Identifying the barriers to nursing power in hospitals

By Dr. Marie L. Campbell

This article is about power, specifically about the power of operating room nurses and how they exercise it in today's high-tech environment. The prospects for nurses being more influential in determining how ORs should run will be addressed, as will how the worklife of nurses might be better organized.

Nursing power and the organization of nurses' work are subjects I'm frequently called upon to discuss because of my research on the organization of nurses' work in hospital. In spite of all the difficulties facing nurses right now, I'm generally optimistic that now is a good time for nurses to be thinking of exercising more "power". Some of the same conditions that are creating challenges in today's hospital workplaces are also creating new opportunities for nurses to have a stronger voice. There is no question that nurses' knowledge and judgement could be put to better use.

What would have to happen to help OR nurses be more effective at getting their ideas acted on? What is power in the current context ?

One of the elements of power in which we are most interested is getting access to decision-making. We need to know who makes what decisions in the agency, and where and when and how. Some of this information is written down in mandates and terms of reference and is therefore available to be investigated and put to use when the need arises. Some other aspects of power are more subtle and are harder for newcomers to comprehend. "Knowing" itself or being "in the know" is one of the ways power is held. There is nothing that makes us less powerful than having things happen to us without warning, out of the blue.

Firstly, we will review nurses' relation to power over the recent past. Then we will discuss some of the changes in our health care system that seem to be breaking down the traditional ways of doing things and creating new opportunities for nurses. There are some interesting contradictions in these changes and nurses need to be familiar with these contradictions.

Finally, we will examine the challenges still facing nurses in trying to be influential both in their hospitals and in the health care delivery system in general.

Nurses haven't always talked openly about power but it has never really been off their agenda. More lady-like terms may have been applied, in the past. For instance, we have always heard a lot about nurses' "autonomy". If we look back into our history, we see evidence of nurses' continuing struggles for control over their education, their work and their workplace. Florence Nightingale was a woman who knew about power. Given the job of looking after wounded soldiers, she saw that her first task was to create order out of a chaotic system for provisioning the British Army. She saw that the regular access to food and supplies, cleanliness and discipline, were elements of the physical and moral order that nursing in the army needed. Later she brought these ideas into her training school, preparing her graduates to exercise the same organizational skills in civilian hospitals. Something we need to note about Florence Nightingale was that her own power to make change was always buttressed by her upper class position in English society. Her biography makes it abundantly clear that she always had, and used successfully, her social connections to politicians and bureaucrats.

In North America, influence gets exercised somewhat differently than in Victorian Britain. It is not done through direct social class connections. Susan Reverby (1987) has written a history of American nursing that gives interesting insights into how American nurses have worked to improve their professional status and power. She argues that nurses took their lead from the medical profession in North America. The Medical Association had seized control of university education and made educational credentials the

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basis for physicians' access to hospitals. They built a medical monopoly which excluded competitors. Nurses too believed that education was the route to follow. Both in the U.S. and Canada, the nursing profession exercises careful control over the credentialling of nurses, levels of education, and so on. Even so, nurses have never been able to turn educational status and nurses' considerable knowledge into power for the profession or for individual nurses.

Traditional barriers

Why have nurses been unable to convert their knowledge into power ? There are a lot of reasons. Certain traditional barriers consistently undermine nurses bid for actual power. These barriers interfere with nurses being heard. These barriers are probably familiar to all nurses, but bear repeating here, if only to remind us that they still impact on our professional lives. OR nurses will recognize specific ways that these traditional barriers continue to interfere with their work.

One barrier that OR nurses must contend with is the traditional "gender relations" in the operating room. We are referring to something more insidious than being the butte of sexist jokes, although this is annoying too. Gender underlies what, and who, is considered important in the operating room. Nurses' work and nurses' knowledge can be taken for granted and undervalued because it is women's work and women's knowledge. Remember, women do the background work in our society, in homes and offices , as well as in hospitals. Like other women throughout history, nurses have not been expected to have opinions or to speak with authority. Their work consists of facilitating others. In hospital operating rooms, that is the organizing principle of OR nurses' work.

OR nurses pride themselves on having a thorough knowledge of all the surgical procedures so that they can think through their scheduled cases in advance and fill every possible need before it arises. This work has the character of being overlooked when its good, and becomes a cause for attention only when it's unsatisfactory. It is very easy then for others to subsume the OR nurses' knowledge under some kind of abstract notion of "good organization" and forget to recognize that a perioperative nurse has built a body of knowledge for use in daily practice, and that it is valuable.

To stress this important point here is an example:

> *An OR moved its booking desk out of the OR into the Admitting Department, when it computerized the booking function. It was apparent to efficiency analysts that having it inside the OR created a traffic jam at the desk. However, after a short trial, it had to be moved back inside the OR because schedules were always getting upset. Bookings had to be situated right where the nurses could have an ear on the activities of the booking clerk. "Case scheduling" is a job that relies on the working knowledge of the OR that operating room nurses, and only nurses possess. Knowledge of procedures, turn around time on special instruments, the availability of staff with specialized skills, and especially knowledge of surgeons and their idiosyncrasies, etc. Without that kind of knowledge attending the case bookings, there was confusion. Analysis of the booking function had not identified that "consultation with nurses" was a routine and crucial part of OR booking. It had always "just happened" and the contribution of nurses' knowledge was overlooked.*

That kind of situation may not appear important, but when nurses' knowledge is overlooked again and again, it undermines a nurses' own sense of herself and her knowledge. It helps to reinforce nurse's subordination if she doesn't realize the value of her knowledge. We need to claim the knowledge that is ours and demonstrate its value.

Being able to explain what nurses know and do will continue to grow in importance as we deal with the issue of "pay equity" and "job evaluation".

The barrier of isolation

A second barrier preventing nurses from exercising power lies in how their work is organized. It doesn't help OR nurses that they work in small groups, isolated from their peers. This isolation deprives them of both information and solidarity within the nursing group that would be supportive. When women have things to say about their lives, they have found that they need the support of other women who see things the way they do. Isolation keeps OR nurses vulnerable in various ways, vulnerable to the special "facilitating" relations that we have suggested are part of their work to produce in the OR. The isolation helps to hide and undervalue their unique contribution.

There are other traditional barriers in hospitals that prevent nurses being heard and their ideas acted upon. The hierarchy in traditional hospital administration is one. Hospitals have always been rigidly hierarchical, with decisions affecting nurses usually being made elsewhere, up the chain of command, not where OR nurses are working and where their knowledge would illuminate what needs to be done. This, fortunately, is one thing that is changing.

The new realities

Traditional barriers are being weakened by hospitals having to respond to the "new realities". One of the most important things to understand about what is happening in health care right now is the contradictory effect on nursing. There are opportunities today for nurses even within the climate of fiscal restraint that is causing the profession so much trouble. When the money situation reaches serious enough proportions, even established traditions are no longer sacred and these circumstances can benefit nurses.

Budget troubles are the driving force behind most of the changes we are living through in the hospital. This new fiscal trouble is the origin of the "new realities". On the one hand we have the rising costs of new technology and increasing expectations from doctors and the public that hospitals must keep up with new procedures and buy the expensive new equipment, but, on the other, we have the government's emphasis on funding restraint. It puts a terrible pressure on all levels of administration.

Hospitals are responding by trying to be more business-like. To be more business-like is to act more like an industry where concerns about profit and loss define what is to be done. "Efficiency" and cost-saving have become the driving force, the focus around which all decisions must now be orientated.

Computers and information processing are an important part of the new focus on efficiency. Computers help to count and cost the use of equipment, supplies, staff and all other resources. Instruments can be tracked and systems for handling and storage made more efficient by the use of computers. Control mechanisms can be developed, comparing costs across different departments, and with similar departments in different hospitals. Utilization studies, in which all aspects of a department's functioning are costed and compared, are now an important part of managing a unit. This on-going scrutiny of "efficiency" depends on the production of lots of new kinds of information.

This means several things for nurses. It's both good news and bad news. The focus on "efficiency" permeates the OR nurses' work and makes some things more difficult, to be sure. Some may find that they are filling out more records and others may be expected to learn to operate a computer. OR nurses' are also expected to get more work done with fewer resources, including fewer nursing staff. For example, an Ottawa, Ontario community hospital's operating room, which normally handled 600 surgical cases a month in 1986 was handling 700 in 1989, with no increase in nurse staffing. That is the new reality. We also know about increased overtime. As women we know the pressures it creates in our personal lives. As nurses, we also know how it affects patient care.

Yet there is another side to this. The new "efficiency" focus also offers nurses some distinct benefits. There are new approaches to management being tried which reduce some of the old fashioned hierarchy which was so oppressive to nurses. As hospitals and administrators learn new management methods, nurses are being offered the opportunity to participate in decision-making, to use their own ideas. New structures are being created for nurses to be heard.

Decentralization is one example. Top level administrators realize that in today's hospitals they cannot have an intimate understanding of everyday functioning at the unit level. One of the things that decentralization does is to place control over unit budgets in the hand of unit managers. The new nurse manager then has the flexibility to run her unit as she wishes, as long as she operates within budget. She can make decisions to suit local conditions and people, including decisions about staffing. An effective nurse manager will listen to her staff and be open to their suggestions. She will make the necessary arrangements, through regular meetings, to tap the knowledge and wishes of her staff. If she can get her staff's cooperation in running the OR effectively and efficiently, she will be more successful at her job.

High commitment management

Decentralization means that budgets are administered at the unit level, and that the people most involved in the unit should be making decisions affecting them. This is the theory of "high commitment" management that many organizations, besides hospitals, are beginning to use. People work best under conditions that they understand and feel some measure of control over. Because the reactions of nurses to stressful and unpleasant working conditions have alarmed hospitals administrators, "better management" - more democratic management, is part of the solution that is being proposed. Besides using the good ideas of nurses' about how to organize work effectively, making nurses happier is today seen to be an efficiency measure. That is why committees have proliferated as hospital managements try to reduce nurse absenteeism and turnover of staff, as they puzzle over recruitment and retention of skilled nurses.

Nurses are being integrated into hospital governance. Changes in decision structures have been occurring at just the same time as nurses are becoming more militant about their demands to be heard. In Ontario, there has been a requirement, by the government, for hospitals to put nurses on Board Committees. There

have also been similar initiatives in Manitoba and Alberta. Nurses' Unions have long held that to be truly effective professionals, nurses need the same access to hospital Boards as physicians have.

What does "better management" and more involvement in management do for nurses"? It seems clear that for nurses to be involved in decision-making is an improvement over the old rigid chain of command. When management is decentralized, nurses can be more influential. People with power are listening and will be attuned to what nurses are saying more now than in the past, because there is greater necessity. Management committees make such communications possible. Routine meetings and "utilization reviews" offer nurses an opportunity to voice their ideas. This new atmosphere is having results. OR nurses tell me that doctors are noticing that the power in hospital is shifting away from them and towards nurses. It is not a landslide, but there is some movement.

An example an OR nurse recently discussed shows the combination of committee structure, data and willingness to listen to nurses. This particular OR nurse compiled data on "late starts" in the OR. She collected data showing conclusively that "late starts" contributed to *increased expenditure on nurses' overtime* and was able to explain this to her OR Committee.

The decision in the OR committee reminded the surgeons of their own interests in the hospital's financial situation, and it resulted in action being taken by the Medical Advisory Committee. This is one instance of how nurses, in their new role as unit managers, are influencing surgeons' behavior. Surgeons now are having to face up to their part in making ORs run efficiently. Whereas previously nurses might just be frustrated by having their well-organized day thrown off by surgeons being late, now there is a shared mind-set, an administrative process and tools for data-collection, all directed towards action.

I have been arguing that the predominant framework for decision-making in hospitals today is cost-efficiency. It is also the underlying orientation for most of the decisions made in OR Committees. Computers generate cost-accounting data, and this data has no gender and no professional attachments. That is one of the interesting features about collecting management information. It creates a certain kind of equality by bringing issues down to dollars and cents. Old ideas that carry privilege and hierarchy often lose out in this new climate. You don't get something just because of who you are. But, and I want to emphasize this - traditional ideas about nursing may lose out too. That is what is contradictory about the new realities.

Nursing values are not always coherent with the predominant mind-set of cost-savings, and nursing managers are often held captive to the efficiency framework, even when philosophically supporting nurses' interests in patient care. Also, sometimes nurses' needs and wishes are going to be in direct conflict with physicians'. It may be necessary, in those cases to find support for nurses outside the nursing department, e.g. in nurses' unions.

Returning to the question of "what is power that affects nurses and that nurses can tap into to improve their work lives", we are now in a position to draw some conclusions. We've been thinking about intra-organizational power. Rules that hospitals make about their internal functioning. Hospitals themselves are less powerful than they were years ago. We see how they are under pressure from outside - the state exerts pressure on them through funding mechanisms - that's the pressure that has introduced the new mind-set of business practice that is altering so much in hospitals. The state also exerts regulatory pressure - hospitals must bargain collectively with staff, must follow labour standards, and implement aspects of pay equity. Finally, hospitals operate in a much more competitive environment with regard to a nursing labour force. This is reflected in the new democratic management.

Hospitals have OR committees with a chairperson, and departments with heads or directors, and board committees. All of these have written terms of reference that say what each is responsible for and how members of committees are selected. Some are appointed, some nominated or elected. The decision process in your hospital should be researched to see how nurses participate. If they don't, how might they?

If you are a staff nurse, and you want to make something happen, discuss it among your co-workers and your head nurse. If your OR is decentralized, your head nurse will understand her role as your voice in the OR Committee. She will help you strategize and collect supportive data. She will know how the committee agenda is set up and how to get your items discussed. If what you want fits the framework of cost-efficiency, you will likely be successful.

Conclusions

The most fundamental challenge for nurses today is learning how to make the most of the new opportunities to participate in managing their work and yet not lose nursing's own vision of patient care. We have only slowly gained sufficient confidence and insight to see that sacrificing ourselves for our patients is not the way to go. There is no foolproof plan for nurses, but the challenge of the day is an important struggle to be engaged in. We have tried to convey what some of the pitfalls along the way may be, in the hope that knowing the framework will help to avoid them.■

Banff Springs Hotel to be site of '91 National OR Conference

In May, 1984, the 8th National Operating Room Nurses Conference was held in Jasper. The Operating Room Nurses Association of Canada (ORNAC) was still in its infancy. As a national organization of specialty nurses, it had "Mountains to Climb," which was the theme of that memorable Spring event.

Two years later, in 1986, among the cavernous heights of the Montreal skyline, the ninth national gathering of operating room nurses took place. This time, the theme was "Over the Mountains," the theme-makers aware of the fact that, even though ORNAC was on the way to emerging as a viable and productive association, there were still hurdles to overcome.

Over the next four years, from 1986 to 1990, ORNAC stabilized. Two more national events were held, one in Vancouver in 1988 (which celebrated the 10th Anniversary of the national gathering) and the most recent in Toronto in early April of this year. Although the mountain motif disappeared in the last two conferences, for those with long memories, the time has arrived to introduce that theme again.

Next year, from May 12 to 17, at the Banff Springs Hotel, Banff, Alberta, operating room nurses from across Canada will be asked to participate in "Moving Mountains," the mountain motif again recurring.

Added to this theme are two related conference objectives that will be part and parcel of the event, namely, "Mastering Skills," and "Maturing Professionally."

Earlier this past decade, ORNAC came into existence; it grew, it flourished; it evolved as a viable, national reality for every operating room nurse in Canada. Now, as the organizers of the 12th National Conference have pointed out, it's time for the association to mature and become more masterful in the pursuit of its objectives - and begin the new task of moving the mountains that stand in the way, and that epitomize the challenges of the 90s. Details of the Operating Room Nurses Association of Canada's 12th National Conference will be appearing in future issues of the *Canadian Operating Room Nursing Journal*. In the meantime, O.R. nurse delegates and exhibitors wishing information can contact:

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Brits say their hospitals are environment hazards

Hospitals pose an environmental hazard and should be labelled with a health warning, the British Medical Association's (BMA) annual meeting in London, England, was told.

Dr. John Dawson, head of the BMA's professional division said: "You are looking at buildings which are potentially dangerous unless substances are washed out of the air that is discharged or filtered from water put down drains."

News Clips

"In hospitals now, you have a range of very high technology waste substances that are radioactive and in some instances are complex organic chemicals which may be biological hazards." Dr. Dawson called for better ways of cleaning up the discharges.

Dr. Sarah Divall, a London doctor, told the meeting that doctors had been accused of producing more radiation from X-rays than nuclear electric generators.

Leafy, green plants can rid any area of odours/gases

Benzene, formaldehyde, carbon monoxide, etc. are toxins found in hospitals, offices and homes. You want to get rid of these odors and gases? Simple! Between 15 and 20 leafy plants are capable of cleaning the air in a 1800-square foot space through the process of photosynthesis. These and other toxins can cause such annoying symptoms as headaches, itchy eyes, scratchy throats and other seemingly allergic reactions.