However, the purchasing procedure decides what she can do. In her meetings with patients she can develop her interest but not as an activity as such. She has also got a new task in that she has to answer the Tele Q in the mornings to help the nurses. According to demands from management, the Haglunda centre must answer more telephone calls. In short, Nina has to give up parts of her main professional interests in relation to measurements of achievements but together with colleagues she also try to discuss the importance of health promotion issues with the primary health care manager.

Nancy tries to coop with a work situation she describes as sometimes very pressing and sometimes very nice. She gets support from her nurse colleagues and talks about the group of nurses as very important for her work situation.

Nora decides to leave the Haglunda centre. The remarkable with her story is that she has faced very difficult situations in her early work life, with an enormous lack of resources, in Afghanistan and Tanzania. Now she works in a safe, well-equipped, nice and very clean Swedish health care centre, and says that “I wish I didn't care” about lack of resources and the sorting function”. She talks about a work situation that she cannot tolerate and decides to leave the job.

The professional ‘no’ is week. The nurses meet the line of authority in the meetings with the supervisor and then as demands from management regarding adaptive behaviour. Nurses are only controlling resources by their adaptation to the defined achievements. They have no other choice but to fulfil achievements to avoid threats of staff reduction. However, the doctors demand to see some patients for a longer period than 15 minutes. It is reasonable to believe that the nurses try to arrange longer meetings with patients in relation to these demands, but mainly because nurses also regard the longer visit as very important in relation to what they regard as the need of patients. This creates a contradictory situation for nurses when meeting patients.

**Literature**

SFS 1982:763 *The Health and Medical Services Act.*

SFS 1985:562 *The patient-record act.*


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CHAPTER 8

Finnish nurses

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1 Introduction

The aim of this report, which is a part of the work package 5 of the PROFKNOW\textsuperscript{124} –project, is to understand Finnish nurses’ views on and responses to the structural changes of the Finnish health care and health care institutions. Changes in the health care are connected to the broader phenomenon of restructuring of welfare state institutions. In this report, these changes are approached by looking at the nurses’ responses to the aspects of their work, profession and professional lives. This analysis is based on the interview and observations of three women nurses who belong to different generations\textsuperscript{125}. The issues of (1) working conditions, (2) professional knowledge, and (3) social position will be examined. A context to their responses will be provided by presenting relevant information about structures and structural changes of health care and nursing profession in Finnish welfare state. The work packages one (Moore 2005) and two (Moore et al. 2005) alongside other sources are used. Brief life-histories will be provided in order to contextualise individual nurses’ views, accounts and responses, and to set them as representatives of their generations.

The aim of this report is to understand nurses’ responses as conditioned by their past and present social positions. Some of the information about the social structures can be used to locate the interviewees on these social positions. For instance, demographic information about the nurses provides tools for this kind of contextualising. In addition, the changes in work organisation and the cultural discourse of professional identity are two aspects of the structural forces that condition nurses’ life. But the response may be understood as a two-fold process in a sense that the conditioning structures which are also objects about which they talk about in their life stories are at least partly constructed through their responses.

1.1 The interviews, observations and their methodology

The nurses were first approach by contacting the head nurses of the town’s health centre. A head nurse gave names and contact details of nurses who she thought would be interested in participating and who would fit the criteria we presented – we needed three nurses of different generations. The nurses were contacted via e-mail and telephone, and three volunteers were found. With each of them a life story interview, a thematic interview and three days of fieldwork was conducted.

The methodological guideline of the life story interviews was to avoid leading the interviewee according to the interviewer’s assumptions and views on the issues in question. The interviewees were simply asked to tell the stories of their lives, and it was mentioned, that the researcher was especially interested in their professional lives, in order to motivate them to pay special attention to their professional histories. They were not discouraged to tell about their personal lives as well. During the interview the interviewer asked questions in order to motivate the storytelling.

\textsuperscript{124} Professional Knowledge in Education and Health: Restructuring work and life between the state and the citizens in Europe. EU 6\textsuperscript{th} Framework Program, Priority Citizens, Contract No. 506493.

\textsuperscript{125} The three female nurses were born in 1973, 1964 and 1956. They will be referred to using pseudonyms: Jenna (1973), Leena (1964) and Helga (1956).
These questions were made in a manner that followed interviewee’s story. The attempt was to let the interviewee decide the storyline her/himself. The aim was to find out the things that the nurses themselves brought up and thus considered as significant in their lives and work.

The thematic interviews were semi-structured in a sense that the given themes (see Appendix 1) were covered without restricting interviewee’s accounts too much within each theme. The interviewer asked more precise questions within each theme, and bore in mind that he should avoid steering interviewee’s views and accounts according to his own views and assumptions.

Three days of fieldwork were conducted with each of the three nurses. The guideline of the observations was to pay attention on the activities of the nurse. The observer wrote field notes which consisted of reports on what happened and when. The observer wrote in a colloquial manner what the nurse did, and how the clients responded, and what was happening in different settings.

The data consists of 37 pages of interview transcripts, translated from Finnish to English, and of 30 pages of field notes in Finnish. This material was further analysed thematically. Short biographies of each nurse were produced, and their answers on different themes were gathered, along side with the analysis of the work packages 1 and 2, and other sources in order to explicate the relevant structures and structural changes in relation to the themes.

1.2 The theoretical position of the study

In this study, the nurses’ responses to the various structures and structural changes are approached by looking at them as socially conditioned practices. In these practices “embodied history” and “objectified history” are brought together, as Pierre Bourdieu (1981, 305) notes. The objectified history is a history which has accumulated over time in procedures, rules, regulations, job descriptions, instruments etc., that form the symbolic and material reality and conditions of the work. The nurses interact with these objects, that may be tangible, such as spaces, documents, instruments and machines, and also intangible, such as ideas and regulations. Also people (patients, clients, doctors, assistants, clients’ relatives) who the nurses interact with, cure, care, advice, and co-operate with can be considered as objects in this sense.

The nurses differ in their approach and style to interact with these objects. This difference is approached here as looking at them as carrying, or being carried by, different habitus. The habitus is a set of dispositions which incline agents to act in a specific manner. The habitus consists of dispositions, capabilities, aptitudes, interests and preferences that agents have concerning different objects. These dispositions are acquired in past practices, in which the agents have been engaged in, in the nurses’ case in their professional education and training, but also in their personal lives, in hobbies and such. Their habitus have been formed in different kind of settings and environments. These different kinds of settings can be approach theoretically, for instance, by approaching their difference in terms of gender, generation, class, educational system etc.

Thus, by the virtue of the habitus, the nurses differ in how they appreciate, are interested in, prefer, and are able to do particular tasks, and in their style and manner to carry out their duties. The new demands, such as for instance, increasing need for detailed documentations may be welcomed as a new, interesting challenge by one nurse, while other finds it totally useless and stressful additional burden on an already too heavy workload.
1.3 The research problem and the questions

We will investigate, how do the structural changes of welfare state, especially in the field of health care and nursing, contribute to professional lives and knowledge, how do they relate to particularities of the individual stories and to the generations that they represent. Furthermore, how do the nurses perceive and respond to the changes in health care policy and related alterations in nurses’ tasks and roles? What implications there are for nurses’ identity and knowledge (expertise)? What are nurses’ conceptions of their professionalism, expertise and knowledge?

2 National context and local context

In this chapter, the structural and institutional context of the nurses’ work will be examined. Changes in Finnish health care system, its administration and financing, and changes in the educational system of the nurses will be mapped. The significant recent changes contributing to the local context will be highlighted as well. Finally, the local context of the study, the health centre and the working units, are described.

2.1 The Finnish health care system and nurses’ education

In 1964, National Health Insurance Act introduced social income during sick leave and reimbursement for private outpatient health services and pharmaceuticals. Another reform was modernization of the hospital system around central hospital in 1950s. The major social policy concern behind the reforms was the regional and social differences in the availability of various health services. The expansion of health care services meant also an increase in the number of medical doctors and need for educated nurses.

Before Public Health Law in 1972 and creation of a system of primary health care centres in municipalities, primary health care was organized by private municipal and town doctors. The specialized care was strengthened in central hospitals in 1972. The predominant division of health services, provided to citizens, to primary health care (health centres) and specialized care (hospitals) was created.

In the 1980s The Ministry of Social Affairs and Health were unified, administration and planning was rationalized and centralized, and health care and social services were put together into the same national planning and financing system (“five-year-planning”). So called population responsibility and system of personal doctors were introduced in the 1980s.

Nurses were educated in 1960s in Nursing Schools which were later called Educational Institutions of Nursing. Education consisted of 2.5 years of general education and after some practical work experience nurses could take one-year specialization studies in a chosen field. In 1980s training took place in the upper secondary level, in Educational Institutions of Health Care. Training was now 3.5 year of duration and included a specialisation. Public health nurses and midwives were also educated at the upper secondary level. In the 1990s nursing educations was transferred to the Polytechnics.

In the 1990s there was a severe economic recession that strengthened the tendencies to increase efficiency in health care and social affairs. Deregulation was increased and municipal autonomy was emphasized in administration and financing of health care in the reforms of the state administration of health care. In 1993, took place the state subsidy reform, in which the allocation of subsidies was made according to needs criteria such as demographic indicators.
instead of previous allocation by actual costs. Consequences of the change have been eminent. From the 1980s to the beginning of 2000 the share of the state in financing health care has steadily decreased from 38.2% to 17.6%, whereas the share of the municipalities has increased from 28.9% to 42.4%. This means that health care is more and more financed by municipal tax which is not based on a progressive tax as the state income tax, but it is based on equal tax percentage that is decided by the municipal council. In addition, households and social insurance have increased their proportion of the health care financing.

Although, the health care system was hit hard by the economic recession the health care services could be maintained their fairly good level. Recession has not caused major changes in health indicators. However, municipalities have been struggling to keep the increase in expenses in control, especially in special health care, in the context were tax income seems to be constantly precarious.

In spite of the strong tendencies for restructuring, increasing efficiency and accountability, for instance, the emphasis on the importance of accessible health services that are available to the entire population is strong. This emphasis also lives strongly in the views of the nurses of this study on the purpose of their work. They describe their work often in terms of advancing the health of the population and of an individual patient. Accessibility to treatment is brought up as a concern as they consider the long queues as problem, for instance. They place themselves on the side of the patient, and present themselves as guardians of patients’ interests and welfare.

Today the most of the registered nurses work on wards in primary health care or in specialized health care: 82% in 2000. In 2001, according to Statistics Finland (Moore 2005, 169; Statistics Finland 2001; Laine et al. 2002, 146), 45% of nurses worked in hospitals, more than third in institutional long-term care, and nearly one fifth in primary health care (out-patient care). 48% of them worked as public health nurses and midwives and 47% as practical nurses. A great portion, 80-85% worked for municipalities and municipal federations. (Moore 2005, 169)

2.2 Recent changes in the local context

The broadening functions of nurses and the divisions of labour between nurses and medical doctors have been much discussed issues in the early years of the 21st century. Nurses have been given new tasks on the grounds of more flexible and effective caring in the context of shortage of medical doctors. At present nurses have also their own nurse’s reception where they treat, guide and follow-up common national deceases. In addition, so called doctor-nurse work-teams have been established. Finally, the Ministry is considering allowing nurses a right to prescribe certain pharmaceuticals. In the background of these changes is the shortage of medical doctors, especially in the remote areas and an official policy for quick and equitable availability of health related services, which has culminated in a recent statue of “national treatment guarantee”.

The National Treatment Guarantee Act and the transfer of duties from doctors to nurses were topical structural changes for the nurses interviewed. The Treatment Guarantee Act, which ensures that when a patient seeks treatment it has to be provided to her within a certain time, was considered by the nurses as a good reform especially from the point of view of the patient. The patients get help in a reasonable time. The transfer of duties, that had not yet taken place, was seen as a challenge, and one could even sense a certain enthusiasm when they talked about it. Especially the Helga saw it in positive light as a change that would enhance nurses’ professional position. Her views on it are somewhat in line with the views of the Finnish Nurses’ Union126, which states as a prerequisite for the broadening of the nurse’s duties a raise in the basic wage.

126 http://www.sairaanhoitajaliitto.fi/vaikuttaminen/?x40501=16048 (13.11.2006)
Emphasis on multi-professional team work was also perceptible in the interviews and observations. Monthly meetings were held in which general issues concerning health centre were treated and decisions were made. The team work is part of decentralising. Administrative responsibility is brought from the national level to the actors on the local level. Technological advances contribute also to nurses’ work. In the health centre new computerized appointment book and electronic patient record were recently introduced.

2.3 Description of Local Context

The three nurses, Helga (born in 1956), Leena (born in 1964) and Jenna (born in 1973), who were interviewed for this study, work in different units of a health centre of a town. A Finnish health centre is defined in the work package two (Moore 2005, 156) as “a functional unit or an organization that provides primary curative, preventive and public health services to its population”. These health centres are publicly owned and run by municipality or by several municipalities together. The studied health centre is one of the approximately 270 health centres in the country (Ibid.; Järvelin 2002, 55). It has separate units in several locations around the town.

The town where the health centre is located is a centre of commerce, culture and administration for the surrounding region. It is located in peripheral region where standard of living is below country’s average. Nevertheless, it has benefited from the states new regional policy that emphasizes the centres of growth and excellence. The town is also an educational centre of the region with a University, a Polytechnic, a Vocational College, an Adult Education Centre and a Sports Institute.

The nurses are all working as so called consultancy nurses in primary health care. Thus, they have their own nurses’ receptions, which they run independently, and they are directly interacting with the clients. They have their own consulting rooms in which they receive and treat patients pointed to them. Now they take care mainly of the population of the district since these people seek medical services from their nearest health centre. The doctors are appointed to certain districts of which they are responsible. Similar kind of division to certain districts with nurses will be made in the near future. They each will have responsibility to provide services to the population of a particular district of the town that is addressed to them. Now each of them cooperates most of the time with certain partner doctors. In the near future, the co-operation will be further specified since there will be so called doctor-nurse teams, in which there will be one nurse who takes care of the patients with the two (or more) doctors of the team. The consultancy nurses’ work differs a lot in terms of independence and co-operation when compared to the common work of nurses, for instance, assisting general practitioners in clinics or wards.

The work settings of each individual nurse differed from each other. The nurses Helga and Leena worked at the same health centre which was located in a district about three kilometres from the town centre. There was a separate doctors’ reception in the unit as well and other nurses who work for a special outpatient department - for instance, a nurse taking care of vaccinations. There were also assistants, an information desk, an office of internal post and a patients’ record office. In the same building there are also hospital wards, an X-ray clinic, a laboratory, a dental clinic, and a physiotherapy clinic.

Although Helga and Leena worked as a consultancy nurses in the same location, at the time of observations their work settings were different: Helga had a permanent consulting room, but Leena had to organise herself a new room each day because of the renovation that was taking place in the building. She had to work in unfamiliar settings, which complicated her work a bit.
Jenna worked in a different location in the town centre that can be considered somewhat untypical. She had her consultation on her own in a building, where there were no colleagues present. The communication with colleagues was almost totally handled via telephone or e-mail. She was responsible of the population of the town centre.

In terms of clients and population the two locations differed from each other. In the town centre there were more elderly people than in the district outside the centre, where there were more families and kids as clients. This was perceptible during observations: in the town centre other patients than elderly people were exceptions really.

All the nurses had office hours from 8 am to 4 pm. All of them had also experiences from shift work which is an important topic in discussions on nurses’ professional position and status, work-life balance, demands of the work and their salary. Leena had earlier in her career difficulties with her work-life balance as she and her husband both had a shift work. These difficulties encouraged her eventually to leave the shift work.

3 Life stories

In this chapter we will introduce our participants by providing brief life stories of each of them, and their accounts on their current interests in work and life. These portraits provide contexts for the interpretation of their activities, accounts and views in the following chapters.

3.1 Jenna, born in 1973

Jenna’s childhood family consisted of a mother, a father and a sister, two years older than she. Her mother was a stay-at-home mother, and her father, now retired, worked as a building contractor in construction industry. They lived the first years of her life in the town she currently lives in. They moved to a town nearby, in a small village there, when she was starting the lower level of the comprehensive school. There she spent her childhood and youth with her family, and went to school there until she took her matriculation examination in 1992.

After graduating from upper secondary school, she started to study Home Economics, for Kitchen Superintendent. She studied for a year after which she was unemployed for a while. She didn’t find that school motivating, and states that she “hadn’t really thought about [her] future at that point”. She participated in a course, preparing young people for working life and studying, organized by the employment office. There she started thinking nursing as an option. She had also considered hairdressing as a career option.

After taking the course of the employment office, she applied for Practical Nurse studies in a vocational institution, and got in. There, she specialized in Child and Youth Care. She graduated in 1996, and was unemployed for a while, since there wasn’t that many jobs available that time. She worked then in a day-care centre for six months, which she considers giving her good work experience. “[T]hen I thought that I might not leave it like that, that I might want to study more. I felt that I wanted to get more out of this line of profession.” She applied for Public Health Nurse at the polytechnic of the region. She got in and liked the studies a lot.

When I got to my own line of profession then, the one that I was really interested in, it was only then that I found the motivation that I wanted to work and study and all. When I got to study for Public Health Nurse, the motivation was really different, and the enthusiasm and all.
The studies for Public Health Nurse took three and a half years, after which she did additional advanced studies in Nursing, which took six months. She got herself a dual degree in Public Heath Nursing and Nursing, in 2002.

In her studies her special areas of interest were Psychology and Psychiatry as well as Child and Youth Care, and also Maternity Welfare. She found the periods in a child welfare clinic interesting as well as the operating training in the operating theatre which included in the advanced studies.

She thinks that the education gave her a good basis for working life. However, she states that “it still is the job itself that teaches you the most. I mean I've noticed that the practice is the best teacher”. She is satisfied with the training available. Only problem there is that you can’t always participate. “[T]here's a lot of good training but you can't always go. There's plenty of advanced knowledge of various things. I've been offered a lot of trainings, too. I mean, there's training for everything possible, different diseases, medical treatment and what not.”

After her Practical Nurse studies, she worked in a day-care centre for a half a year. Then, after completing her studies for Public Health Nurse and Nurse, she substituted for a few days at the time in a hospital on different wards. She got also a longer period of substitution, about three to four months of duration. She was also unemployed for a while until she got a temporary, at first part-time, post in a town nearby. There, she had contract for eight months, after which she applied for an open post as a Public Health Nurse in the health centre of another town nearby. She got the post, and worked there for a year and a half. Then she successfully applied for a post of Public Health Nurse in the municipal Public Health Nurse reception in the town. Since autumn 2005 she has worked there, for about four months at the moment.

Her family and friends are living in the town as well which is the reason that she likes to live and work there. She seems satisfied with her current job. She has some 3-4 years of working experience as a nurse.

3.2 Leena, born in 1964

Leena was born (in 1964) in a town, which is located ca. 50 kilometres from her present home town. There were a mother, a father and six children in her childhood family. They have been moving around a lot in the region because of his father’s work in the employ of a company. Family moved away from the town, she was born in, when she was five years old. She states that she has basically spent the most of her childhood and youth in her present home town.

She went to comprehensive school in the town, and after that proceeded to upper secondary school, from which she, however, dropped out. She states that at the time she did not have much desire or motivation to study. She went after dropping out to a home economy school, in which they learned how to do house work, cook, to do the laundry and such. She thinks that the reason to go to that school was just that she had to do something, it didn’t matter what it was.

After that she worked part-time for a year in a kitchen on the employment subsidy. Then she went to a commercial school for two years. She states that she was also quite lazy there, and didn’t do much home work. She just took exams without reading and studying as she did in comprehensive and upper secondary school.

She worked in a summer as a hospital attendant. Then she got a temporary post in a bank, in which she worked for short of a year. She was unemployed for few months before getting a job in an insurance company. She worked at the customer service of the insurance company for five
years. Her work consisted of selling insurances and entering them to a computer. Then she went on a maternity leave after which she returned back to work for half a year. Then another maternity leave followed. She states that during her maternity leaves she started thinking that she would like to do something else. She had found work in the insurance company quite monotonous and dull, and didn't want to work there for the rest of her life. She thought that she would like to study something, no matter what.

Then she applied for and got in the Public Health Nurse studies. The studies took four and half years. She got herself a Public Health Nurse’s degree in 1996. At the time it was college-level training, not yet a higher vocational diploma. She recalls that Public Health Nursing studies were kind of a start of studies for her. She states that studies were quite demanding; they had to read much and do a lot of exercises. She did, however, manage well, and graduated with good marks.

She thought when she had got a degree in Public Health Nursing that she would also need a nurse’s registration and certificate of qualification, in order to be fully qualified to apply nurses’ posts. To get a qualification she applied for Nurse’s education as an adult student. During her Nursing studies she worked in the central hospital. She got organized her self less work hours (30 hours a week) in order to study at the same time. She also did some gigs in the health centre she currently works at.

After getting a degree in Public Health Nursing, she left for another maternity leave right away. Then she was at home for three years, during which she took a paramedic course. In 2000 she got a part-time job in a geriatric hospital. She worked there for a bit more than a year. She states that she was amazed of the hardness of the work, especially in the dementia ward. She nevertheless enjoyed working with the elderly. She tells that she for some reason gets well on with old people, they like her a lot.

After she had finished her Nursing studies she went to work in a private health care clinic. She worked there for three months but decided to leave the job and apply for a temporary job in insurance company. The work in the private health care clinic was shift work. This caused difficulties in her family life because her husband had a shift work as well. That was the reason she decided to change the job. She went after working in insurance company back to nursing holding temporary posts in a garrison hospital and in the health care phone service before she got her current, permanent post.

Now she has been working as a nurse for 4 years. She, however, has some kind of experience of health work for more than that, at least over last 10 years. She has had another career besides nursing in an insurance company. Choice of nursing as a career was made later after working several years elsewhere.

3.3 Helga, born in 1956

Helga’s childhood family was a big one consisting of a mother, a father and six children. Her father was a forest worker, a lumberjack, and her mother worked in an industrial facility. Her mother came from the countryside. She describes her childhood family as a “working-class family”. She has spent most her life in the town with the exception of the period in Helsinki. Three of her siblings are now nurses, one is an entrepreneur, one works in a locking device factory and one works as a dairymaid.

She went first to primary school and then continued with folk school (comprehensive school) within the old education system. “And in those days we had this old form secondary school where some pupils went, but I didn’t, although I was urged to that, of course. I went to this so-
called folk school for nine years.” After completing folk school she went to work in a couple of factories. After three months she realized that it was by no means her line of job. She applied for a job in the health care centre of the town. She got a job there as a nursing assistant and a facilities assistant. She did her comprehensive school and upper secondary school studies at the same time besides working.

She had started thinking that the education she had so far wasn’t enough. She started private studies, enrolled in a school as a private student. She completed comprehensive school and continued to upper secondary school which she never finished. Instead, she went to receptionist training.

*I completed first year like this, as a private student, taking exams with the adult education centre groups, but then I thought that I’d get myself a profession for a change, and I started this receptionist training.*

After completing the receptionist training in 1981, she was admitted in, and continued directly in the nursing school. She took there a specialization unit for internal medicine which granted her the competency for Ward Nurse. She graduated as a nurse in 1984. She tells that she worked all the time beside her studies, most of it in central hospital. In a town nearby, she worked as a Domestic Nurse, and after that in another town she worked in a mental hospital.

*That wasn’t my line of job. The rest of my work I’ve done here. So, like I said, I started in the health centre as a Nursing Assistant, and I also worked as nurse there for a while, but most of my nursing career I did in the central hospital. That is, in our central hospital, and I worked, like, originally in internal medicine, in cardiology and other internal medicine, and of course a bit on the surgical as well.*

Although she didn't complete her studies in upper secondary school, she did get to the university. There she studied for Health Education Teacher.

*At that time it was fashionable to study Nursing Sciences and things like that, but as I wasn’t interested in that, I started studying Education, like for Health Education Teacher. I almost finished that, and then shoved it in a box and into a cupboard. I most probably won’t ever finish it, as I lost my interest in it. I even taught for a few years then. Somehow I just feel that this job I have now, and might have for some time onwards, that this is my line of job.*

She worked also as a nursing teacher in the polytechnic of the town. Before starting to work in her current job in 1998, she had worked as a nurse in many different units, worked as a teacher and studied in the university, and also stayed a couple of years with her son at home.

*But then, at some point, oh yes, let’s go backwards a bit, at some point in [the town nearby] I got myself a post, a regular post, and from that post I was on leave then, for the Receptionist studies. And then I resigned. And then, after a certain period of time on internal medicine I got a post in the emergency room, in the emergency room of [a hospital]. I held that post for a while, and then took off again, when I felt that I wasn’t happy with the job. I resigned, and started teaching in the health care institute of [a town], or at that time it was just called a school. I stayed there for a couple of years. Then I started thinking that – I was doing both things at the same time, I mean while working in the hospital and teaching at the school, I also studied in the university. But I felt that it wasn’t my line of job either. Between all that I had my son, and stayed home with him for a few years, and then came to work here. I suppose I spent some time teaching in the polytechnic around that time. Was it in 1998 then when I finally came here in the health centre, to this job that I have now? We used to have emergency duty here then, but it’s been a bit different for two years now, as emergency duty has been transferred elsewhere, and we only have the nurse’s reception here.*
Currently, she is a single mother, and lives with her son, who was born in the beginning of the 1990s. After he was born she didn’t work for couple of years. She felt that she would like to stay home with her son. This was possible because she got child care benefit for a while, and then her husband, presumably, paid her maintenance for the child. She states that she keeps her personal life distinct from her professional life. She didn’t give much information about her personal life.

She has been working as a nurse nearly 20 years. Her experiences in health care related work reach beyond that, since she started 25 years ago as a nurse assistant in a health centre.

### 3.4 Conclusions on the life stories

The nurses have apparent differences in their background but also similarities. Helga’s parents did not probably have any vocational education. The younger nurses’, Leena’s and Jenna’s parents had some education. The nurses’ other career options are distinctive regarding their backgrounds. Helga followed her “working-class” background when she went after school to work in factories for a while. However, she did end up in the university eventually. Jenna had hairdressing and home economy as her other career options. Leena had a short career in the customer service of an insurance company before her nursing career.

The nurses’ siblings are also distinctive in terms of the career choices. Three of the Helga’s siblings worked as nurses. Also other nurses had some of their siblings working in health care or such. This indicates to the social contexts of their families, in which they were brought up with their siblings. These social contexts could be described as belonging to somewhere between non-academic middle class and working class.

The nurses did not enter the Nursing School right away when they came out of school. They first studied something else. Especially, Jenna and Leena tell that they had after comprehensive and upper secondary school some trouble to find a suitable occupation. Also Helga, even though she presents herself as an active student, did not enter straight to Nursing School, but took Receptionist Training, and before that worked in factories.

Considering work-life balance, the nurses keep their work distinct from their personal lives. The nurses emphasise importance of keeping professional distance to the patients and their issues. Jenna states that people do see her partly as a nurse in her private life also: they ask her advice on health issues etc. She states seeing herself carrying the nurses’ identity with her.

Their office hours as consulting nurses from 8 am to 4 pm can be considered to be a lot less problematic than, for instance, shift-work in hospital wards. Especially Leena had found shift-work complicated.

Helga and Leena were confident taking maternity leaves. Jenna didn’t have children. Helga even took a longer leave for some three years. This is possible because of the child care benefits, and because Leena’s husband was working and Helga’s child’s father was presumably supporting them.

### 4 Working conditions

Working conditions, organisation and management of work are described in this chapter. The descriptions are based on observations, interviews and information available in work packages. They include issues concerning work arrangements and division of labour at the work place, and the management of work: issues concerning control, supervision, autonomy, decision-making.
co-operation, planning, evaluation and documentation. The nurses’ responses will also be paid attention to, especially concerning structural changes in organisation and management of work.

4.1 Organisation of Work

As mentioned above, the nurses are all working as consultancy nurses, running their own consultations in their own rooms quite autonomously. The main framework of the course of their workday is an electronic, computerized appointment book to which they are connected through the network. This system is fairly new at the time of the interviews. In the appointment book detailed schedules of the workdays are presented. The patient appointments can be entered into the book by the centralised phone service (Ensineuvo), by doctors, other nurses and also by the nurses themselves. They can also place appointments to the books of others at the unit, to other nurses as well as to the doctors. The large part of the communication with colleagues is, thus, carried out through the computer network. Messages can be sent through the system. The patient record is there as well. The entries put there are immediately available to all the users of the network. There is also a possibility to enter a training time (or a meeting or such) in the appointment book. The time is then reserved so that the nurse can go to the training, and other appointments cannot be placed there.

The centralised phone service makes the first estimation of the need for care and distributes appointment through the system. All the patient contacts are channelled first to the phone service. Helga states that this has been a significant change, as before the clients contacted nurses directly. Now, the nurses contact the patient via telephone only when they give, for instance, phone consultation. The patient can’t call to the nurses, which enables them to concentrate on their duties without interruptions.

Duties and tasks

The patient work forms the self-evident core of the daily activities. Most of the time, the nurses work independently with patients. Occasionally they assist a doctor or co-operated with another nurse in a procedures such as removing moles. Making preparations is also a part of their daily tasks. They consult patient record, laboratory results, document client-visits, prepare instruments and equipment for themselves and occasionally, for instance, for a doctor. Acquiring equipment and sending them to maintenance is one of their duties. Planning and organising takes also a good portion of work time: the daily tasks are planned and organised, and duties are distributed with colleagues. Nurses can, for instance, change patients and such. There are meetings in which decisions concerning the unit are made. In addition to these formal meetings nurses hold their own meetings and discussions where they plan and organise tasks, routines and activities. For instance, they discuss about what medical supplies are to be ordered. They agree on vacations and such, as well.

The documentation of each client contact is, according to the nurses, a very important duty. In principle, all the contacts, visits, phone calls and messages have to be documented.

The nurses report that they occasionally participated in training. The youngest nurse, Jenna seems to be most eager to participate in training. Helga considers training as important. Nevertheless, she states that some training sessions might be quite useless, for her at least, because of their poor contents. She gave an example of a training session, where the trainer was mostly interested in her/his own voice, not in the substance of the training. However, all the nurses see training as an important part of their professional growth. There will be a lot of training in the near future when the transfer of tasks from doctors to nurses is carried out.
addition, the nurses state that they also occasionally train nursing students themselves: they have interns, who they supervise and work with.

Acquiring knowledge on issues concerning the patients and updating one’s knowledge on current practices is also a part of their duties. The nurses’ and doctors’ databases on the internet were used by all the nurses occasionally during the observations. Advice for the patients is often given on the basis of information found on the internet. The youngest nurse, Jenna seems to be most interested in browsing through the pages. They also have professional journals, guidebooks and instructions available. The nurses receive occasionally information and instructions on new practices which they study when they have extra time. They all are motivated to get new information.

The most common task of all the nurses during the observation was blood pressure measurement. Many of the blood pressure patients are elderly people, who are making control-calls frequently (often weekly or every other week). Their medication and overall condition is checked each time. The nurses and the most of the patients have very strong routines concerning frequent tasks such as blood pressure measurement. The co-operation makes procedures smooth and easy, as both the nurse and the patient know exactly what is happening. The well-established, trusting relationship with patients seems to make exchange of information on the patient’s health easier. Other tasks conducted with the patients are ear-flushing, injections, treatment of wounds, removal of the stitches, giving sick leaves and counselling. We did not have opportunity to observe counselling and health education given by the nurses occasionally. The counselling is, for instance, given about health issues concerning sex and birth control, eating habits, exercise and healthy way of life.

Co-operation and the division of labour

The division of labour is manifested in observed co-operation, and in the nurses’ reports on how they co-operate with colleagues: doctors, auxiliary nurses, assistants and administration personnel. The co-operation with the partner doctors is obligatory, as is the collaboration with health centre assistants, X-ray clinic, dental clinic and the hospital. The most of the voluntary and unofficial co-operation takes place with the nurse colleagues.

Co-operation with doctors is mainly carried out by sending a patient to a doctor, doing a procedure to a patient that a doctor has ordered, and consulting a doctor on issues concerning a patient. Usually the nurses work alone with the patients. The work is autonomous, and they decide by themselves, how they will carry out their tasks. Leena’s close co-operation with doctors was followed during her observation. Helga and Jenna did not assist doctors during the fieldwork. Leena assisted doctors in procedures such as the excision of a mole. The nurse’s role was clearly an assisting, subordinate role in the procedure. She prepared necessary instruments, the patient and disinfected the surrounding area of the mole. During the operation, when the doctor carried out the excision, she gave her/him instruments and followed her/his orders. The roles seemed to be clearly hierarchically distinct. The doctor was in a superior position. However, the functions of a doctor and a nurse were clearly divided during the operation. After the excision the nurse treated the wound, disinfected it and put the bandage on. (see Moore & Antikainen & Kosonen 2005, 35: Moore 1995)

Regarding the instances when Leena assisted a doctor, there was, for instance, an occasion where the doctor was almost an hour late from the appointment. However, neither Leena nor the patient was frustrated by this.

The excision of a mole is a good example of the line between nurses and doctors rights to carry out certain tasks. Nurses cannot carry out excision, because they do not have right to use internal
anaesthesia. They can use external anaesthesia cream for instance. Another threshold concerning excision is that nurses are not allowed remove living tissue. They can remove dead scar tissue, but they cannot touch the living tissue. These kinds of limits are, at the moment, changing since there is a transfer of duties from doctor to nurses taking place. Nurse’s area of rights and functions is broadening.

Co-operation with other nurses is more frequent compared to that with the doctors. The nurses change information constantly and organised their work with others. They also have some tasks, which they carry out together. There were some procedures in which a nurse was assisting the other. Ordering medical and other supplies is a task that was carried out together: the needs were discussed together. The nurses’ assessment of co-operation and work community is positive. They state that co-operation works well, which was also apparent, as I observed them working together. Jenna was an exception in this respect as she worked alone in her unit.

Helga talks about auxiliary nurses in a context in which she ponders about distribution of tasks. She refers to them as ‘girls’, and talks about them in as if they were equal workers. Thus, there seem not to be any distinction explicitly made to auxiliary nurses. Their work seems to be highly appreciated by the nurses.

The nurses bring up the managing of the patient queues as a common problem. Most of the changes are associated to achievement of division of labour that would be most efficient to deal with the patient queues.

4.2 Management of work

The management of work includes issues concerning control, supervision, autonomy, decision-making, co-operation, planning, evaluation and documentation.

The administration of the health care the town is organised, according to the organisation table, so, that the Municipal Board of Social Welfare and Health Care makes decisions. The leading head doctor is the head of Health Care in the municipality, and the leading head nurses are her/his immediate subordinates. The head nurses, who are the superiors to the nurses, are subordinates to the leading head nurses. Today, administration and management is increasingly brought down on the grass root level so that, the personnel takes more part in the meetings than before.

The issues concerning the whole health centre are discussed in monthly meetings, where there are all the nurses, health centre assistants and the departmental head nurse present. As there are now changes taking place, new ways of action are introduced and the systems are changing a lot, there are also meeting, where the whole personnel is present. These common meeting are a rather new format of management. They are due to the decentralisation, transferring administrative responsibility from national organs to local ones.

The nurses have differing view on their status in the common meeting. Jenna sees that the views of nurses are well taken into consideration.

They do listen to the nurses, too, and their opinions are taken into consideration, so I feel that the decisions could be made together as well. We, nurses are important in delivering information to the upper level, reporting what goes on here in practise, relaying the constant feedback from the patients. They do listen to us, and try to make the decisions on the basis of the feedback the patients give us as well, yes.

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Leena holds an opposing view claiming that there has been resistance on doctors’ part. According to her, some doctors feel that the nurses are stepping on their toes. She states that, as they are used to working independently, they have difficulties in working in teams. Helga sees decision-making rather as a process:

[We make decisions together on, like, well, the guidelines. Like at the moment the meetings are mostly about the change. I mean, we need to think about the solutions together, how to proceed. We do discuss things, and sometimes we leave the decisions open, continue pondering, and try to collect our thoughts.]

The nurses assess management as well-working, in positive terms. They have occasional discussions with their supervisor, the head nurse of the unit. Nevertheless, the supervisor and the management are not present in their daily work. They state that there is nearly no monitoring and controlling on the part of the supervisor. According to them, the control and accountability comes through the clients’ responses and possible complaints.

Helga describes the nurses’ relationship to the management of the unit in terms of “trust”.

[Of course the management monitors us, but the management here doesn’t mean that there would be someone standing behind our shoulders all the time, the head nurse or someone. We’re quite, you know, they trust us, I’d say that, for that’s how I see it.]

Relationship to the management is seen as a mutual trust-relationship. This implies to common, shared values, goals and objectives, to the common assumptions about how things should be organized.

The nurses also emphasize the meaning of self-control and responsibility. Knowing, what one is doing, and knowing one’s limits are seen as important things.

Interviewer: How do you see your work is monitored and controlled?
Leena: Well, here it’s mostly up to yourself, I mean, there’s nobody to watch the way I treat the client who comes here. So you’ve got a big responsibility. Of course the clients may complain then, and we do get supervision or control from our supervisors. So it’s very much about you yourself being sure that you know this thing, and you’re saying the right thing to the client. You need to be sharp with yourself.

A considerable change, that is taking place on organizational level, is the transfer of the duties from the doctors to the nurses. In another unit in the town they are having a trial period of the transfer at the time of the interviews. The nurses are trained to do the tasks that are transferred from the doctors to them. According to Jenna, this gives doctors more time to see patients, and it is flexible also for the patients since they get treatment more quickly, as a nurse could help too. This helps to reduce the queues. Helga finds the change as a good challenge. In addition, she sees as a change that would enhance nurses’ professional status and also salary. As mentioned earlier, the Finnish Nurses’ Union’s statements are notably similar to Helga’s views. This is no surprise, since Helga is an active member of the union. She is also involved in a process, where the nurses define the core tasks of their job. She mentions that she is, currently, preparing a paper with some of her colleagues, in which they make their statement on the nurses’ current demands.

Organisational change was taking place in the health centre during the observation period. Helga and Jenna, who were observed and interviewed first, addressed to this change as taking place in the near future. The change had taken at the time of the observation of Leena. The change meant that the number of consulting nurses was increased. The nurses and the doctors formed working units, in which they work in pairs, or two doctors have one nurse as their working partner, for instance. They are assigned to the certain regions of the town of which they are responsible. The changes were made partly because of the execution of the Treatment Guarantee Act. As the change had just taken place when Leena’s work was observed, she didn’t have yet as much appointments as other nurses because the system has not started giving her enough patients.
Leena is satisfied with the change, as it’ll reduce the queues and also reduce the possible overlapping of tasks between the nurses and the doctors. It makes the distribution of labour more clear.

5 Professional knowledge

In this chapter nurses’ professional knowledge and expertise will be looked at, on the one hand, from the point of view of structures, such as categorisations of tasks, skills and qualifications, and organisation of work and division of labour in terms of duties, tasks and skills, and on the other hand, from the point of view of nurses’ responses to these structures.

We will develop an idea of an opposition between curing and caring as a principle opposition, by which the mental structures of the nurses and social structures can be analysed as corresponding. This opposition seems to be predominant in the nurses’ talk, as they bring up various oppositions, for instance, such as technical and human, biomedical and holistic, task orientation and whole patient, biomedical machinery and human touch, which can be considered as somewhat parallel to it. The opposition is thus considered as a mental structure by which the nurses make their professional knowledge and expertise understandable, and engage in negotiations on their professionalism with other professionals and with laymen, especially, with their clients.

The predominant categorisation of skills and knowledge, in research reviewed in work package one (Moore et al. 2005), is one, which corresponds to the principle opposition of curing and caring. That is to put them in two categories: technical skills (technical procedures done by hand: injecting, tending the wounds, operating the sphygmomanometer), which, for instance, the nurse Helga refers to as “tricks”, and social skills or human relation-skills.

Eriksson-Piela (2003, Eriksson 2002; See Moore at al. 2005, 36) has analysed how nurses construct discursively their position in the hospital hierarchy. She sees the nurses’ position as experts as twofold, as their professional qualifications are based on the one hand on biomedical and technical knowledge of medicine and on the other hand on the knowledge of nursing science that emphasises emotional engagement to the relationship with the client, human-to-human skills and care. Thus, it seems that the mental structure corresponds to the institutional structure of nurses’ qualifications, education and knowledge-base, that is twofold, basing on medicine and nursing science.

In addition, the opposition of curing and caring can be considered as corresponding to the division of labour, especially between doctors and nurses, and organisation of the health care, as Eriksson-Piela (2003) notes. That is, the mental opposition between curing and caring and their parallel oppositions are linked to the prevalent social structure of hospitals and health care clinics. ‘Caring’, ‘human touch’ and the parallel categories of meaning are at the core of nurses’ professional self-definition that construct and maintain nurses’ specificity especially in relation to the doctors. So the oppositional categories are used to define occupational groups and to distinguish them from the others.

Pelttari (1997; See Moore et al. 2005, 32-33) has studied the changing qualification demands of the nurses, at the early stage of nurse education in polytechnics in the first half of the 1990s. She presents a collection of “human to human” requirements that she found in her research. They are following: interaction skills, empathy, friendliness, responsibility, caring, holistic ability to meet and help people, the ability to act as the patient’s/client’s advocate, multicultural abilities, health promoting skills, constant self-up-dating, readiness to develop oneself, and ability to cope with change. In the future (from the point of view of 1997), she sees that emphasis will be on multi-
professional communication skills, research and knowledge searching abilities, managing skills and skill supporting patient’s/client’s self-care. These skills on the list are also predominant in the talk of the nurses of the study.

A notable thing, considering the study of Pelttari (1997) for instance, is that the emphasis on caring side of nursing has been increasing since the first departments of nursing science were established in 1979. Nursing science has been producing increasingly complex classifications of what the nurse’s professional knowledge and expertise consists of or should consist of. These classifications have gradually been institutionalised, as they have been used to build the basis of the nurses’ professional qualifications, education and training.

Helga states, related to the introduction of the nursing science, that nurses’ education is today more theoretical than before. According to her, before the emphasis was more on practicing the work. When nursing science was introduced, it was emphasised strongly in nurses’ education, she states. Furthermore, she sometimes feels that today nurses are not trained into worker’s role but rather role of a manager.

5.1 Nurses’ accounts on their core skills and knowledge

The nurses’ accounts on their professional knowledge and skills, as mentioned, seem to present their core skills and knowledge according to the supposed opposition of curing and caring.

The manual skills are considered by all the nurses as self-evidently essential. Mastering of these skills can, according to Jenna, be acquired only through practice. In education the basis is laid by showing and explaining the certain manual procedures, but the confidence performing them is only gain through repetition in real work. Jenna thinks that she has a lot to learn still about these skills. The most experienced nurse, Helga states with confidence that she has very good skills. She refers to manual, technical skills as “tricks”. According to her, one must “put theory and knowledge into practise”.

On social and human relation skills, Jenna states that: “Being able to be with people, to listen to them and their issues, to take a right kind of view of their issues in every situation. That’s important, I think.” She talks also about social skills referring them as customer skills. Using the labels “client” and “customer skills” is a sign of customer orientation being part of the general discourse of nursing and health care concerning the relation to the patient.

The nurses emphasize sensitivity, ability “to have certain touch with people” and ability to read people as essential to their work. Helga sees that a nurse has to take into account physical as well as mental side of a patient. She explains that a patient may come with a minor physical problem to consultation, but really have mental or emotional problems that come up as questions or subtle signs that a nurse has to be able to read. Leena refers to intuition and to “quite a sensitive radar” that are helpful in her work:

Well, I think I’m good with people usually, and I think that - at least I see that the interaction is quite warm. And well, I have quite a sensitive radar, I mean for example I’m quite good at, my intuition tells me how to lead the conversation, or what is the problem. And I think I’m quite good at seeking information.

The nurses present themselves as holistic care-takers. They do not concern only the physical problems of the clients but also the mental and emotional problems. The caring side of the principle opposition of curing and caring is strongly emphasised and brought forth, as they talk about their everyday work with the clients and their professional skills and knowledge. As they emphasise the relative proximity to the clients, for instance compared to supposed distance of the
doctor to clients, they implicitly claim superior knowledge on clients’ issues to other professionals. They, indeed, are the ones, closest to the clients, as they also establish long-lasting relationships with many of them, especially with those making frequent control-calls.

The nurses state that their clients are important sources of knowledge. Jenna states that she has learned a lot from the clients because of their good knowledge on their own health and problems. During observations it was apparent that the clients played a big part in procedures. Procedures were carried out as a co-operation of the nurse and the client. The clients are seen not as a passive receiver of care but an active party, especially considering the emphasis placed on the clients’ self-care. The nurses’ brought up as an important feature of their work the task of advancing clients’ self-care. Jenna found it rewarding to notice that her clients had realised how to take good care of themselves. She had also a public health nurse’s degree, in addition to general nurse’s degree, and she told that she enjoyed giving health education and advice to the patients as part of her work.

Although the relationship to client is described as close and often in emotional terms, and the knowledge that clients provide almost merges with nurses’ expert knowledge, the nurses do emphasize their professionalism in relation to the clients. They state that it is important to keep certain distance to the client and hang on to the professional role of the nurse. Leena states that “[a good nurse] is a professional, not putting herself on the line too much, but keeps the line clear, maintaining the nurse status, not getting too involved in the patients' stuff.”

All the nurses have a rather similar view on ideal use of skills and knowledge. They emphasize responsibility, accuracy, and knowing what one’s doing. According to the Leena’s view, what is important is “doing everything right, according to the current knowledge”. Helga states that: “[A]ll the decision-making is based on the fact that you need to know what you’re doing and what you decide.” Jenna says that important thing is to “use one’s knowledge right”. An ideal nurse, according to their view, knows her limits and acts accordingly.

The nurses bring forth a versatile picture of nurses’ knowledge and skills. Continuous learning in practice is emphasised, various sources of knowledge are used: nurses are not limited in conventional knowledge sources rather they use creatively knowledge provided by their patients and their colleagues. Their view of knowledge is rather flexible and integrated to their work activities and their professional identity. The patient work is seen rather as a continuum, a process, than as a series of distinct procedures, as they form long lasting relationships with their frequently visiting clients.

The nurses do not mention diagnostic skills or administrative skills and related requirements such as documentation, evaluation, planning etc. as part of their essential skills when asked specifically about their skills. They do talk about them in other contexts of their story. Considering for instance diagnostic skills, it might be that, because it is clearly part of doctors’ professional domain and special knowledge, they do not mention it because it is not significant in making nurses distinct from doctors. Consequently, considering the opposition between curing and caring and the related parallel oppositions, the nurses seem to adopt a strategy of making themselves distinct as professionals by placing emphasis on the caring side and on the related skills and tasks. And as caring has become institutionalised in nursing science and curriculum, it has become official and legitimate knowledge. This can also be considered as enhancing the nurses’ social and professional position.
6 Social position

In this chapter nurses’ perception of their social position and their response to it will be analysed. The institutional and official positioning of nursing will be brought forth as a structure which nurses respond to. Nurses’ perception of social position can be approached by looking at how they emphasize certain aspects of it. Salary and earnings are material aspects of social position. The symbolic aspects of social position are the ones through which they make themselves distinct from other professionals, and claim for their own professional status. Responsibility, autonomy, education, physical and mental demands of the work and public respect are such symbolic aspects of social position. The social position can also be approached by looking at division of labour in health in terms of the nurses’ mental categories of their professional knowledge and skills as belonging to curing and caring.

Nurses’ professional position and status is defined as official and institutionalised, as an objective structure, in Classification of Occupations of Statistics Finland\(^\text{128}\). In Classification of Occupations of 1997 nurses were classified as Professionals. In Classification of 2001 their status had dropped one level lower to the category of Technicians and associate professionals. Counterarguments were raised claiming that this was due to the undervaluing of female dominated professions. Having an official status professional contributes to negotiations on salary, curricula and recruiting. (Eriksson 2002, 41)

The Classification of Occupations creates a hierarchical categorization of occupations and professions. This categorization is an institutional and official one in a sense that it provides a basis for policy formation, professional struggles etc. It is an objective structure which contributes also to individual nurses’ perceptions and responses. This objective structure is interpreted, negotiated, promoted and objected by them, and thus, constructed as a social and cultural institution. The question is: what is the formation of this object? What do the nurses perceive as constituents of their professional position and status? Answer to these questions can be found by looking at the issues that the nurses bring up when they describe their work and negotiate their position and status.

The nurses brought up following issues when they were addressing the important features of their work: salary, responsibility, autonomy, education, physical and mental demands of the work and public respect. These issues contribute to the status of the nursing profession. The salary was frequently brought up a topic. It was considered to be too low considering especially the demands of the work such as heavy responsibility, physical and mental demands, and the long education. Jenna states that

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\text{You must know how to make independent decisions. We’re dealing with people’s health after all, so the decisions that we make are very responsible. [...] It’s very hard physically, lifting patients and all. Taking all that into consideration, the responsibility and physical demands, the salary is too small.}
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Helga stated that the reform of the distribution of duties between doctors and nurses, which is taking place in the organization at the moment, enhances the professional status of nurses. Nurses were, in the organization at the time of the interview, preparing a paper, a job description, which would, according to her, say much about the independence and responsibility in nurses’ work. It would also be a criterion for wage claims. She brings up independence and responsibility as features of nurses work that should be emphasized.

Helga describes the consultation nurses’ work as very independent and autonomous. The nurse emphasizes this position by describing her daily work as constant process of decision-making.

\(^\text{128}\) http://tilastokeskus.fi/tk/tt/luokitukset/lk_en/ammatti_index.html
She tells that she has to make decision in every turn: she has to decide on whether certain treatment, or further treatment, is needed or not, she has to decide whether the patient should be sent to a doctor or not etc. She presents her position in work organisation as an autonomous actor and, in relation to doctors, as a gate-keeper, or rather as an equal professional that has an autonomous and functionally essential position in the unit. The emphasis on autonomy and independence is present in Jenna’s description, as well:

_I like the independence here, you get to make your own decisions and there’s no one here, as I have my own office and my own independent consultation. I like it that I get to decide how I run things there. I really like that. Then again, I'd like to be able to ask someone every now and then, but basically I'm very satisfied with this, to be able to work here by myself._

Scientific knowledge base of nursing science and medical science is a structural factor which nurses rely on claiming professional position as experts. They emphasize constant need for updating the knowledge on recent practices and modes of operation. The nurses refer often to the scientific knowledge base of their profession. However, one gets an expression that they are not fully aware of the advances in the scientific discussion of the nursing science. They don’t go any further from just referring to it. Helga is an exception here because she had studied in the university and had insights about what was going on, what was discussed about at the time she went there. Nevertheless, nurses have limited access to evaluate their knowledge base acquired in professional education.

In the previous chapter it was mentioned that nurses emphasized certain skills and areas of knowledge, some other things were not paid attention. Their emphasis can be seen contributing to their professional position. By emphasising for instance their social skills and emotional abilities, those associated with caring, they make themselves distinct on the one hand from doctors’ domain in diagnostics and advanced procedures, and on the other hand from assistants’ merely physical tasks and their inability in curing. One could think this as a professional strategy to hold a position as an expert of certain domain, namely caring, to claim expertise there.

The nurses’ professional identity can be considered in terms of their views on and responses to the core values and ideals that are associated with nursing. Shared values can be seen as a discursive structure to which they respond as they describe their ideals and strivings. Jenna sees nurses as mediators between patients or clients and the upper level, management and the authorities. She states that “nurses are important in delivering information” from clients to the authorities. All the nurses emphasized the client’s interest and wellbeing. They presented themselves as sort of advocates of the client, and had tendency to take the side of the client while discussing issues such as accessibility of health services. Presenting such an identity the nurses make themselves distinct from doctors’ implicitly assumed distance to the client in personal and emotional terms.

The advancing the health of the population and an individual client lived strongly in the nurses’ discourse. This emphasis is in line with general discourse of Finnish health care. Jenna describes the meaning of her work: the goal is “to take good care of them and make their lives last longer”

The nurses’ identity is integrated to these greater purposes and ideals.

Institutional definitions of professional position and status contribute to professional lives of individual nurses, to their perception of the constituents of their status as professionals. This status can be looked at from different angles: it can be approached in terms of expertise, claims to possess expert knowledge that differentiates the work of nurses from that of laymen, ‘lower’ and ‘higher’ professionals (assistants/auxiliary nurses and doctors) and outsiders of the profession. It can be approached in terms of comparisons to other professions. The salary was a significant factor for the interviewees. The claims for better position and status, and for salary,
for instance, as a constituent of professional position and status, were supported by bringing up the features of nurses’ work such as responsibility, need to make decisions, autonomy, long education, and physically and mentally demands of the work (workload and work pace).

7 Conclusions

The structural changes in nurses’ working conditions, such as organisational changes currently taking place and enactment of Treatment Guarantee, changes in their duties, tasks and demands for new knowledge, and in their social and professional position do contribute to their professional identities and to the professional strategies they adopt in order to cope with these changes. The nurses’ core tasks have remained similar throughout the history of nursing: nurses treat illnesses and maintain the patients’ health. The changes take place rather in peripheries of nursing, in the frame and conditions of work.

The changes in their work, that have taken place, are not only administrative or organisational changes but also technological changes. Often these technological changes do, however, go hand in hand with changes in administration and management. For instance, the framework of the studied nurses’ work was the computerized appointment book with patient record. This technology forms the basic mechanism of control and management.

The new management and decentralisation was perceptible in a form of common meetings that are today held on the issues concerning organisation and management of work. The goal is to bring all actors to participate in decision-making. The administration and management is brought to the grass root level which challenges traditional hierarchies. The nurses reported that some doctors had trouble adapting to common decision-making, which report can be seen as manifestation of the changes in hierarchies and in social and professional positions of actors.

The nurses were willing to take the challenge brought by transfer duties from doctor to nurses. This broadening of nurses’ duties, tasks and rights was estimated in positive terms. The benefits for nurses’ social position in material terms, as better earnings, and in symbolic terms, as better recognition of their responsibility and independence, were put forth.

One can think nurses’ responses in terms of professional strategies of accommodation and resistance to the changes. The aspects of the structures and structural changes were either brought forth or pushed aside by nurses. The nurses brought forth certain tasks, areas of knowledge and skills, and certain role models and identities in order to make themselves distinct from others, in particular from doctors and assistants. They enhanced their position as experts and professionals by emphasizing their human-to-human-skills, their mediator role between clients and authorities, and their role as advocates of the patients. For instance, the significance of diagnostic skill was pushed aside because they wouldn’t be able to compete with doctors’ expertise on that domain.

Considering the nurses as representatives of their generations only few remarks can be made. All the nurses were able and willing to use the modern technology, the appointment book and the electronic patient record, and data bases to acquire information about new practises and such. The youngest nurse, Jenna, however, showed the most interest for acquiring information on the internet. All were equally eager to learn new things and to update their knowledge: one cannot distinguish them from each other on the basis of that. The work experience was a thing that could be seen in the confidence of the Helga compared to two others.
References


