Chapter Five
DATA ANALYSIS FOR READING ONE

5 Introduction

In the previous chapter, the research paradigm, methodology and methods utilised in this feminist study were described. This chapter is the first of two data analysis chapters. The data analysis in this chapter is based on Reading One of the interview transcripts, using the voice-centred relational approach to data analysis, developed by Gilligan (1982) and described in Chapter Four. Reading One focuses on each NUM's story as a whole and provides insights into the construct of power within the NUMs' working world in a way that reflects the aims of this study, which were to 1) explore what it is like to be a nursing unit manager in the context of the New South Wales public healthcare system, and 2) gain insight into the participants' perceptions of the preparation and support they received for the role of NUM. By using the voice-centred relational approach to data analysis, nuances within the NUMs' stories became significant and provide valuable insights into their working lives that would not have been possible using any other methods of qualitative data analysis.

As Brown and Gilligan (1992:18) suggest, in order to use this method of data analysis effectively, the questions asked of participants need to be sufficiently broad to draw out their experiences, connections and relationships. This is because, according to Gilligan (1982), the voice-centred relational approach to data analysis uncovers the intricate web of relationships, interactions and connections that is the central organizing feature of women's lives. Thus, in this study, as described in the previous chapter, the questions asked of the NUMs were subject to careful consideration and review through pre-pilot and pilot studies, to ensure they were broad enough to allow the NUMs to tell their stories in their own way. In this chapter, the data are organized in such a

way that the NUMs' stories are the central feature, interwoven with my interpretation of and responses to their stories.

My decision to present the data in this way is based on Gilligan's (1982) approach to the presentation of interview data in her book, *In a Different Voice,* in which participants' responses to broad questions are grouped together. Gilligan (1982) weaves her own interpretations of the participants' experiences throughout the text. These include observations about the participants' voice, power and imagery, which together paint a powerful picture of the different voices of women and girls. Gilligan (1982:2) suggests that the voices of women and the oppressed can be more accurately heard within their 'social context, where factors of social status and power combine'. Further to this, Brown and Gilligan (1992) explain that the first reading using the voice-centred relational approach to data analysis provides the pathway into another person's life story. This occurs as the listener (or researcher) attends to the drama and the events of each story, listening for words and silences and the webs of interaction, so that the 'interplay and orchestration of feelings and thoughts allow understanding of what is said and what is not said (Brown & Gilligan 1992:27). In addition, the first reading 'requires that we reflect on ourselves as people, in the privileged position of interpreting the life events of another' (Brown & Gilligan 1992:27). As discussed in the preceding chapter, the way that I have applied this method of data analysis to the NUMs' stories in this study reflects my own interpretation of Gilligan's (1982) method.

This chapter is organised in the following way. First, a demographic profile of the participants is presented which includes information about the NUMs' ages, their education, and their years of experience as a nurse and as a NUM. This information is discussed in relation to the literature regarding the aging of the nursing workforce and the education and support of NUMs. Second, I present excerpts from the NUMs' stories, focusing on their working lives. This is interwoven with my responses, interpretations and observations.

5.1 Demographic profile of participants

This section provides a demographic profile of the NUMs who participated in this study. This information is valuable as it assists in providing background about the age, the years of experience and education levels of the participants. A frequency distribution was a useful way of collectively presenting data about this group of NUMs.

I decided against including individual demographics because with only 42 NUM positions in New England Area Health Service, I was concerned that individual descriptions might breach participant confidentiality. For the same reason, some of the demographic information collected has been further collapsed to form the summary in Table 5.1. For example, the age range interval has been made broader to avoid identifying younger or older NUMs, while gender has not been included at all, because as already stated, only a small number of the NUMs in NEAH at the time of the study were male.

The data in Table 5.1 indicate how long the participants have been registered nurses and how long they have been NUMs, which was useful when considering how well prepared they felt to take on the role.

Table 5.1 DEMOGRAPHIC PROFILE OF NURSING UNIT MANAGERS (n=20)

AGE RANGE n=20		NUMBER OF YEARS AS RN n=20		YEARS AS NUM n=20	
20-40 years	4	5-20 years	8	1-5 years	11
41-50 years	12	21-40 years	12	6-10 years	6
51 + years	4			11+ years	3

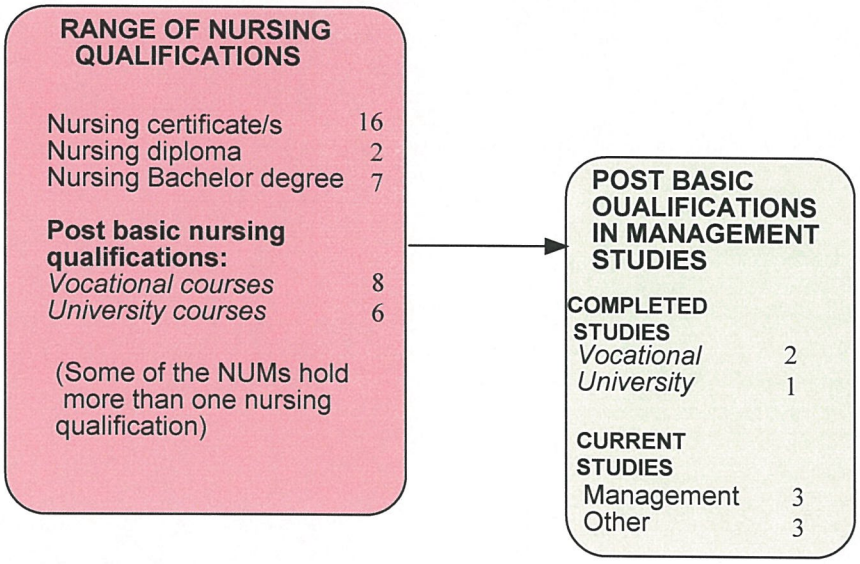
(Paliadelis 2005)

It can be seen in Table 5.1 that the majority of participants are over 40 years of age. This is consistent with the national statistics, which report an aging nursing workforce in Australia (Department of Education, Science & Training

(DEST) & The Department of Health & Ageing 2002; O'Brien-Pallas, Duffield & Alksnis 2004). Most of the NUMs have been nurses for between 21 and 40 years, and NUMs for fewer than 10 years. Both Johnstone (2003) and Duffield et al. (2001) discuss the high turnover of NUMs in NSW during the 1990's, and it appears that the group of NUMs in my study has a similarly high turnover rate, in that only a minority have been in their job for a decade or more. The relevance of this high turnover rate will become apparent when the participants talk about what it is like to be a NUM.

Table 5.2 summarises the range of qualifications held by the NUMs in this study. It needs to be noted that until 1986 a nursing certificate was the required qualification to gain registration as a nurse in Australia. In some States and Territories, this was changed to a Diploma of Nursing in the late 1980's, and then by the early 1990's all registered nurses in Australia were required to have a Bachelors degree to gain registration. Many nurses who held certificates undertook further studies to gain either a Diploma or Bachelors degree to align themselves with the base level of qualification required to become a registered nurse (Paliadelis 2001). In this study, I asked each NUM to indicate their highest level of nursing qualification, with some participants ticking more than one level of nursing qualification as shown in the results in Table 5.2. I have chosen not to identify which qualifications were held by individual NUMs as this could potentially identify them. Instead, I have condensed the data related to the NUMs' education level to show that sixteen of the NUMs hold a nursing certificate, two have nursing diplomas and seven a Bachelors degree. It can be deduced from this that some of the NUMs hold more than one of these nursing qualifications.

Table 5.2 RANGE OF QUALIFICATIONS OF NURSING UNIT MANAGERS



(Paliadelis 2005)

In addition to asking the NUMs about their level of nursing qualification, I also asked the NUMs to indicate whether they have, or were studying towards, any other qualifications. Within this category are vocational and postgraduate degree programs. As seen in Table 5.2, fourteen of the NUMs held some form of post-basic qualifications at the time of the study. I asked the NUMs to identify whether their post-basic qualifications were relevant to their current position. Three of the NUMs indicated that they had successfully completed management studies, two in the vocational sector, such as those offered by TAFE (Technical and Further Education) Colleges. One NUM had completed a postgraduate university program in management. An interesting fact is that while the majority of the NUMs held some form of post-basic qualification, most were not in management studies. Of the six NUMs who were enrolled in an education program at the time of the study, only three were pursuing management related courses and a further three were pursuing studies not related to nursing management.

As discussed in Chapter Two, the literature suggests that nurses are under-prepared for the managerial aspects of their role, particularly with the exponential growth in the administrative and financial responsibilities of NUMs (Chan 2001; Courtney et al. 2002; Duffield & Franks 2001; Jones & Cheek 2003; Waters et al. 2003). From the demographic data presented in

Table 5.2, it can be seen that only six of the participants have or are working towards formal management qualifications. Their lack of formal management education is consistent with the literature, which suggests that NUMs lack management qualifications because many management courses are not relevant to nurses and also because they are not encouraged or supported by the organization to enrol in such study programs (Brightman & Moran 2001; Courtney et al. 2002; Jones & Cheek 2003).

Having provided a demographic profile of the NUMs as a group, I will now introduce each of them. At this point, I acknowledge that I have given each participant a gender neutral pseudonym. In addition, I will refer to all participants as 'she/her' when necessary, in order to make my interpretations and observations flow smoothly. By referring to all participants in this way the confidentiality of the minority of male NUMs employed by NEAH will remain protected.

5.2 Reading One

During the first reading of the NUMs' interview transcripts, I also listened to the audiotapes, so that their voices as well as their words gave me an overall sense of the unfolding drama of their lives. In this first reading, I focused on each NUM's story, searching for their meanings, their metaphors and their interactions. Brown & Gilligan (1992:27) describe this as locating the participant in the 'geography of their psychological landscape', and in this case, I was searching for an overall sense of the construct of power within the NUMs' working lives. The NUMs stories are presented and discussed in this chapter based on Reading One, under headings that reflect the purpose and aims of the study. Throughout this chapter, bold text is used in some excerpts to denote the participants' vocal emphasis. This was suggested by Silverman (1993) to convey to the reader the participants' verbal intonation.

5.2.1 *What is it like to be a NUM?*

One of the first questions I asked of each NUM was 'Can you tell me what it is like to be a NUM?' This question was designed to address the study's first aim, which was to explore what it is like to be a NUM in the context of the New South Wales public healthcare system, and to gain a sense of the

construct of power within the role. As described by Doucet and Mauthner (1998), who also used the voice-centred relational approach to data analysis in various studies, the first reading reveals the whole story, including the plot and the characters. Thus, in response to this question, the NUMs told me stories of their role and responsibilities, the organizational expectations of them, and how they felt about their jobs. All these aspects provide insight into the construct of power within their working lives. I commence with an excerpt from Ali's story:

> *The role involves a clinical and administrative load, in that I work clinically at least 4 days a week and one day as a defined management day. However, every shift that I am on duty I am functioning at an administrative level, either in damage control or organizing* ***anything that comes through the door*** *[long pause]. I feel there is a tendency for hospitals to spend a whole lot of time and a whole lot of money looking after equipment, but my personal opinion is that they don't tend to look after staff in quite the same way. (Ali)*

I interviewed Ali in my office, as she felt it would be more private because she had no access to a private office at work. Ali spoke in a forthright way and I hardly had to prompt her to tell me about being a NUM. I did find it hard to comprehend that Ali's managerial responsibilities were supposed to be achieved in just one day a week, when no private office space was made available in which to complete the numerous administrative tasks. Her comments about the lack of care of staff reminded me of Russell's (2000:195) comment that nursing services often appear on the 'debit side of the ledger', meaning that nurses are often undervalued in healthcare settings because they are seen as a financial drain on limited healthcare budgets, rather than as an asset in healthcare delivery. Also, Ali's decision to come to my office to be interviewed resonates with my understanding of the findings of a study by Halford and Leonard (2003) in which nurses were found to have minimal access to many parts of a hospital, and spent most of their working lives confined to their own ward. The lack of office space may also reflect the patriarchal nature of healthcare workplaces, in which nurses are not afforded the same status or power as other healthcare professionals (Dendaas 2004).

Ali's long pause also hinted at what she was not saying. As Brown and Gilligan (1992:20) suggest, pauses, silences, and stops and starts in stories

indicate some of the struggles and complexities inherent in many women's lives. In Ali's case, she paused between telling me about her excessive workload and then telling me how that made her feel. This type of pause is described by Brown and Gilligan (1992:30) as 'self-silencing', and the authors attribute such silences, in women's stories, to the impact of a male-voiced culture, which discounts the importance of feelings, in favour of more objective, disembodied data. Ali's feelings about her job clearly indicated to me her dissatisfaction with the values she sees as important to the healthcare system.

Billie, the second NUM I spoke with, provided a more detailed account of the responsibilities expected of her, which gave me a greater understanding of the NUMs' substantive workload:

> *Staff management, day-to-day staff issues, budget control, monitoring expenses and cost of equipment, and casual staff, how much of those we need, general management of day-to-day functions, quality assurance, performance appraisals, liaising with administration then passing the information back to staff about developments within the hospital.* ***Oh God*** *[pause] and then you're a general staff manager and an administration manager. I also have the experience clinically, so I'm able to step in if necessary and help if the need arises. I'm aware that as a nursing unit manager, I am representing two faction s– administration and staff – and you can't be seen to be behaving in too much of a one-sided manner. But, there are key things that nurses have been trained to do, encouraged to do, you know, [pause] all the extra things, like talk to patients, educate them, but there is so little time because of budgetary constraints. (Billie)*

I felt I understood why Billie said *Oh God,* as this role sounded overwhelming to me. This response also reflects concerns raised by Jones and Cheek (2003) and Duffield and Franks (2001) that the NUM's role continues to evolve as well as expand. The conflicting agendas of nursing and management roles can be clearly heard in this interview, which is consistent with the findings of a number of international studies (Apker 2002; Bolton 2003; Cooper et al. 2002; Oroviogoicoechea 1996). Again, this interview was conducted in my office, as this NUM had to attend a meeting that brought her close to my office, so it was mutually convenient. This NUM's comments about the extra things that she found herself doing, such as talking to patients, clearly reflect the caring

nature of nursing work and demonstrate how she found her desire to do these things at odds with the expectations of a traditional management role (Halford & Leonard 2003; Hayes, Allinson & Armstrong 2004).

The next participant was Charlie, who had some difficulty finding a room in her workplace to hold the interview. The interview was eventually conducted in a consultation room that is normally used by medical staff to speak privately to patients or relatives. Charlie's response to the question about what it is like to be a NUM focused more on a human resource management perspective, rather than a broad description of the role responsibilities, described by the first two participants:

> *Right, well my job involves organising staff, as in staff profiles for staffing for shifts, performance management, education sessions, a sounding board for staff because sometimes they just want to whinge, they don't want to make any complaints, they just want things off their chest, in doing that you sort of pick up which of the staff are having problems, their weaknesses either clinical or emotional, or if they're getting burnt out or things like that. (Charlie)*
>
> Interviewer: Can you tell me anything else about being a NUM?
>
> *Well I find the paperwork, the amount of paperwork, more than I imagined, actually, I couldn't believe how much paperwork there is to do. There is also performance management, like with staff* ***and budgeting*** *[long pause]. Also sometimes I have a problem with my clinical, my compassion, you know, I think that sometimes as a manager all I'm supposed to care about is the dollar. (Charlie)*

This description provides a snapshot of the values that are important to this NUM. Charlie is concerned about staff morale, but has limited time to be a sounding board for staff because of her administrative load, particularly the paperwork required for performance management and budgeting. Charlie describes her desire to care for her staff as a problem, indicating that her feelings of compassion do not really fit with her image of a manager. As Gilligan (1982) suggests, the voice-centred relational method of data analysis uncovers the way that people talk about their lives, the words they use, and their descriptions of their feelings, revealing what is important to them. Thus, Charlie's use of the word *compassion* reflects the strong propensity she has for considering the needs of others. As discussed in the literature, a conflict seems

to exist between the role expectations of nurses and managers (Duffield & Franks 2001; Jones & Cheek 2003).

After I asked Charlie if there was anything else she could tell me about being a NUM, she started speaking in the first person and told me of her feelings of conflict about her job, caused by her belief that she is expected to care about money more than people. I believe that this shift to first person is significant, as it indicates the personal nature of the inner conflict described by this NUM. At this point, the interview was delayed, as Charlie had to respond to an urgent telephone call. When she returned she made the following comment:.

> *I think in this day and age, I think it [the NUM's role] is becoming more and more involved because of the political side of things, there is more and more paperwork coming through. (Charlie)*

This comment is indicative of the increased pressure placed on NUMs to do more with less in a financially constrained public healthcare system, a point described in the literature (Duffy & Chan 2001; Hegney, Plank & Parker 2003).

The next interview was with Dom, who ushered me into a tea-room shared by other nursing staff. The staff who were having their morning tea kindly agreed to leave so that we could conduct the interview. However, we were interrupted several times by apologetic nursing staff who wanted to access their personal belongings. I did not have the opportunity to see Dom's office because she said it was too small to conduct the interview in. Dom explained her role as being more focused on the clinical aspects of the job, which is understandable as this NUM described having substantive clinical responsibilities:

> *I work mostly clinical, I have one day management a week and 4 days clinical. In my management role I do quality, rosters, I oversee all the ordering, I make sure the unit runs well and that everything that goes on in the unit is up to date. I try to have everything as up to date as I can, clinical guidelines, medication guidelines. Being a mentor for staff, making sure they have appropriate education to work here. I also attend meetings, clinical meetings, nurse unit manager meetings, quality meetings, budget meetings [pause and sigh]* ***in fact it's never ending.*** *(Dom)*

Dom's comments are similar to those made by Charlie, regarding the expanding scope of the role. The pause and sigh between listing all the meetings she was required to attend and her comment that it was *never ending*, I interpreted as frustration about this aspect of her workload. Also, the importance of mentoring was mentioned, suggesting that Dom, like Charlie, wants to care for her staff, by mentoring them and giving them appropriate education. This would be made more difficult if meetings took her away from the ward for much of the time. The next participant, Eddie, discussed the challenges of coping with multiple responsibilities in the context of a fiscally constrained healthcare system. Eddie arranged for us to talk in an interview room normally reserved for private conversations between patients, their relatives and staff. Eddie described her role as also being primarily focused on clinical responsibilities:

> *I see my primary function as being a clinician, I spend three quarters of my time in a clinical role and the other quarter I spend doing management stuff [pause] sort of in my spare time, as I call it, because we are short-staffed. I can't afford to be primarily a manager who does paperwork. We've all got to get in there and provide a service, and if we don't get in as managers and do our fair share* ***we're not going to have a service.*** *(Eddie)*

Eddie was very keen to get through the interview quickly and get on with the job. She seemed to me to be experiencing a lack of time to tackle the managerial aspects of her role, causing her to lump them all together under the heading of *management stuff*. She indicated that this *management stuff* was done in her spare time because her primary function was that of a clinician. According to this participant, the amount of time available to complete her administrative role was approximately a quarter of her working time. This is consistent with the difficulty inherent in having a clinician-manager role, described by McConnell (2003) and Boucher (2001), who both indicate that professionals in management roles tend to devote more time to their professional duties, which McConnell (2003) describes as wearing the hat that fits best. Eddie's comments about the importance of her clinical role also reflect the difficulties NUMs face with the widening gap between the demands on the healthcare system and the system's capacity to cope (McLoughlin & Leatherman 2003). For example, in a system dogged by

nursing staff shortages, NUMs often assume an additional clinical load to ease the burden on their nursing staff. It was evident to me that this NUM placed the care of patients above all else and was willing to neglect the managerial aspects of her role to provide that care.

The next interview with Frankie was one of the most difficult from my perspective because this NUM shared an office with others. Frankie said she did not have access to any alternative private space so the interview was conducted with other people present. I felt this lack of privacy may have influenced Frankie's ability to be open, but despite this drawback, she told me this about her role:

> *I don't have a clinical load, but if it's really, really busy I go in and give them [the nursing staff] a hand. But it's supposed to be non-clinical, which means it's purely management. I've got rosters, budgets, skill mixes, I've got quality activities, I've got statistics to do, in between going to all those dreadful bloody meetings that we have to go to, where you seem to hear the same sort of information over and over. Staff morale, disciplinary issues if there are any, sorting out differences between staff. It's also budgets, looking at the way staff does the stores, whether they're over ordering, it's looking at new equipment, looking at fundraising, trying to raise money so that we can get stuff we can't get out of our budget. (Frankie)*

Frankie's role was more management orientated than those of some of the other respondents and she described having a diverse range of responsibilities, including the need to raise money for equipment not covered in the allocated budget. Frankie's comments reminded me of those made by Diers (2004:325) that 'nursing unit/ward managers are managing small businesses, often with budgets in the millions of dollars, and their budgets are set on somebody's pie-in-the-sky guesstimate'. Frankie's fundraising efforts highlighted how difficult it can be trying to provide appropriate care for patients within a limited budget over which the NUM has little control. Staff morale was also mentioned by Frankie, as was sorting out differences between staff. I found it very interesting that this NUM started off referring to her role as *it*, saying *it's supposed to be non-clinical and it's purely management*, rather than using 'I' or 'my'.. This indicates to me a certain distance between her sense of self and the role. Gilligan (1982) suggests that women's sense of integrity is intimately connected to their sense of self in relation to others.

Thus, Frankie's verbal distancing from her role may reflect the difficulty she has in seeing herself as a manager.

So far, all but one of the NUMs has mentioned the importance of staff morale, saying how they strive to look after their staff by being a mentor and a sounding board. Speedy (2004) suggests that women managers are more likely to try and be inclusive of staff, by striving to build positive relationships, by sharing information, and by caring about them. Similarly, Taylor, Gilligan and Sullivan (1995) in their study of the relationships of women and girls, indicate that the notion of caring for others by including and listening to them is a key feature of female relationships, but one that is not valued or promoted within male-voiced cultures. Certainly, in the healthcare context where the dominant culture is patriarchal, as described in Chapter Three, the importance of listening to and caring for others is not in evidence, as it is in all of the NUMs' stories so far.

The next participant was Gia, who cancelled one scheduled interview due to work commitments, but was able to find a spare hour the following week. Gia said this about being a NUM:

> *I'm the conduit for everything that happens on this unit. For example, I'm responsible for physical, human and financial resources in order to optimise patient care outcomes. So when you look at what that means, it means I do the rosters, I monitor how the budget is spent, I'm the clinical manager at the coalface, I allocate human resources on a weekly, a monthly and a yearly basis. I've got to relay information, receive information and give a professional opinion. I've got to know what my resources are, today. I'm also the ward clerk, because we don't replace them when they have an ADO [accrued day off]. (Gia)*

Gia was interrupted twice during the course of the interview by nursing staff wanting urgent advice about clinical issues. These staff members appeared to treat Gia as a font of clinical knowledge, and it seemed to me that she was comfortable and confident in that aspect of her role. For example, one of Gia's comments, *I'm a clinical manager at the coalface*, and her response to the interruptions by nursing staff, reflected her clinical expertise and strong clinical focus. The job description for NUMs (NEAH 2004) and Duffield et al's comments (2001:685) indicate that NUMs are expected to have expert clinical

competency, so that they can act as senior resource persons for less experienced nursing staff. This is obviously not always easy, as the time taken to attend to clinical duties reduces the time available for their expanding managerial responsibilities.

I contacted the next NUM, Hali, on several occasions to arrange a suitable interview time. When we finally met, I had to wait quite a long time for Hali to complete clinical tasks before she could see me. Hali told me this:

> *My job involves the day-to-day management of the ward, the staffing, and the patient allocation to the appropriate staff, just making sure you are following up on loose ends. I do the rostering, all the rosters, I respond to any requirements, monthly reports, quality reports, OH&S [occupational health and safety] reports, look at the budget each month and send off a budget report, and basically solve problems that are out there. Every couple of days I do a complete round of the ward checking medication charts and care plans to make sure they're all done, they're [nursing staff] pretty compliant most of the time, but then they don't know when a check is going to happen. (Hali)*
>
> Interviewer: Does your role include a clinical load?
>
> *No, I don't have a patient load as such, I allocate the girls [nursing staff], and I do the follow-up, so that if I see that someone is running behind then I'll go and shower someone or do the medication round. If I had to do 90% managerial and 10% nursing* ***then I wouldn't want it.*** *(Hali)*

From her comments that she would not want a role that was 90% managerial, it appeared that Hali also favours the clinical aspects of her job, despite the fact that she does not actually have any direct clinical responsibilities. Hali clearly focuses a lot of her attention on patient care, describing the strategies she uses to ensure the nursing staff are providing quality patient care. This impression of Hali as a manager resonated with my understanding of the conflict nurses feel when they have to abandon bedside care to manage a ward. On another level, this conflict also typifies the stereotypic image of nurses versus that of managers, discussed in Chapter Three. Thus, on both levels it is easy to understand why this NUM might feel more comfortable performing familiar nursing duties than adopting a managerial persona. Furthermore, I linked Hali's comments to my understanding of Kanter's (1977) theory, which suggests that first-line managers, who lack access to the

structures of organizational power, spend time overseeing the performance of their staff.

The next interview with Jaz left me with an entirely different impression. Jaz was one of the more difficult NUMs to schedule for an interview. She cancelled two interviews due to last minute work commitments, and one when I arrived at her office door. The interview finally went ahead with only one interruption, when Jaz had to answer the telephone. Jaz said this about being a NUM:

> *I went from being the NUM of [name of one clinical area] with approximately 0.5 managerial time each week, to a full-time nurse manager, with some clinical input still when needed. I have gone from being a clinical person to a manager basically overnight, and* ***I must say*** *without much in-service on how to do that. It's the big picture stuff I'm trying to manage now, not the day -to-day stuff. I found I had to distance myself from a whole lot of issues [long pause]. It's physically and mentally very exhausting. (Jaz)*

Jaz was quietly spoken and gave me the impression of calm efficiency. She thought carefully before answering the question and referred several times to *the big picture stuff* throughout the interview, which indicated to me that she was trying to shift her focus away from the smaller details. According to Kanter (1977), this sort of behaviour is conducive to a flow of power from manager to subordinate, as the manager trusts the workers to complete their tasks effectively. Similarly, Fosbinder and Everson-Bates (2000) indicate that the ability to see the big picture is one of the most important predictors of success for NUMs. Despite the impression of calm that I described, Jaz paused at this point and then indicated that the demands of the role were taking their toll, in that she felt physically and mentally exhausted. From Jaz's description, it was also clear she felt that she lacked sufficient training for her role, as she describes the rapid change from clinical person to manager basically overnight, adding that she received no preparation to assume a more management orientated role. This is consistent with the findings of other Australian studies (Cronenwett 2001; Jones & Cheek 2003; NSW Health Department 2001), and is also reflected in the demographic profile provided in Table 5.2, which indicates that few of the NUMs in this study had formal management qualifications.

Kim, the next NUM interviewed, also cancelled several times due to ill health, but I was able to finally arrange a time to meet with her in her office. This is her description of her role:

> *As a nursing unit manager I'm responsible for the clinical, the day-to-day clinical management of patient care, that means on any given day I spend at least three hours on the wards. I give patient care, I look at care plans and ensure that the staff have the facilities to do their job, and the processes that we have in place for documentation of patient care, sorting out problems as they arise, dealing with medical staff and equipment, staff issues, performance appraisals, budgetary issues and trying to keep a lid on all that [long pause]* ***It's a very big job****. Oh and rosters, yes,[pause] we are sort of told to do more and more with less and less. I don't have a patient load you know, but I'm responsible for the provision of care to the patient [long pause]. It's really hard for me, I come to work still feeling like I have to do the clinical work, I feel I need to be out there doing the actual work, and I've nearly run myself into the ground, trying to do that and all the other stuff. (Kim)*

Kim looked tired to me, she sounded dejected and sat slumped in her chair. From all the interviews so far, this one left me feeling depressed because Kim's story and appearance suggested to me that she felt overwhelmed by her role. Kim felt that her role was challenging because of the many demands, which made it difficult for her to achieve all that was expected of her. Kim paused for quite some time on two occasions, before resuming her story and telling me her feelings about the conflicting demands of her job. This is interesting as Speedy (2004) suggests that women are more likely to talk of feelings, while men talk of doing. By using a voice-centred relational approach to data analysis I have been able to uncover this difference, allowing for new insights into the working lives of the NUMs in this study. In addition, Brown and Gilligan (1982) describe the way in which women may deliberately silence themselves because they fear revealing their feelings in a male-voiced world. These authors suggest that pauses and silences are significant in stories, as they denote times when people are struggling with their feelings. Women do this because they have become used to hiding their feelings in a world where the feelings are discounted in favour of objectivity (Brown & Gilligan 1992). Thus, the pauses in this NUM's story expose her feelings about her role. For example, after each pause, Kim makes a profound statement that summarises her feelings about her life as a NUM, such as, *It's a*

very big job, and *It's really hard for me.* Kim's pauses indicate the struggle she has in articulating these feelings. This is just one example of when I believe that the significance of voice and silence has been enhanced by the use of a feminist methodology and the voice-centred relational approach to data analysis.

The next NUM, Lee, was interviewed in her office:

> ***My job is bigger than Ben Hur.*** *As the nurse manager you're responsible for the clinical running of the unit, for all the patients and all the practices, you're responsible for your staff and work relations, education, you're looking after all their needs. It's very difficult being in middle-management, it's a huge, huge job, you have to fulfil your role in terms of quality, workplace health and safety and all those things, like future development and government action plans. There's meetings and discussions about bricks and mortar, equipment, purchasing, fundraising, as well as patients and relatives. (Lee)*

I thought that Lee looked very tired at the time of the interview, yet despite this she seemed happy to talk to me although she organized papers on her desk and checked rosters on the computer screen during our meeting, giving me the impression that I was holding her up. Her comment about the job being *bigger than Ben Hur* reinforces the comments made by many of the other NUMs and the beliefs of several authors that the job of a NUM in Australia is still expanding (Duffield & Franks 2001; Jones & Cheek 2003). Lee also talks about her desire to look after the needs of her staff, in common with most of the other NUMs. So far, all the participants have spoken about the difficulties they face in meeting the managerial demands of the job whilst also coordinating the provision of quality nursing care and caring for their staff.

Mel, the next NUM interviewed, was relatively new to the job and spoke about the difference between acting in a NUM's role and assuming the position permanently. Mel's office was the location of the interview and she made the following comments about her role:

> *Being acting [as a NUM], I just sort of coordinated activities within the unit, tried to make everyone as happy as I could. When I started permanently I started doing the ordering myself, rather than leaving it up to the staff, because I already knew what we needed, and I've always been under budget except once, we've got very expensive*

medical supplies you know. I get one management day a fortnight, so I treat myself as basically a team leader, coordinating and organising and that sort of stuff. I also have to do monthly OH&S reports and budget reports. (Mel)

Interviewer: You do all that in one day a fortnight?

Yeah, one day a fortnight, although I get in here [the office] whenever I can, normally after lunch, and I try and spend an hour or two, but sometimes it's difficult. (Mel)

This NUM seemed to be brimming with enthusiasm, as she smiled frequently and spoke with confidence. However, I could not help wondering if she would continue to cope, with only one management day every two weeks to complete all the reports, rosters and other administrative tasks she described. Mel's comments indicated that she was proud of coming in under budget, highlighting the importance placed on cost containment within healthcare organizations (Apker 2002). Also, I wondered why she had taken on the additional responsibility of ordering supplies, a task usually left to nursing staff, when the NUM's role already carries a heavy workload. I thought that maybe this NUM had taken over the ordering to relieve the staff of some of their load or alternatively by doing the ordering this NUM would have more control over the limited resources available. However, maybe Mel's behaviour reflects a lack of organizational power. As described by Kanter (1977:186), powerless first-line managers do not readily delegate tasks.

Nat, the next NUM I met with, was one of the most difficult to schedule for an interview. This NUM cancelled three times, causing me to ask her if she had changed her mind about participating in the study. She assured me that she was still willing to be interviewed, but found it difficult to find the time. I finally met with her in her office, on the fourth attempt. Nat, also a fairly new NUM, said this about her role:

I coordinate the staff in [several clinical areas] and try to make sure we've got a complement of staff in all those places, and if not trying to backfill. Just doing the basic running of the clinical day-to-day work, as well as doing the management side of things, as far as trying to get new equipment and watch the budget, you know I have to monitor it to see what's being spent. (Nat)

Interviewer: Anything else?

I think I'm actually managing to work much smarter these days, not trying to do fifty things at once, and not so worried about pleasing everybody [pause]. I think I will

have to try harder to look after myself, so that I can look after the people I work with better. (Nat)

This NUM looked very pale and rather sad to me. She did not make eye contact and did not smile. I got the impression via these non-verbal messages, as well as the slump of her shoulders and her drawn expression, that she felt overwhelmed in her role, despite the comment she made about *working smarter these days.* Nat referred twice to her feelings regarding other staff: the first time, she said she was not so worried about pleasing everybody and then, after pausing, she added that she wanted to look after the staff better. In all the NUMs' stories, so far, I sensed that from their perspective, an integral part of their role revolved around caring for patients and staff.

The next NUM to be interviewed, Oma, indicated a willingness to participate after receiving the first invitation letter, but she was then difficult to contact. I left several messages over a number of months but to no avail. Finally, Oma telephoned me one day to ask if I could conduct a telephone interview. A telephone interview obviously did not allow me to observe this NUM's working environment, nor to record any non-verbal observations, but it was a useful alternative when a face-to-face meeting was too difficult to organise. Oma made the following comments:

I am responsible for many different factors of the operation at the coalface. I am responsible for day-to-day management of the unit in terms of resource allocation, in terms of, you know like human resource allocation, ensuring that the skill mixes are correct on the ward, ensuring that the staffing levels are adequate to meet the activity on the ward. I'm also responsible for the ward's budget, to a degree anyway. I mean some things are beyond my control but each month I have to do a budget report. I'm also responsible for the quality activity in the department, for rostering and ensuring that the rostering meets the award requirements and also gives people a reasonable life style as well. I'm responsible for ensuring that the staff appraisals are done on an annual basis, I monitor that they attend their compulsory lectures. Basically management of the financial, human and physical resources in the ward. (Oma)

Oma's comments are similar to those of the other NUMs who also discussed the extensive responsibilities of the role. This participant hinted at the difficulties she experiences in managing a budget over which she has little control. Persson and Thylefors (1999) found that one of the challenges for

NUMs was that resource allocations are often decided at a higher level, yet the NUM is still responsible for preparing monthly budget reports and providing quality care within those budgetary constraints. According to Kanter (1977), a lack of input into decisions about budgets reduces a manager's access to organizational power. Oma also spoke about rostering in a way that would provide the nursing staff with a reasonable lifestyle. Anecdotally, this is no mean feat, as nursing shift hours can potentially isolate staff from their family, friends and community. Thus, Oma's desire to give her staff a reasonable lifestyle indicates her desire to care for her staff.

I interviewed Parry, the next NUM, in a patients' sitting room, as she did not have access to any private office space. This was what she told me about being a NUM:

> *You've got all your patient care, all your clinical stuff and things like that and then you've got all your management stuff like your budgets, your drugs and all those bits and pieces, all those things that fall into it. So, you're in charge of the lot, rosters and staffing and everything. (Parry)*

Parry sounded happy and she smiled a lot. She laughed after she finished telling me about what the job entailed, and then said, *I think I got the job because* ***I was the only one that applied.*** I suspect that sometimes nurses are not keen to apply for NUMs' positions because of the inherent conflicts caused by the duality of the role as well as the excessive workload and poor remuneration that comes with the job, as described in Chapter One. Parry's description of the role responsibilities was similar to the other NUMs' descriptions. In addition, I found Parry's use of the word 'you' interesting, as she consistently referred to her role responsibilities in the second person. I felt this may have suggested a distancing from the role and a lack of identification with it.

Ros, the next NUM interviewed, contacted me one morning to ask for a telephone interview, saying that she had some spare time that afternoon. Ros spoke to me in a clear, confident voice, and said this about her role:

> *I'm responsible for all nursing staff in this area, plus equipment and stock, making sure the ward runs on time, making sure there's no problem. Oh! and budgeting of course,* ***and probably every other job that no body else wants.*** *(Ros)*

Interviewer: Sounds challenging.

Yes it is very challenging. It's very easy for them [senior hospital administrators] to sit behind a desk and say this is what you should do with your $50,000, but you should be able to have some input into that decision. (Ros)

Although Ros sounded confident on the telephone, I thought that her comments illustrated the frustration she experienced when she had to coordinate the delivery of quality care within an allocated budget into which she had no input. According to Apker (2002), a lack of input into decision-making, huge workloads and a lack of resources can cause significant stress for NUMs, which can lead to burnout. Also, Ros's comment about assuming additional responsibilities that nobody else wanted, confirmed the expanding role and suggests that NUMs are used as the dogsbodies of healthcare, as described by Sullivan (2004). Further evidence of this can be heard in a number of the descriptions of role expansion described by a majority of the NUMs.

So far, the participants have all described a role that seems to reflect a lack of access to the structures of organizational power. For example, the NUMs repeatedly mention a lack of staff, resources, time, and authority to make decisions, reflective of Kanter's (1977) structural determinants of organizational power. Their experiences suggest to me that the NUM's role is significantly influenced by the traditional image of nurses as the housewives of healthcare (Buresh & Gordon 2000; Centre for Nursing Advocacy 2004), in that they are expected to nurture and provide care, support and empathy for staff and patients, without having a voice in organizational decision making.

Sam, the next NUM I spoke to, also requested a telephone interview. However, in this case, the participant said she felt more comfortable talking to me over the telephone, as this would better protect her identity, rather than if I visited her office. Therefore, I readily agreed to conduct a telephone interview and this is what Sam told me about being a NUM:

I don't have a clinical load at all and I think a lot of other NUM's do, but mainly this job keeps me fairly well occupied. Sometimes my calendar could be totally busy, mainly due to the day-to-day managing of staff that I've got under me, and I need to go to a lot of meetings, I'm on a lot of committees. On Friday, for instance, I've got to

> *go to a financial seminar all day. So when that happens, when I'm at something all day, I come back and the emails keep coming in, the mail keeps coming in, so it takes me another half a day to clear what I should have done the day before. (Sam)*

Again, this NUM's comment about having to spend time catching up if away from her desk for just one day indicates to me that being a NUM is a very demanding role.

The next NUM, Tia, whom I interviewed in her office, also described having a very demanding role:

> *Well, [long pause] my job involves managing [more than one clinical area] consecutively at one time, so basically I have to see what's happening everywhere. I do quite a bit of clinical as well, probably more in [one of the clinical areas] than in any of the other area. However if the wheels fall off in any of the areas I try my best to help when I can, when I'm available. I co-ordinate the staff in all the areas and try to make sure that we've got all the staff we need. I'm in charge of the basic running of the units as well as the management side of things as well. (Tia)*

Tia's comments about the extent of her role are very similar to those of the other participants, and reflect the findings of a study by Courtney et al. (2002) that NUMs in regional and rural areas have a broader range of responsibilities than their city-based counterparts. Tia was obviously very busy on the day of the interview, as staff repeatedly interrupted us to ask her for clinical advice. As discussed in Chapter Two, NUMs are promoted on the basis of their clinical excellence, so junior nursing staff often view them as clinical educators and resource persons.

The next interview with Val was also conducted via the telephone. This was the only interview that was not audiotaped, at the request of the participant. Therefore I made notes in my journal while listening to Val on the speaker-phone. The first time she telephoned, an incident in her unit/ward caused her to end the conversation very quickly. She subsequently telephoned again several days later and we continued our conversation. As I was only taking notes, I cannot quote this NUM verbatim with any degree of accuracy, so I will summarise in my own words what she said about her role.

Val said that she had been a NUM in a variety of different clinical settings over the preceding few years, and so felt she could speak with some authority when she said that the role was constantly changing and growing, and with every change came greater responsibility. This NUM said the current job was huge and very challenging, although she enjoyed the challenges. Val spoke about having responsibilities for staffing, budgeting, equipment, clinical practice and education of staff. Val said she took work home because there were not enough hours in the day to get everything done.

The final interview was with Willow, who had also held several NUM positions. Willow spoke to me in her office and told me the following about being a NUM:

> *Well I've been a NUM for quite a few years now and the role just keeps getting* ***bigger and bigger*** *[laughter]. There was a time when matron did all the rosters, and the hospital administrator ordered all the supplies, all the charge nurse did was concentrate on looking after the patients, but not anymore. Now I have to look after the staff, the rosters, the budgets, the supplies, and file millions of reports, well it feels like millions, and attend lots of pointless meetings,* ***where no one listens to me anyway!*** *[laughter] (Willow)*

I felt that in many ways this final participant summarised a number of the points made earlier by the other NUMs regarding the expansion of their role, the increases in the amount of paperwork and the responsibility they feel for looking after the needs of nursing staff. Willow, like a number of the other NUMs, talked about having to attend a lot of meetings, and indicated that attendance seemed pointless as no one listened to her. I found it interesting that a commonality in a number of the NUMs' stories was that their attendance at numerous meetings did not seem to equate to a meaningful role in the decision-making processes of the organization.

Even though Willow laughed during her interview, I sensed she felt concerned about not being heard. Buresh & Gordon (2000) contend that nurses' opinions and ideas are rarely heard in healthcare organizations, as nurses lack the authority or status of other healthcare professionals (Apker 2002; Parsons & Stonestreet 2003; Sullivan 2004; Waters et al. 2003; Wilmott 1998). This lack of voice seems to also limit the role of the NUMs in my study.

I listened to Willow's responses knowing that I had heard similar sentiments in nearly all the other stories. I tried not to prolong this interview, as Willow watched the door constantly and seemed very keen to finish the interview.

This section has introduced each NUM and provided an overview of their stories, based on Reading One of the transcripts. It focused on what it is like to be a NUM, and addressed the first aim of the study. While the NUMs' experiences presented throughout the remainder of this chapter are still based on Reading One of the interview transcripts, the next heading reflects the second aim of this study.

5.2.2 Preparation and support for NUMs

All of the NUMs described what it was like for them when they first took on the NUM role. Many of them explained why they thought they were successful in gaining the NUM position and then went on to describe how they gained the skills they needed to function as a NUM. Some of the participants volunteered this information in the course of the conversation, while others were asked some of the prompting questions to further explore these issues. The following three prompting questions in the interview schedule cover the aim of gaining insight into the participants' perceptions of the preparation and support they received for the role:

1. Can you tell me what it was like for you when you first made the transition to NUM?
2. Why do you think you were successful in gaining the position of NUM?
3. How have you gained the skills needed in your role?

While the NUMs all described unique experiences in moving from nurse to NUM, they collectively indicated that they felt somewhat uncertain and under-prepared when they first assumed the role. However, as only a minority of the NUMs had undertaken management education programs such feelings were understandable. The NUMs dealt with their lack of formal management preparation in a number of ways, some by seeking advice from textbooks, while others learned from more experienced NUMs. However, most of the NUMs just struggled through the early transition days, learning their job by trial and error, which is illustrated by the following examples:

At that time there was a climate in the health service I was in, which was a smaller rural hospital, where if you had been there for a while, as I had been, there was an assumption of knowledge. There was an assumption that if you trained there, which I had done, and then gone away and come back that I knew how everything worked. I wanted to get a stronger handle on how to run the job and also to help me identify whether my ideas and the way I like to work are conducive to management, so I just went looking and found a three- week course. (Ali)

When I became the NUM I really had no management experience at all and I think I got thrown in at the deep end and I just had to sink or swim and I was just lucky that I swam. And it was a bit of a hit-and-miss affair. I would say I made mistakes, just like anyone else does, but I think I learnt basically to look at other people and I just had my own values and that's just basically how I learnt. I didn't do any formal education to become a manager or anything like that, I just learnt on the job. (Eddie)

I researched the position very well. I'd previously been in a NUM's position and I left that and said I would never do it again. But the staff in this ward were extremely supportive, they really wanted me to apply, they encouraged me to apply, so all in all I didn't have a bad transition because I had support. Our [nursing executive] is fantastic. She's really supportive. You can go and ask her anything. You never get made to feel like you're a fool. I also access other NUMs who help with things if I'm not really very sure. (Hali)

Yeah, I had a hell of a time to start with because it was a new role for me, I had a lot of learning to do. (Nat)
Interviewer: So can you tell me how have you gained the skills needed in your role?
It's all been on-the-job learning for me. I have bought three different books on management, and I've found them all really good, just books I've read out of interest. (Nat)

These examples illustrate some of the challenges faced by the NUMs when they were newly appointed. From the demographic profile provided earlier, it is significant that only three of the NUMs had obtained formal management qualifications, and only a further three were studying management courses at the time of this study. Only one participant described seeking out a formal course of study in an effort to gain the skills needed for the role. This is consistent with comments made by Jones and Cheek (2003) who indicate that

appropriate educational preparation of NUMs in Australia remains an unmet need, as many courses are costly, time-consuming and irrelevant to the NUM's role. Similarly, a number of international studies have identified a similar lack of suitable education for NUMs, plus a general reluctance by nurses to participate in such courses (Crossan 2003; Kleinman 2003; Reedy & Learmouth 2000). It was interesting to note that one participant, Hali, said that she had left a NUM position in the past, saying she would never do it again. However, she was persuaded by the support of nursing staff, including a senior nursing executive, to again apply for a NUM's position. This experience reinforces the importance of support to these NUMs and links to one of the reasons for NUMs high turnover rate, described in the literature as due to stress and dissatisfaction caused by a lack of support (Duffield et al. 2001; Johnstone 2003).

The NUMs' stories contained further examples of the impact of a lack of training on their performance of the role, which contributed to the difficulties they experienced in the early days of taking on the NUM role:

> *It's very, very difficult, you worry about everything, because there is no real training that you get to help you shift into the role. (Parry)*

Willow also found it difficult to develop the skills needed to be a NUM:

> *I mean how do you learn to manage budgets, staff appraisals? I haven't had time to do any courses, although I think I'm supposed to, but I don't have the time or the inclination at this stage of my career. (Willow)*

The lack of training evident in both these NUMs' comments needs to be considered in light of the current context of the NSW healthcare system. For example, under the nurses' State Award (NSW Public Hospitals Nurses (State) Award 1999), there are no financial benefits attached to further study for nurses in clinical or management roles. Anecdotally, there is also a lack of study leave to pursue formal qualifications. This is because study leave is limited and NUMs' are rarely able to be released from their duties, due to the nursing shortage. So, while the literature suggests that appropriate preparation and education is vital if nurses are to play an effective management role in their organization (Fosbinder, Everson-Bates & Hendrix

2000; Kleinman 2003; Scoble & Russell 2003), these NUMs described a lack of incentive or support to enrol in management studies.

I need to note that for some of the NUMs in this study, their early experiences of the role that initially caused them challenges have since been overcome. So, while some of the participants could recall the difficulties they faced in the past, they now felt comfortable and competent in the NUM's role. For example, Frankie said this:

> *I've been a nurse unit manager for a long time, but you know it was very, very difficult at first. It was difficult in that you worked beside staff for years and years and as soon as you start to climb the ladder, well it's like the tall poppy syndrome. Everyone wants to stick the knife in and give it a little twist, when you've got your guard down. (Frankie)*

This NUM spoke with confidence, and although she described having difficulties when she was a new NUM, she went on to say that she now felt comfortable in the role, a sentiment that was absent in the majority of the NUMs' stories.

As well as describing a lack of appropriate education and training for the role, a number of the NUMs also commented on the level of initial and ongoing organizational support they received. Some examples follow:

> *I don't feel like I've had any support whatsoever from the management of this place. I feel that they don't know how to deal with a lot of things, and when they do try and deal with them it's too little too late, and they don't seem to learn from it anyway. I will say that initially I did have faith in the administrators of this place until I ended up needing help and support and didn't get it, nobody listened or cared. (Nat)*

Nat's description of the lack of support she encountered saddened me. I felt that coping with an overwhelming role, for which one has little training, would be very difficult, and that feeling unsupported in that role, as Nat does, would be devastating.

Mel, the fairly new NUM, had a different perspective:

Management are very supportive [long pause] but at this stage I haven't actually had any conflicts or decisions about things happening on the ward, it's only been a little while since I've been in this position, but it's been pretty good so far. (Mel)

Mel's comment indicates that she has yet to find out how supportive the organization might be in times of conflict or difficulty. In addition, the long pause in Mel's story suggested to me that her statement about the supportiveness of the organization was under review as soon as she had voiced that opinion.

While all the NUMs described having a role for which they felt ill prepared and poorly supported by the organization, many also described the informal education and support they received from other NUMs and nursing staff. For example, Billie said the following:

I get support from the other NUMs that I know, sometimes we have morning tea or just get on the phone to each other, because you know there isn't much education for NUMs.(Billie)

Overall, the NUMs' stories indicate that they had little formal preparation or organizational support. Making the transition from nurse to NUM for the majority of the participants seemed to have consisted of learning by trial and error, reading management books or asking advice of more experienced NUMs (Paliadelis 2005). The importance of the social, rather than the educational, support that the NUMs received from each other and nursing colleagues is discussed in more detail in Reading Three of the next chapter, which specifically focuses on the NUMs' working relationships.

To this point this chapter has provided an analysis of the data based on Reading One in response to the two study aims. However, as discussed in Chapter One, both aims were developed to explore the construct of power within the NUMs' working lives. As previously discussed, even though an exploration of power in the NUMs' working lives was the overarching purpose of this study, no specific questions were asked about this construct, in order to avoid the negative connotations associated with power. I felt that such questions may have confused or led the participant, which in turn may have limited or biased their responses. Therefore, the following analysis, still

based on Reading One of the transcripts, indirectly explores the construct of power by attending to the participants' stories about being a NUM.

5.2.3 The construct of organizational power for NUMs

While considering the NUMs stories as a whole, during Reading One, I noticed that many of the NUMs volunteered information that provided insight into the organization in which they work. The construct of power is to be found embedded in this aspect of their stories. As previously discussed no interview questions asked directly about the construct of power because power is not a topic that sits easily with nurses, due to traditional connotations of power as controlling or exploitative (Speedy & Jackson 2004). Therefore, within the NUMs stories' their observations, feeling and thoughts about the organizational culture in which they work provided an indirect route into the construct of organizational power within their working lives. Some of the NUMs discussed their place within the organization in the course of the conversation, while others were asked some of the following prompting questions which indirectly revealed information about the construct of power:

1. What part do you play in your organization?
2. Can you tell me about your work relationships?
3. Do you think your nursing values are reflected in the values of your organization?
4. Are your opinions heard in your organization?
5. How are your achievements rewarded?

These broad questions were designed to elicit information about each NUM's place within the workplace culture and her level of access to opportunity, support, information and resources, if these issues had not already been discussed during the interview. The following excerpts, again based on Reading One, are examples from the NUMs' stories that I have related to the construct of organizational power:

> *In the organization, in terms of the daily management of the ward, NUMs are fairly autonomous. We have NUM and CNS [clinical nurse specialist] meetings, we have monthly meetings with the DON [Director of Nursing] and we also have a monthly department heads meeting that is chaired by the executive officer [long pause]. Still most decisions come from above and then we have no say in them. (Oma)*

Oma's comments reflect the insular nature of the nursing hierarchy within healthcare organizations. This description indicates that NUMs are not integrated into the wider decision-making bodies of their organization, as nurses interact predominantly with other nurses. Furthermore, after a long pause, Oma reveals that despite having to attend numerous meetings, most decisions come from above, which seems to suggest that Oma is aware of her own lack of organizational power.

Kim provided another perspective on her organizational role:

> *I mean, I think I work hard. [long pause] I think I try to achieve those things that are important within the scope of the job description, but* ***I can't do everything****. I think we just get more and more pressure from them [senior management] and I mean I even believe that within this area health service I would hazard a guess that at least half of the staff do not know* ***who the area director of nursing is.*** *So you're feeling basically isolated at you own level and within your own facility. (Kim)*

Kim's comments indicate that she feels ignored by the organization's senior management, overwhelmed by her expansive role and also distant from senior nursing colleagues. Kim's description of trying to achieve the important 'things' can be linked back to her earlier comment that caring for patients was the most important part of her work. Kim also described feeling a sense of isolation from the nursing hierarchy, which no other participant described. I found it pleasantly surprising that no other NUM described a feeling of isolation, since the health region contains many small facilities geographically distant from the nursing administrative centre. Kim's comment about not knowing the area Director of Nursing also suggests that she experienced a limited flow of information from above, which, according to Kanter (1977), reduces organizational power.

Willow also provided some interesting comments about her role within the organization that sheds some light on her access to organizational power:

> *There is so much bullshit going on in hospitals today, we don't have any fun anymore. I work hard, I try to look after my staff and my patients, and I try not to go over budget 'cos that makes them mad.*
> Interviewer: Them?

Yeah, the powers that be, the people upstairs, those with the power to decide, you know. (Willow)

Willow was the only NUM who actually referred to the construct of organizational power directly, although a number of the other NUMs indicated a sense of frustration at their lack of clout, particularly when it came to decision making and a lack of organizational support. As Kanter (1977) indicates, a lack of support and limited access to organizational information reduces the power of a role. A collective picture of the organizational role described by these NUMs suggests a systemic lack of access to the structures of power described by Kanter (1977) as opportunity, information, support and resources.

The following excerpts provide examples of whether the NUMs felt their opinions were heard and how their achievements were rewarded, as according to Kanter (1977), power is embedded in these organizational processes. Interestingly, in most cases the NUMs discussed rewards by explaining how **they** listened to, cared for, and rewarded their staff. Even when pressed, many of the NUMs reiterated that they felt rewarded by the hard work of their staff, and again explained how they acknowledged this. For example, when I asked Ros how her achievements were acknowledged or rewarded, this is what she told me:

By the amount or lack of complaints from staff and patients, also there's a waiting list of people who want to come and work here [in this ward], so I look on that as a sign of success. Also, I always try to let everyone else know what a good job they do. (Ros)

I asked Del whether she felt her opinions were valued and respected by her organization. Her response does not directly answer the question but instead refers to how she values and respects her staff:

I'm very supportive of all the staff, I share information and keep them in the loop. (Del)

I then asked, 'But how are **your** achievements rewarded?', to which Del replied *By my staff, they are just great.* This is a telling response, as it indicates the importance of caring for and valuing staff for this NUM, so much so, that

she identifies the support of her staff as her reward. Eddie also talks about being rewarded:

> *On a one-to-one basis with my managers, I feel respected and I'm told yes, you do know what you're talking about. But then in a group of people it just doesn't seem to happen[pause] Its' a bit of a funny situation because one minute you feel valued, the next you're put on the spot in front of other people. The thing is, from health service managers up they just think differently to what a nursing unit manager does, or most of the ones I know do. (Eddie)*

This discussion about rewards indicates that Eddie believes that members of the organization who are not nurses do not think like nurses. Eddie's comment suggests that NUMs are not part of the wider management structure of the organization. In addition, Eddie paused before sharing her feelings about not being valued by other members of the organization.

Sam was the only NUM who had positive things to say about being rewarded for her achievements:

> *Our manager is really good and we've got a good culture here, we recognise people at the general staff meeting, we talk about the good work they've done [pause] We don't make a big deal of it but people are acknowledged for their good work. (Sam)*

This comment confirms that positive feelings flow from a workplace culture in which staff efforts are acknowledged and rewarded. Tia, on the other hand, indicated that her achievements had never been acknowledged, let alone, rewarded:

> *It's dreadful, absolutely dreadful, not once was I told whether I was doing OK or whether I wasn't. I was totally in the dark, and no one thought to say she's not doing too bad (Tia)*

In all the interviews, the idea of being rewarded seemed to be the most difficult for the NUMs to address. The whole concept of being rewarded for a job well done seemed to be unfamiliar to the NUMs, with one participant saying that being rewarded for achievements was more a management strategy than a reflection of any genuine desire to thank staff for a job well done:

I must say this probably sounds very cynical but that sort of thing [being rewarded for achievements] I just think of that as a management tool, you know like I think you know, it's like the warm fuzzy thing and I tend to think that it's not terribly sincere. You know that's OK, until something goes wrong and ***all of that stuff's forgotten.*** *(Oma)*

Obviously, this NUM did not feel genuinely appreciated or valued for her contribution to healthcare.

Moving on from the participants' experiences of rewards, several NUMs volunteered information that illuminated aspects of their organizational role and their lack of organizational power. For example, Ali provided insight into her experiences of change within the healthcare organization that places nurses at the powerless end of a hierarchical system:

As nurses we have to make changes ... because we have to save money, there's not enough money for the budget. So you've suddenly got hundreds of thousands slashed off the hospital budget, because there's not enough money from the government or the state government, so now you have to find ways to cut back. It's very, very difficult to ***sell that idea to nurses****. The other thing is, there is some inequity in the various areas, for example... the medical side of things have been very proactive and very strong, so that medical practitioners have* ***huge*** *amounts of support financially, and resources, you name it [pause], but nurses lack cohesion. (Ali)*

I felt that Ali's comment about a lack of cohesion reflects the outcomes of having a disempowered nursing workforce, as a lack of cohesion suggests to me that nurses feel disconnected from, and disregarded within, the organizational culture of healthcare. In addition, this comment reflects Daiski's (2004) assertion that nurses continue to be cast into subservient roles because they come to accept the power inequalities in healthcare as normal.

Further evidence of the NUMs' lack of power can be heard in Hali's story. She discusses the frustration she feels when her decisions about the number of nursing staff required to care for patients on a shift are overturned by more senior management:

I would say the main area that there's frustration is staffing, I think if you're saying to them [senior management], I need seven nurses on this shift, ***that's it****, not*

negotiable, that's what you need. Yet, they just go ahead and change it without finding out why that many nurses are needed. (Hali)

Other frustrations can also be heard in many of the NUMs stories:

I find that the job's just getting so big, or mine is, and for the other NUMs too, the expectations of us, it's frustrating (Lee)

I lie awake at night worrying about the lack of resources, budgetary constraints and you don't get enough sleep, you come to work feeling absolutely unable to cope for the day. Then there's the issues of what do you do when you go home at the end of the day Do you drink more wine than you thought you should because you're just so stressed? (Kim)

Kim's comments reinforce the collective experiences of all the NUMs with regard to their expanding role and their limited access to the structures of organizational power. Although Kim's response to the pressures of an overwhelming workload are not ideal, it may be that her alcohol consumption is a product of prolonged stress. As Mrayyan (2004:326) says: 'in today's healthcare environment the role of the nurse has become more complicated and is linked to multiple responsibilities'. I believe that this statement applies equally to the NUM's role. For example, Frankie said, *I think the role is difficult most days and* ***even harder on others.***

5.3 The researcher's reflections on Reading One

Throughout Reading One, the NUMs described having an expanding role that includes a vast array of administrative tasks, but embedded within each story the NUMs spoke of the importance they placed on caring for staff and patients. As discussed in Chapter Three, caring is a core value that underpins the theory and practice of nursing. Gilligan (1982) argues that caring is at the core of all women's identity, and that women's embeddedness in the lives of others and their connection to others, is the basis of their moral development. This view contradicts the traditional male-orientated development theories, such as those suggested by Erikson (1950), in which development is characterised by breaking ties with others and becoming autonomous. Separation and individuality are seen as the goal of a traditional male pathway to maturity (Gilligan 1982). Gilligan further argues that in a male-voiced world, caring is devalued and discounted because it is seen as a

weakness. However, she continues: 'when the distinction between helping and pleasing frees the activity of taking care from the wish for approval by others, then caring becomes a strength that anchors personal integrity and indicates mature female development' (Gilligan 1982:171).

Certainly, the desire to connect with and care for others is a strength that flows through the stories of all these NUMs. However, I believe that this strong caring focus is a double-edged sword for the participants, because overt caring is incongruent with the organizational expectations of managers. In her study of the moral development of women Gilligan (1982) found that career ambition and the acquisition of power caused women conflict, as they sensed that a loss of compassion and caring is the trade-off required for success in a male-voiced world. The NUMs in this study demonstrated the inner conflict they experienced because of the incongruence between their desire to care and their traditional image of a manager.

Another commonality evident in all the NUMs' stories is the absence of comments that they felt valued. None talked of feeling respected, or of playing a valuable role in the decision-making structures of their organization, or of having their achievements acknowledged or rewarded. As suggested by Pearson (2003) and Sullivan (2004), nurses become used to working in a hierarchical system where their role is rigidly defined and they are not highly visible or valued. I felt that the NUMs in this study struggled to cope with the overwhelming demands of their job in an organizational context in which they lacked status and power. The organizational role the NUMs described consisted of trying to balance their clinical and managerial duties, while caring for patients and staff, and contending with challenges such as staff shortages, financial constraints and a lack of time and equipment. They tried to do all this in a culture that denied them the opportunity to influence decisions about any of these challenges. As Willow said, 'the power to make decisions resides upstairs'. This demonstrates that the participants' role within the organization is not a powerful or prestigious one.

Further organizational power issues were revealed when the NUMs were asked about how they are rewarded for their achievements. Kanter (1977)

theorised that organizational power flows from having a role that is easily recognizable as powerful. Rewards and symbols commensurate with status are part of that visibility, yet the NUMs did not describe receiving any rewards. As Kanter (1977) indicates, managers with organizational power have access to resources as a source of prestige and are also able to distribute resources to workers as rewards, but this was not evident in the NUMs' stories.

5.4 Conclusion

In this chapter, I have analysed the NUMs stories based on Reading One of the transcripts, using the voice-centred relational approach to data analysis (Brown & Gilligan 1992). An analysis of the NUMs' stories as a whole has provided insights into how they experience their working world, which has provided evidence of the construct of power within their role.

A demographic profile of the participants was presented and compared with the existing literature about NUMs in Australia. The NUMs' stories were then presented in their own words, based on Reading One of the transcripts. Their stories were interwoven with my interpretation to provide a picture of their working lives that reflected the purpose and aims of the study. In the next chapter, the data analysis continues based on three more readings that form part of the voice-centred relational approach to data analysis. These readings shift the focus from the NUMs' stories as a whole to a deeper understanding of how the NUMs spoke of themselves, their relationships, and the organizational context of healthcare.

Chapter Six
DATA ANALYSIS FOR READINGS TWO, THREE and FOUR

6 Introduction

The previous chapter focused on the NUMs' stories as a whole, based on Reading One of the transcripts, using Gilligan's (1982) voice-centred relational approach to data analysis. This chapter provides an analysis of the data based on Readings Two, Three and Four of the transcripts. According to Brown and Gilligan (1992), the ebb and flow of people's lives can only be heard in their relational experiences and the voice-centred relational method of data analysis allows the researcher to develop a depth of understanding regarding each person's meaning within their own relational and contextual landscape. This exploration of relational experiences was considered vital to this study, if issues of power for the NUMs were to be exposed and understood. As the overarching aim of feminist studies is to expose oppression, this analysis will assist in uncovering the NUMs' experiences of an oppressive and patriarchal healthcare system. Raising awareness of oppression is the first step towards empowerment.

In this chapter, the NUMs' stories are considered from three different perspectives: the participants' sense of self (Reading Two); their working relationships (Reading Three); and their role within an organizational context (Reading Four). Collectively, these readings explore aspects of each participant's working life to tease out information not evident in the first reading. For example, opaque and sometimes indirect discourse is exposed within the NUMs' stories that relate to their relationships within a societal and political context (Brown & Gilligan 1992). This method of data analysis turns the act of reading the transcripts into an act of attending to the different voices, in order to more fully understand the layered complexities of peoples'

lives. By analysing the NUMs' stories in this way, further insights are gained regarding the construct of power within their working world.

In addition to the three readings, this chapter also includes my reflective account of the NUMs' stories and context. Reflection is an important activity in any feminist study, and it is an integral part of the voice-centred relational approach to data analysis, as it acknowledges the researcher as a core component of the research process. Therefore, the last section of this chapter is devoted to my reflections on the NUMs' stories, which also include my perceptions of their working environment based on observations recorded in my journal.

6.1 Overview of Readings Two, Three and Four of the NUMs' stories

In each of the three readings discussed in this chapter, I analyse different aspects of the participants' stories, in order to uncover the construct of power within their narratives. Reading Two, according to Brown and Gilligan (1992:28), opens the door to 'who is speaking, in what body'. This reading seeks to uncover the participant's sense of self. This is achieved by listening for the voice of 'I', so that during this reading I seek to understand how participants see and represent themselves.

Reading Three focuses attention on the participants' relationships, to hear how self is experienced in the landscape of relational life. In this reading, I attend to aspects of the NUMs' stories in which they discuss their thoughts and feelings about their working relationships. According to Brown and Gilligan (1992), this focus allows for the emergence of the reality of women's voices, which does not normally occur in research that is grounded in a male-voiced culture.

Reading Four requires another shift of focus to listen for the NUMs' experiences of the organizational context in which they work. This reading creates an awareness of the cultural norms and values that might narrow or limit the lives of participants, in particular gendered stereotypes that can exploit or disempower people (Doucet & Mauthner 1998). As previously discussed, the data analysis method used in this study of NUMs is based on

my interpretation of Brown and Gilligan's (1992) voice-centred relational approach to data analysis. According to Doucet and Mauthner (1998), this method does not need to be rigidly applied, but can be moulded to suit the discipline and study aims. Thus, for this study, these three readings focus on uncovering further insights that address how the NUMs experience the construct of power within their working lives.

The headings used throughout this chapter are based on the focus of each of the readings, and they are also relevant to the study aims. Furthermore, throughout this chapter aspects of the NUMs' stories are linked to the existing literature and the theoretical framework, to provide further insights into the challenges these NUMs face in their working lives, within the context of the Australian public healthcare system.

6.2 Reading Two: NUMs' speaking of themselves

As discussed in Chapter Four, the second reading of the transcripts considers how the participants' speak of themselves (Brown & Gilligan 1992). By adopting this focus I was able to hear how the NUMs represent themselves, as well as to discover their interpretation of how others perceive them. This reading is consistent with a feminist methodology, where the aim is to hear the authentic voice of each participant (Olesen 2000). In addition, this reading provides further data regarding the NUMs' experiences of their working lives and their access to organizational power.

In order to be able to hear how the NUMs spoke of themselves, I read and listened to their stories, looking for places where the NUMs made 'I', 'me' or 'my' statements, so that I could connect with each NUM on 'their own terms' (Brown & Gilligan 1992:27). During this reading I was also able to compare the NUMs' self-perceptions with the gendered images and lack of voice experienced by nurses described in the literature (Buresh & Gordon 2000; Darbyshire 2000; Diers 2004; Sullivan 2004). I also sought to understand more about the NUMs' role identity by asking them whether they saw themselves primarily as nurses or managers.

The literature indicates that nurses have a strong professional identity but lack power when compared to other healthcare professionals (Fagermoen

1997; Flynn & Aiken 2002; Kirpal 2004; Schank & Weis 2001). I was therefore interested in discovering whether the NUMs retained a nursing identity. The following prompting questions were asked if the participant's sense of identity had not already been discussed during the interview:

1. Do you think of yourself as primarily a manager or a nurse?
2. How do you integrate your nursing and managerial roles?

These questions were designed to clarify the nature of the relationship between the NUMs' nursing identity and their managerial role and to reveal how the construct of power is linked to identity in healthcare workplaces. As well as being interested in discovering whether the NUMs thought of themselves as primarily nurses or as managers, I also wished to explore how they reconciled and integrated these two aspects of their role, as the literature indicates that the role of clinician–manager is poorly understood (Boucher 2001; Fulop & Eastman 2004; Lewis 2004a; McConnell 2002). I suspected that by exploring the NUM's perceptions of their role identity, more light would be shed on some of the issues and conflicts identified in the previous data analysis chapter and reinforced in the literature (Bloor 1999; Clare, Jackson & Walker 2001; Ingersoll et al. 2002). Taylor, Gilligan and Sullivan (1995) suggest that Reading Two should not only be used to hear how participants speak of themselves but also to explore how they think and feel.

Thus, this reading provides further valuable information about what it is like to be a NUM in the context of the Australian healthcare system, by exploring the NUMs' sense of self. I was also interested in hearing why each NUM agreed to participate in this study. As discussed in Chapter Four, each interview commenced with an opening question that asked why the NUM agreed to participate. It was important to me that the NUMs were given an opportunity to describe their reasons for, and their feelings about, being part of this project, as I did not feel it was equitable to only present my motivations for conducting this research. Thus, I asked each NUM why they agreed to be interviewed and their responses provide insights that reflect further aspects of their self-perceptions as well as some of their thoughts and feelings about my study. Examples of their responses will be interwoven throughout this chapter.

While conducting the analysis for Reading Two, I became aware that for the majority of the NUMs their sense of self was closely aligned with their nursing identity. It is interesting to note that while three of the NUMs said they thought of themselves primarily as managers, the other seventeen identified themselves primarily as nurses, and talked about giving priority to the nursing aspects of their role. Even the three NUMs who identified themselves as managers hinted at some ambivalence about that self-perception.

When considering the NUMs' comments, I also reflected on the NUMs' demographic profile, which showed that the majority of these NUMs have been nurses for more than 20 years. As previously mentioned in Chapter Three, according to a number of authors (Kirpal 2004; Weis & Schank 2000), a nursing identity develops over time until it becomes embedded in nursing practice. The longer one is a nurse the stronger one's nursing identity. I have chosen a number of excerpts from the NUMs' stories that demonstrate how they see themselves:

> *I'd have to say I'm a manager, because my concept of 'nurse' is sort of at the bedside, the clinical side of things. The title of the role even explains it, 'Nurse Manager'. So I'm trying to manage nurses, I'm not actually doing anything with the patients, which I miss [long pause]. I like the patient care. (Billie)*

Billie says she is a manager because she no longer exclusively provides bedside care for patients. However, this NUM regrets not having the opportunity to provide more patient care. I sensed sadness in this NUM, and her pause preceded a simple truth about her reasons for being sad, which was that she liked providing patient care. Notice in this quote the repeated use of the term 'I', which according to Brown and Gilligan (1992), is indicative of a participant's identity and feelings. Charlie also felt unhappy about being primarily a manager:

> *I think I only get time to be a manager, and I think that's sad. I think because of the complexity of the NUM's position, I don't think I get the opportunity to do as much clinical as I'd like, because if I take on a clinical procedure I'm always getting pulled away and interrupted. (Charlie)*

It is clear that these two NUMs are not very comfortable with their managerial identity, and while they acknowledge that they are managers, their comments indicate that they miss providing care and retain the heart of a nurse. Charlie's reason for participating in this study further demonstrated the importance of caring, when she said *I just wanted to help you*. Several other NUMs also indicated that they agreed to participate in order to help me. For example, Ros, said *you need people, and I just wanted to help*. Similarly, Tia said *I just wanted to help you out and see what you were going to ask*. Helping me was not the only reason given for participation, as some NUMs agreed to be interviewed out of curiosity, while others felt it was one way to have a voice. Further reasons for their participation will be discussed later in this chapter.

Returning to the question of whether the NUMs saw themselves as primarily nurses or managers, the following examples highlight the strong nursing identity of some of the participants.

> ***Oh! A nurse, definitely a nurse,*** *I think a manager cares about money, but we don't, we care about patients. In my practice the patient will always come first, I will argue black and blue with people if they start bringing dollars into it and all that sort of thing, cos it just doesn't equate. (Eddie)*

This NUMs' self-perception, like that of most of the other NUMs, indicates to me the strength and importance of retaining a nursing identity. Notice the use of the term 'we', which shows the strong identification this participant has with other nurses. Also, this NUM has definite views about what she sees as the core business of nurses as opposed to the core business of managers. Similar sentiments can also be heard in the next participant's comments:

> *I'm primarily a nurse. I do struggle with both roles [long pause]. No, I don't really because ultimately I am a patient advocate. I do what I have to do and I use the management position to get the outcomes I want. If it's a patient issue or a paper issue, the paper issue takes a big second to the patient issue. (Hali)*

Hali's long pause after she said that she struggled with both roles suggested to me that the conflict she refers to between the nursing and management aspects of the role was not actually a struggle, because following the pause she indicated that her nursing responsibilities always took precedence. She sees herself as a patient advocate and hints that she uses her management

position to reinforce this role. Similarly, Mel indicated that when faced with the need to make a choice, she also sees herself primarily as a nurse:

> *To the patients I portray myself as a nurse, but to the staff I try to act more like a manager. I guess I've always tried to learn about management, but if I'm in a hurry and I can't quite decide which way to go I'd normally give in to the patients. I'm a nurse so I will tend to just favour the patients needs more than the management needs. (Mel)*

Nat also sees herself as a nurse, indicating the enjoyment she feels in maintaining a clinical presence:

> *No, I still think I'm a nurse, because I really enjoy the clinical component, if there's an opportunity for me to do anything clinical I really enjoy doing it, I could still quite easily step out of this [NUM] role and go back to just being clinical without any animosity. (Nat)*

Nat makes it clear that she enjoys being a nurse and would readily go back to a clinical nursing role, which makes me think that she does not really see herself as a manager. In the next quote, Sam speaks with emphasis and feeling, and I found the strength of her belief about how nurses think, to be convincing:

> ***I think nurses always think of themselves as nurses.*** *[pause] It's a clinical thing, I still can't keep away from it, but I'm torn between what I should be doing and what I'd like to do. (Sam)*

Sam's comment clearly demonstrates her sense of self. As well, she suggests that all nurses have a strong nursing identity, which causes them inner conflict when they are torn between doing nursing duties and meeting organizational goals. The obvious conflict Sam describes between what she should be doing and what she would like to do, which is to nurse, reflects the conflicts inherent in the role. This same inner conflict was evident in many of the other NUMs' stories. Willow, for example, says she too sees herself as a nurse, which, to her, incorporates thinking, feeling and acting as a nurse:

> *I'm a nurse,* ***and a good one****, I'm probably only an average manager. I think to be in this job you have to think like a nurse, so logically you have to be a nurse. (Willow)*

As Taylor, Gilligan and Sullivan (1995) contend, a sense of self is evident in how people speak of themselves, as well as what they think, feel and do. Willow said she is a good nurse, but *only an average manager* because she thinks like a nurse, which further reinforces her strong nursing identity and the conflict inherent in her dual role.

These responses all reveal valuable information about the NUMs' collective sense of self, with the majority of the NUMs identifying themselves as nurses. This is consistent with the literature (Kirpal 2004; Schank & Weis 2001), which indicates that nurses have a strong professional identity. This nursing identity is reinforced by the number of years these NUMs have been nurses, presented in the demographic profile in Table 5.1. In addition, the insights gained in this reading illuminate why the NUMs experience such conflict in their role. For example, one of the participants, Val, said that no matter what job she held she would always think of herself as a nurse. As Brown and Gilligan (1992:28) suggest, Reading Two has allowed me to 'know [the participants] on their own terms', by focusing attention on each participants' sense of identity. Thus, in this study I found that – not surprisingly – the NUMs retained the hearts and minds of nurses.

Many of the NUMs' comments reinforce those of McConnell (2002) and Boucher (2001), who explain that professionals experience inner conflict when their professional identity conflicts with their managerial responsibilities. As Bolton (2003:122) puts it, the 'roles of ward and clinical nurse managers are full of conflict and contradiction' because the managerial responsibilities are clearly at odds with the NUMs' identity as a nurse. According to McConnell (2002), professionals in management roles tend to wear the hat that fits best, and this was certainly evident in this study. Other studies (Boucher 2001; Gabel 2002), also show that after many years of being a nurse, a management identity is difficult to achieve, particularly because these NUMs have had minimal preparation or education to equip them to deal with the managerial demands of the job. In my own experience as a nurse–academic I can identify with this, as I too retain a strong nursing identity. When asked what I do for a living I still automatically say, 'I'm a nurse'. Only when questioned about my place of employment do I volunteer the information that I am actually a nursing academic, employed by a university.

By focusing on the 'I' in each of the stories I was able to hear how each of the participants brought themselves, their thoughts and their feelings into their stories. Their individual voices were strong and full of conviction as nurses, and yet they were also full of inner conflict and some distress when describing the managerial aspects of their role. For example, Billie said, *I bring to the role the best of me that I can, but I feel like I'm between a rock and a hard place.* Other NUMs also talked about the value conflicts they experienced as a NUM. Charlie commented that *because of budgets, I can't always meet my values and then I feel really awful, I go home, have a few wines and a good cry.* Schein (1999:19) believes that to understand the impact of organizational culture on workers one must 'think historically' about the assumptions that become, over time, taken-for-granted beliefs. Speedy (1987) suggests that nurses find it difficult to break free from their historical roots because the values of nursing are so closely aligned with feminine values. Speedy (1987:26) exhorts nurses to value 'the multiple dimensions of nursing' by celebrating their caring and compassion while rejecting the subservient role expected of them. So, for these participants, their historical role as nurses greatly influences their identity as well as organizational expectations of them. Billie refers to this:

> *I have found it very hard, personally, to stand up for what nurses want and believe, and at the same time do what administration wants. I try to hold the profession [of nursing] in respect, but all the time admin devalues it. I find I can never fulfil the role [of NUM] as they would like me to. (Billie)*

Billie makes explicit the nature of the internal conflict that results from a clash of values between nurses and managers. The type of management style, based on caring for others, described by the NUMs, has little kudos in a working world that is defined predominantly by a white middle-class male worldview, as healthcare organizations are (Taylor, Gilligan & Sullivan 1995). Thus, this method of data analysis has assisted in highlighting the different voice, which in this case, is the voice of the NUMs as nurses, exposing the values they strive to uphold within the healthcare context. Gia describes how she struggles with the role expected of her: *I'm as efficient as I can be, and I just can't do anymore, I don't want to do anymore.* Similarly, Jaz said: *I hate the fact that I don't have enough time during the day, time is my greatest enemy and tiredness my*

second. Kim commented that *there is far more expected of me than I can ever achieve.*

The conflicts the participants faced in not being able to perform in their role as they would like were evident in all the interviews. Further to this, the cause of this conflict was evident on two levels. For example, conflict exists because nursing is constructed as a feminine role, concerned with caring, while management is perceived as a masculine role, concerned with domination and control (Clare, Jackson & Walker 2001; Hayes, Allinson & Armstrong 2004; Kolb et al. 2003; Manias & Street 2001; Sullivan 2004). On the second level, conflict is also evident in the incompatibility that exists between the values and priorities of those who deliver nursing care and those who fund it.

Some of the NUMs said that their sense of identity as nurses caused them to be frustrated by a lack of time to do their job, while others described a lack of staff and resources as their greatest frustration. These challenges reflect the lack of access to the structures of power, which in turn limits the NUMs' ability to influence organizational decisions about staffing and resources. In all the stories, the NUMs described experiencing a sense of personal failure because they were unable to meet the organizational expectations of them. They spoke about the frustration of not being able to work within their own set of values and of feeling inefficient, stressed and exhausted trying to achieve all that was expected of them. This is congruent with earlier findings described in the literature, which show that the role of the NUM has continued to expand until the administrative demands have become excessive (Bolton 2003; Brewer & Lok 1995; Duffield and Franks 2001; Duffield et al. 2001; Loo & Thorpe 2004).

In this study, I found it interesting that the participants blamed themselves for their inability to cope with an overwhelming workload. It was evident that excessive demands on the NUMs' time and energy, and an inability to achieve all that was expected of them, negatively impacted on their self-esteem. This can be heard in several of the narratives when the NUMs' talked about themselves in disparaging terms. For example, Charlie said *I got the job because they needed an* ***idiot***, while, Eddie commented, *I got the job because I was the only person that wanted it, no other reason.* The participants described the threat to

their sense of self as arising from the excessive and conflicting work demands of being a NUM.

I felt that many of the conflicts and frustrations experienced by these NUMs stemmed from a lack of access to the structures of organizational power, causing the NUMs to feel unheard and undervalued. For example, Frankie said: *I get really annoyed at times because I am told to manage, and then it's look at your budget and see where you are going wrong,* ***when there's a lot of it I can't control.*** This lack of control, and lack of voice can be heard in several of the NUMs' 'I' statements and the same reasons were also given to explain why several of the NUMs participated in this study. For example, Eddie gave the following reason for being interviewed:

> *I think that I've got something to say, because we, as NUMs, don't get the chance to discuss our roles, like with management, I sometimes feel bogged under and I just feel I've got nowhere to go. So, this is just my way of voicing my opinions. (Eddie)*

Similarly, Hali said she agreed to participate for the following reason:

> *Probably because I think I'm the meat in the sandwich. You're told what your role is but sometimes I feel like a bit of a voice in the wilderness and no one's really listening. I didn't respond the first time [to the first invitation letter], and then when you contacted me a second time I actually thought well yeah, I've got something to say and this is probably a really good avenue to do it. (Hali)*

Kim felt the same way, explaining that she agreed to participate because *nursing unit managers don't have much of a voice.*

As Kanter (1977) suggests, happy and successful managers need to know they are heard and respected. They need the power to initiate change, to take risks, and still have the backing of the organization. This recipe for successful, powerful managers was not in evidence in the NUMs' stories.

As well as feeling unheard and overwhelmed by excessive workloads, some of the NUMs in this study described themselves as isolated within the organization, and as having no sense of being supported. For example, Parry said:

> *I wasn't given any direction or instruction about how to do this job, and after five years I've only just found out that there is an operational plan that could help me. Really, I guess I feel really isolated in my job. (Parry)*

Similarly, Nat also felt she was not being supported or heard:

> *The only input I get is to put in a proposal [for resources], and I get really fed up with being told to put a proposal in a letter, I do it year after year, I mean how much information do I have to give to get it approved? (Nat)*

As discussed in Chapter Two, nurses traditionally have not been able to access organizational power to make decisions because their role is based on gendered assumptions that they should follow the directions of others, in a traditionally subservient way (Fealy 2004; Girvin 1998). Schein (1985) indicated that such assumptions are extremely powerful, in that they shape the organizational culture and members' understandings of the scope of particular roles.

In an effort to understand the impact that assumptions about nurses may have on the way these NUMs see themselves, in Chapter Three I considered the contextual history of the nursing profession. Based on the literature (Buresh & Gordon 2000; Diers 2004; Speedy 1987; Sullivan 2004; Turkel 2001), I argued that it is the historical, gender-biased nature of the nurse's image and the dominant role that medicine plays in healthcare that contribute to nurses' lack of voice and access to the structures organizational power. As demonstrated by this reading, a nursing identity and sense of self could be clearly heard in the way the NUMs spoke of themselves.

According to Kanter (1977), gender bias is not the only factor that influences female managers' access to organizational power, but it does play a part in limiting the scope of all nurses' roles, which in turn reduces the NUMs' access to the structures of organizational power. This reading has identified that a majority of the NUMs in this study identified themselves as nurses. I am convinced that having a strong nursing image, underpinned by the gendered nature of nursing work and organizational assumptions about nurses, are the reasons why these NUMs experienced a low status role within the healthcare system (Davies 1998; Girvin 1998; Hunt 2004). According to Schein (1992), it is difficult to bring to awareness such basic assumptions that underpin

organizational roles, so it is understandable that the participants in this study did not discuss the links between their sense of self as nurses and the limited access they have to the structures of organizational power.

I believe that Reading Two has demonstrated that the NUMs think of themselves primarily as nurses. Collectively the 'feeling, thinking, acting I' described by Brown and Gilligan (1992:33) was heard clearly in all the NUMs' voices, providing ample evidence of their strong nursing identity. For example, the participants demonstrated their nursing identity and the challenges this creates for them with comments such as these: *I'm a nurse and a good one, I think nurses always think of themselves as nurses, I bring to the role the best of me, I have found it hard, I can't always meet my values, I find I can never fulfil the role as they would like me to.* According to Clare, Jackson and Walker (2001:171), nurses are the backbone of healthcare, yet they remain 'at the bottom of the pile when it comes to the healthcare system because nurses lack the professional status, power and credibility of medicine'. Furthermore, as the literature indicates, NUMs are not well prepared to assume the managerial aspects of their role because they lack the business skills expected of managers (Gordon 2004). According to Mills (1992:94), 'when females do occupy supervisory positions their judgement is less likely to be trusted than that of male supervisors'.

The experiences of the participants in this study clearly highlight the impact of organizational assumptions and a traditional male-voiced culture on the NUMs' self image and role. Collectively, the NUMs' talked about striving to do their job in an environment where they lack authority, input, time, resources, information and support. The participants were frustrated because they could not work according to their nursing values, and because they were not involved in organizational decisions. This led to an inability to mobilise appropriate resources and reduced their opportunities to vocalise their concerns. Thus, by using Brown and Gilligan's (1992) voice-centred relational approach to data analysis, the different voices of the NUMs have been heard speaking as nurses. However, on another level the NUMs described the frustrations they felt with the organizational expectations of them as managers. These frustrations are classic reflections of Kanter's (1977) description of a first-line manager, although none of the NUMs explicitly

linked the challenges they faced with the construct of organizational power. Rather, they tended to blame themselves for not being able to rise to the challenges of their role.

It is my belief that the NUMs' sense of self demonstrates the lack of recognition that nurses suffer in healthcare organizations. Because of their enduring public image as women who care in 'virtuous silence', nurses are forever cast into the role of housewife within healthcare contexts (Buresh & Gordon 2000:32). Such a belief is based on deeply embedded assumptions that clearly reflect the lack of organizational power implicit in the NUM's work role.

Many examples in the NUMs stories indicated to me that, as NUMs, they struggled to manage their wards in a caring way but found their efforts devalued and ignored in favour of the financially driven agendas of healthcare organizations. According to Upenieks (2003), nurses who strive to attain positions of power in healthcare settings find themselves thwarted by the male power structures embedded within the organization. In 1987, Speedy identified that medicine – the dominant sub culture in healthcare – works to maintain the status quo. Similarly, Chandler (1991:20) believes that nurses will continue to be forced into poorly designed job roles where they are denied access to 'positional power' while traditional male dominated power structures control healthcare environments. Today, little has changed, because nurses are still oppressed and virtually voiceless in the patriarchal culture of healthcare, and this has impacted on the NUM's role. Furthermore, I suspect that this situation will not change unless the NUMs decide to act.

According to Kanter (1977:174), organizational power is closely linked to the 'overall state of the system', in that formal power is invested in certain ranks and is maintained by the incumbents' credibility as a leader. I felt it significant that some of the participants in this study said they found it difficult to stand up for what nurses' want and many talked about a general lack of input into the decision-making processes of the organization. I believe that what these NUMs want is the organizational power to manage their wards and care for patients and staff according to their values, and to be respected and consulted within the healthcare context as equal partners in healthcare delivery.

However, I believe that the participants' strong nursing identity, coupled with organizational assumptions about nurses' roles, has socialised them into a role defined by patriarchal assumptions. Nurses have been cast as powerless for too long, and as this study shows, these participants continue to display the behaviour expected of nurses. Strategies to address this finding will be discussed in the next chapter.

In summary, Reading Two has assisted in uncovering further insights into the experiences of being a NUM in the context of the Australian public healthcare system. In addition, this reading has identified that the NUMs retain a strong image of themselves as nurses, which causes them to struggle with the organizational expectations of them as managers and limits their voice and organizational power.

Having considered the way in which the participants in this study speak of themselves, the next reading explores how they describe their relationships with others in their working environment. Reading Three uncovers aspects of the NUMs' experiences that address the study purpose and aims. Findings from Reading Three can also be linked to the literature about the image of nursing and its impact on organizational culture and power.

6.3 Reading Three: The NUMs' working relationships

This reading explores how the NUMs spoke about their working relationships with others in their organization. This third reading is designed to uncover the relational self, by requiring the researcher to direct attention to aspects of the NUMs' stories that describe their place within relationships. In order to do this I listened for times when the NUMs changed from talking about 'I' or 'me' to 'they' or 'them' (Brown and Gilligan 1992). In this way, I was able to hear how the NUMs saw their role within their working relationships and I listened for the NUMs' understandings of those relationships. As Brown and Gilligan (1992:41) suggest, the value of focusing on relationships in feminist research is that it provides an opening into the way in which some relationships seek to 'muffle voices' and trivialize the contribution of women.

Kanter (1977:181) discusses the importance of work relationships as a means of gaining access to organizational power, stating that 'in a large, complex

system it is almost a necessity for power to come from social connections'. Kanter goes on to say that such connections must be 'long term and stable' if they are to be of benefit to workers and the organization (Kanter 1977:181). According to Bell and Nkomo (1992), an exploration of the roles of women managers must be viewed through an historical and relational lens, if their experiences of their organizational roles are to be used to challenge existing assumptions. Thus, by exploring the working relationships of the NUMs in this study more can be known about the construct of organizational power within their role. In this reading, I pay particular attention to the NUMs' descriptions of their role in relation to others, and their beliefs about the thoughts and feelings of others. Therefore, the value of this third reading is to explore whether the NUMs' stories of their work relationships could uncover more about the level of power embedded in their role.

Some of the participants described their role within working relationships in general terms while others focused on particular relationships, such as those with other nursing staff, with other NUMs, other healthcare professionals, hospital administrators and mentors. According to several authors (Bell & Nkomo 1992; Gilligan 1982; Mills 1992), by adopting a feminist approach, relational information about people's working lives can reveal the impact that gender and role have on participants' experiences. Several participants discussed the impact that their nursing identity has on their relationships with others within the organization. For example, this is what Charlie says about her relationship with medical staff:

> *At times I tread a very fine line. It's hard to see yourself as anything but a nurse, as I have to spend my time keeping them, the medical staff on side. I have to take on board whatever they say, I have to be their sounding board, and at the same time try to manage a ward. (Charlie)*

This comment indicates how Charlie sees herself within her professional relationship with medical staff. It is within such comments that the 'relational self' can be heard (Brown & Gilligan 1992). Clearly, self is not present as a disembodied entity; rather, the concept of self is embedded in the human experiences of relationships. Charlie's description of her relationship with medical staff provides a clear example of the subservient role of nurses within healthcare organizations. Note also the change in Charlie's comments from

self-perceptions, such as *I tread a very fine line,* to a perception of the role she plays within a working relationship, such as *I have to take on board whatever they say*. In this case, 'they' refers to medical staff.

Another participant had similar perceptions of her working relationships with medical staff:

> *Sometimes the doctors treat nurses as their wife or their child, I think it's their problem, not ours. I try not to take it on board, but it's really hard to be assertive. (Dom)*

It is within comments such as these that the oppression of nurses can be heard. In particular, the 'they' referred to in both these examples indicates the medical domination of these NUMs. This reinforces Mill's (1992) belief that workforce roles are influenced by an assumption that females are associated with domestic roles while males are linked to public spheres of responsibility. Eddie also commented on her relationship with medical staff, saying: *A good relationship with the doctors helps, but they don't help, so it's a bit of a hit-and-miss affair.*

Thus, I believe that these examples illustrate the oppressed role that these NUMs experience in their relationships with medical staff. Most of the participants discussed their feelings and thoughts about relationships in more general terms, with one NUM, Ali, talking about the difficult relationships she experienced when she first assumed the NUM's role:

> *I thought I would get heaps of support from the ward staff [when I took over the NUM role], but I had to learn which of them to watch, who to listen to, and who would support me.*
> Interviewer: When you say ward staff, do you mean nursing staff?
> *Not necessarily, some of the bitchiness came from medicos, and admin staff too. (Ali)*

Another of the NUMs also spoke about having challenging relationships with administrators:

> *You're either a manager for the people or a manager for the administration. They [administration] make it so hard, they knock back everything because of money. You're viewed as a bad manager if you're over budget. (Billie)*

Billie identifies healthcare administration as 'they', indicating that despite her role as a manager, she does not see herself in the same camp, because *they knock back everything because of money.* As discussed in Reading Two, nurses place patient care ahead of the need to balance budgets, further reinforcing the relational aspects of the conflicts these NUMs experience.

Dom also alluded to the conflicts that arose because of competing organizational goals:

> *I think you've got to work on relationships, there's always them and us. I can see it on the ward, everyone expects the NUM to do everything,* ***that's the sort of position we're in.*** *(Dom)*

When prompted Dom explained that 'them' refers to medical and administrative staff, not to nurses. Jaz also discusses how her work relationships contributed to internal value conflicts:

> *It's really hard to be a nursing unit manager, because I have some personal values about how people should be treated and spoken to, the most important thing is to have honesty and respect. I think if you treat people poorly then the first thing that happens is you build up negativity, in yourself and others. I try to treat all the staff the way I would like to be treated, nurses, domestics, admin, cleaners and medicos, but not everyone does that. (Jaz)*

Kim also refers to the need for respect within the workplace:

> *I step in and try to sort out problems before they end up in an awful mess, I think if people were polite [long pause], you know medical staff really are a law unto themselves. (Kim)*

According to Clare, Jackson and Walker (2001), nurses find themselves cast into subservient roles within healthcare organizations as nursing has traditionally been subservient to medicine. This image influences how others perceive nurses and how nurses perceive themselves within an organizational context. Burnes (2000) contends that organizational cultures are founded and built by the dominant group. As Schein (1992) suggests, over time such beliefs become embedded as basic assumptions that influence all aspects of the culture. In this study, the NUMs' relationships with medical staff and those in healthcare administration suggests that their part in the relationship is a less

influential one. For example, Kim says that medical staff are *a law unto themselves*, indicating that doctors are more autonomous because they are not subject to the same level of organizational control as nurses. Dom thought that doctors sometimes treated nurses as their wife or their child. I found this comment particularly disturbing as it not only indicates that nurses experience a secondary role in their relationship with medical doctors, but also clearly reflects the assumption that nurses are responsible for domestic duties and the traditionally feminine aspects of patient care.

As Manias and Street (2001) found in their study of the relationship between doctors and nurses, doctors are the ones who define and limit nurses' contributions to healthcare. These authors conclude that based on doctors' authoritative positions of power, nurses experience a lack of voice and visibility, which devalues the caring focus of their role. Concerns about the less influential role that nurses play in healthcare organizations can also be seen in other literature (Buresh & Gordon 2000; Girvin 1998; Speedy & Jackson 2004), and this is reinforced by the NUMs' perceptions of their part in some of their organizational relationships.

It is my contention that the lack of organizational power heard in these NUMs' stories is not just the result of the impact of historically gendered image of nurses, but is also a reflection of their limited access to organizational power structures, a limitation that has become embedded within the NUM's role. As Kanter (1977) explains, while women managers' lack of access to organizational power is often attributed to gender, it is more a reflection of their role construction. Based on assumptions about the scope of certain roles, the incumbent's access to the structures of organizational power remain limited. Thus, the NUMs' lack of access to organizational power structures is the result of not only the subservient image of nurses but also the organizational assumptions about who should have power that over time have become embedded in the culture.

It was not just the relationships with medical staff that the NUMs in this study discussed. For example Oma and Charlie spoke of other relationships within the organization:

I've been nursing since the 1980s. That's a long time, and I think that people at the coalface are delivering the best care that they can, sometimes under very difficult circumstance, but the only time people get spoken to is if things aren't right or senior people are unhappy with things. Then they don't mention the times when nurses do well, no one ever pats them on the back. (Oma)

I think that a good NUM to the management [of the organization] is someone who can pull out all the reports, there and then, someone who knows what the budget is, someone who can rattle off all the things that they want, but to the [nursing] staff a good NUM is someone who supports them, someone who fights for them. (Charlie)

These excerpts highlight the dichotomy that exists between organizational perceptions of the core business of first-line managers versus the NUMs' beliefs about their core business. Dominant views are, according to Schein (1992), reflected in organizational expectations of workers' roles. Charlie's comment that nursing staff would prefer to work under a NUM who fights for them rather than for someone who has all the paperwork at their fingertips reinforces Kanter's (1977) belief that workers prefer to work under powerful bosses. Conversely, if a manager lacks power then staff will suffer powerlessness as well (Kanter 1979). Willow also made some interesting comments about her working relationships:

I get on well with all the staff on my ward, well mostly anyway. I treat them as equals, we have a few laughs and we work hard. I get on OK with some of the doctors, the ones that aren't really formal and officious. I think I get on OK with the admin staff that I know but I don't really think the hospital has the same values, they focus on money and cost cutting, so I don't have a lot in common with the way they think. I sometimes put in my two bob's worth about things that affect my ward, my staff. ***Doesn't mean that anyone actually takes any notice.*** *(Willow)*

Willow's comments indicates that while she tries to treat work colleagues as equals, she still feels like the less dominant member within most of her working relationships, evidenced by her comment that no one takes any notice of her opinions. In addition, Willow's comment about values further reinforces the incongruence between nursing priorities and those of hospital administrators. It seems that from Willow's perspective, her values were considered less important. To an even greater degree, Tia also felt unheard and ignored:

I have to say that I have been through some crises here and I haven't had support from anyone, no one in admin cared. I do try to deal with issues, but they're no help, I'd hate to see anyone else go down the same path.

In Reading Three thus exposed the NUMs thoughts about the less powerful and less valued role they have within their work relationships with medical staff and administrators. However, positive feelings were also evident in the NUMs descriptions of the relationships they have with other nurses. As discussed in the previous chapter the NUMs depended on other NUMs and nursing colleagues for educational support, as they lacked formal organizational support to gain management qualifications. However, the NUMs in this study also relied on other NUMs and nursing colleagues for social support. For example, Ali discusses the sense of community she feels with all the staff on her ward:

Our way of taking control is to try and find the best way that we can as a group, as a unit, with all the nursing staff involved. (Ali)

Similarly, Frankie had this to say:

I have the support of the nurses on my ward, other NUMs and the health service manager I think because of our values as nurses we care for each other. If anything happens then we're there to support each other. (Frankie)

Frankie's comment supports those made earlier, that the values nurses share contribute to the support they offer each other in the face of a lack of power they experience within the healthcare organization.

Gia also talked about her perceptions of relationships with other nurses:

What you find is that you have a professional relationship with the nurses you work with. They're your workmates as well and that's the most important thing. What I mean is they're the most important thing, because they're the instrument that's going to help you look after the patients, because we're a team. (Gia)

These comments show that Gia felt uplifted by her relationships with nursing colleagues. Other NUMs also spoke of their relationships with other nurses as a source of support. Hali said *Our* [nursing executive] *is fantastic. She's really supportive. You can go and ask her anything. You never get made to feel like you're a*

fool. Hali went on to talk about a situation before the arrival of this particular senior nursing executive, when things were not as good because changes were imposed on the ward without consultation with the NUM or the nursing staff. Hali recalled: *It was terrible, there was heaps of discontent, it was terrible for the patients too, they* [the hospital administration] *talked about cost saving, but I don't believe there was any, I believe it was just cost shifting.* Lee also discussed the support she gained from her relationship with other NUMs:

> *You know, it's really helpful debriefing to other NUMs. You can't debrief to your staff, and you can't debrief to the hierarchy, 'cos most aren't nurses, but to other NUMs you can say "how did you deal with this situation?". Then you find out you're not the only one in that situation. (Lee)*

Again, I can hear in Lee's story the underlying belief that nurses share a strong and unique set of values that place them apart from other healthcare staff. It seems that within some of their working relationships the NUMs feel that their values are not well understood or respected by non-nursing members of the organization. This makes them feel that their voices are not heard, and that their role is less important than that of medical and administrative staff. These NUMs have tended to develop positive working relationships with other nurses, who they feel will respect their values, and it is within these relationships that the NUMs gain respect and support.

For example, Mel has some positive things to say about her relationships with other nurses. *Most of the staff are great, the Director of Nursing and the other NUMs are really good, they're really helpful and our communication is good.* Parry explains how having a supportive relationship with other nurses helped her:

> *With other nursing staff I have a great relationship. As a nurse, you've got to be interested in the other person's life, because you're working so close, and you know that some people don't deal with some things very well. Like I don't deal with sick children very well, but someone else deals with it really well, so they say "I'll take over that bit", and to me that is a pretty good working relationship. (Parry)*

Parry's comments exemplify the way in which the caring values of nurses are translated into care and support for nursing colleagues. Ros also commented on the need for strong supportive relationships with other NUMs:

There is one thing I think that every hospital has to have, and that is a good network amongst NUMs. You need someone you can go to without fear of ridicule, we need that support. (Ros)

Sam too, talked about the need for support:

I have a mentor in [another nursing unit manager] within the health service. When it gets a bit tough I go and talk it out. (Sam)

Oma felt the same way, saying:

I know that some organizations don't have peer support groups, but we have a sort of NUM support group that meets every so often and all the NUMs get together and have a bit of a chat about issues that affect them. When I was a new NUM, a group like that would have been really useful. (Oma)

Val also made comments about the support she received from other NUMs and added that as an experienced NUM she made every attempt to provide support for those new to the role.

So far, this third reading has revealed that when the NUMs say 'they', and 'them', they are referring to medical staff and healthcare administrators, rather than other nursing staff, who they more commonly referred to as 'we'. Unanimously the NUMs in this study felt negative about their working relationships with medical and administrative staff, which the NUMs explained by reference to the disregard they felt was evident for their values and their feelings of disempowerment within such relationships. Conversely, for the most part the NUMs felt respected and supported by their relationships with other nurses. They felt that other nurses spoke the same language and had a common goal, which was caring for others to the best of their ability.

In summary, I found it interesting that all of the positive comments about working relationships referred to relationships with other nurses and the nursing hierarchy, while the negative comments concerned relationships with medical and hospital administration staff. None of the NUMs considered their relationships with these groups of workers to be positive or supportive. Their experiences are consistent with the literature regarding doctor–nurse relationships (Blue & Fitzgerald 2002; British Medical Journal 2000). Relevant also is Fulop and Eastman's (2004) belief that in an environment dominated by a number of competing professional groups, administrators often fear and resent those in the position of clinician–manager. When fear and resentment

exist in a relationship, it is unlikely that such a relationship will be supportive.

I believe that the NUMs' positive relationships with other nurses reinforce their strong professional identity as nurses. Kirpal (2004) indicates that nurses value caring as central to their role. In addition, caring is also the yardstick by which nurses judge their working relationships. Similarly, Gilligan (1982) suggests that caring is devalued in a male-voiced world because it is a strength more highly developed in women than in men. Thus, it may be that the NUMs' distinctive and strong nursing focus affects the way they perceived and interacted with other groups within the healthcare organization. Evidence for this can be seen in Willow's comment that *I don't really think that the hospital had the same values* [as nurses]. This comment reinforces the findings from a study by Hau (2004) in which it was suggested that nurses' professional values and beliefs are often at odds with those of healthcare organizations, because nursing is based on a caring culture. Similarly, the NUMs' descriptions of their work relationships reflect the beliefs of Mickan and Boyce (2002) that healthcare organizations have unique issues of management because of the professional rivalries, value clashes and the complex nature of the work.

In the next and final reading, the NUMs' thoughts and feelings about the context of healthcare are uncovered to further explore the construct of power within the working world of NUMs.

6.4 Reading Four: the NUMs' relationship with the organizational context of healthcare

According to Brown and Gilligan (1992:29), Reading Four exposes the 'institutional restraints and cultural norms and values' that can silence voices, constrain expression and narrow relationships by imposing gender stereotypes. In this study of NUMs, this reading is vital in exposing the oppressive and silencing effect that organizational assumptions about nurses' roles have on the participants. This reading creates a space in which the limiting factors imposed on the NUMs by the organization can be seen for what they are, which is patriarchal assumptions about the roles of nurses. In

particular, this reading exposes the construct of organizational power embedded within the NUM's role.

In this reading, I listened for the NUMs' accounts of their working world that reflect the cultural, organizational, and social context in which they work. I was interested in exploring the links between the broad social and cultural contexts of healthcare and the NUMs' stories. The information uncovered in this reading is explained using Kanter's (1977) theory of organizational power, as a means of understanding more about the organizational role expected of the NUMs. I found evidence of the construct of power within many of their stories.

According to Way (1997:707) 'individuals cannot be separated from their cultural and societal contexts', because the culture in which people live is alive in their stories and experiences. For the participants in this study, the cultural and societal context in which they work is reflected and revealed in their comments about the organizational structures of the healthcare system. This reading helped me to better understand their role, their lack of voice and their lack of access to organizational power.

The NUMs' frustration with an oppressive organizational culture is clearly heard in this reading. In particular, their experiences of imposed change within the healthcare system demonstrate tensions that would not otherwise have been exposed. The pressure of being required to do more with less, discussed in Chapter Four, is also clearly heard in the following excerpts:

> *It's difficult for nurses now, because you're told you have to save money somewhere, but the difference between a nurse and a manager is, well a manager cares about money, but we don't, we care about patients. Nurses will always put the patient first.*
> Interviewer: Do you think your nursing values are reflected in the values of your organization?
> *No, they just want to see the figures at the end of the year, to see if you're in the black. I just can't see that the organization has the patients' interests at the forefront. (Eddie)*

Eddie added further comments about her perceptions of the healthcare organization's values: *You feel that you give your life to the institution and they just treat you like crap.* Similarly, Sam said, *we* [nurses] *are undervalued as*

managers. Frankie also has something to say about the impact of recent changes to the healthcare system:

> *I trained in the 1970s and in those days we tended to have everything that we needed. Today we're tightened up so much, we have to work with limited staff numbers, with limited resources. I think that if you're going to run a hospital, essential equipment should be supplied. Our equipment here is really old, we [nursing staff] raised [a significant sum of money] and bought new equipment. It's incredible that the nursing staff have to provide the equipment for the organization. (Frankie)*

This comment demonstrates that this NUM feels that nurses are 'the dogsbodies' of healthcare. For example, medical staff and senior administrative staff are not expected to bake lamingtons or serve teas at the hospital fete to raise money for vital equipment. Nurses are the ones who assume these additional duties.

Jaz talks about the impact that organizational cost-cutting has on her and her nursing staff: *I hate having to explain to staff why things are happening, like cuts to beds or cuts to stores. It's very disheartening you know, the staff really take it to heart*. Tia also commented on the impact of cost-containment: *I believe that the current role of NUM is only manageable if the wheels don't fall off, but as soon as there's a crisis we're stuffed,* ***and then it's always our fault***.

The belief that when things go wrong, it is always the NUMs fault symbolises the organizational assumptions that keeps these NUMs disempowered.

Dom describes her recent experiences of the healthcare organization:

> *In the past 3-4 years we have had redundancies, and there has been a lot of anger making it a horrible place to work. I was one of a few people not made redundant, and it's been very, very hard, because some people resigned in protest. (Dom)*

According to some authors (Buresh & Gordon 2000; Clare, Jackson & Walker 2001; Davies 2004; Diers 2004), negativity has become endemic in the nursing profession based on the low status and lack of access to power that nurses have within healthcare organizations. Val said that the job of NUM was becoming *more and more challenging because the list of tasks to be completed keeps growing*. This participant added that the organization does not care enough about nursing staff to do anything to reduce their workload. Anecdotally,

little is done to improve the morale of NUMs, because the challenges they face are generally disregarded, devalued or ignored by those in positions of power within the organization.

Other comments that reflected the relationship these NUMs have with the context of healthcare came from Kim who described the impact of financial constraints on her role: *I have to do more and more with less and less and deal with the stress that puts on me.* Kim was one of the participants who made direct reference to the organizational expectations of NUMs, by describing the application process she went through to gain her position:

> *When I wrote the application for the position, it was like studying for an exam. Because the criteria for fulfilling the position are so vast, they cover so many areas, as a NUM you are expected to be able to* ***do everything.*** *(Kim)*

Looking at the job description for NUMs provided in Chapter One, I understood Kim's concerns. The essential criteria for a NUM position require applicants to be excellent clinicians and demonstrate knowledge of financial, human and physical resource management, have leadership, teaching and computer skills (New England Area Health Service 2004). Kim went on to talk about her experiences once she gained the position: *I keep trying to think of myself as a manager, but they* [the organization] *don't ever let you forget you're a nurse.* This comment suggests that not only do the NUMs have a strong nursing identity, but they are also perceived by the organization as nurses rather than managers. Schein (1992) explains that such assumptions influence organizational understandings of roles. Kanter (1977) contends that the organizational power of a role can be seen in the organizational role construction. Thus, if the NUM's position is primarily seen as a nursing position, then the NUMs will continue to lack access to the organizational power needed to be an effective manager.

Lee also discussed the expanding role of the NUM and described how she coped with the overwhelming job demands: *I take a lot of work home, I wish I had* [a hospital computer software package] *at home, then I could do the rosters in the evening.* This comment reinforces my contention that the NUMs strived to achieve everything expected of them, no matter how unrealistic, with limited awareness that a lack of access to organizational power is built into their role.

Nat also had some concerns about her ability to cope with the job: *Well at this point I'm giving this job until February, then I'll see if the issues that I've had have been resolved, if not, then I'll probably reassess my current role, maybe I'm meant to be a clinical person.* Should Nat decide to vacate the NUM position, it may be hard to fill, as Parry believes that not many nurses are keen to assume NUM positions:

> *They advertised it three times, the first time they didn't get any applicants, the second time they got two who weren't deemed suitable, and the third time I thought I can't stand this anymore we've been six months without a NUM, we need somebody, so that's why I applied. (Parry)*

Gia's perception of her role within the organization clearly demonstrates the limiting nature of traditional organizational assumptions about nurses:

> *The administration here is as good as the healthcare system overall allows it to be. They involve NUMs when they believe it is appropriate. (Gia)*

In this comment Gia acknowledges the complex relationship that exists between the NUM's role, the healthcare organization and the assumptions and values that underpin it.

In this fourth reading, all the NUMs' comments reveal how the construct of organizational power impacts on their working lives, based on the disempowerment of their role within the patriarchal healthcare culture. Kanter (1977:250) explains that 'organizational roles carry characteristic images of the kind of people that should occupy them', and in this study the NUMs' appear to have a subservient image.

In summary, this reading has demonstrated that the participants in this study did not have a positive experience of their role within the organization, nor did they feel valued, respected or powerful within the context of healthcare in Australia. They all described having a lack of input into the decision-making processes of their organization and feeling overworked. This finding is consistent with international findings, such as those of Apker (2002), Bolton (2003) and Wilmott (1998), who identified that NUMs experience pressures imposed by leaner healthcare systems, which require them to assume greater responsibilities without the power to mobilise adequate resources. The NUMs

in this study also described working in an environment that limited their ability to work within their own value system. As discussed previously, caring is the core of nursing, yet nurses are expected to assume roles where the importance of caring is discounted, devalued or ignored. This provides further evidence that an understanding of how the construct of power flows through the NUMs' stories in this study demonstrates how they are undervalued and oppressed within the healthcare system, because their concerns are overlooked and their values are trivialized.

6.5 Summary of Readings Two, Three and Four

From the three readings presented in this chapter, it has become clear that the participants in this study feel unheard, undervalued, disempowered, stressed and frustrated in their role. The NUMs all described having a complex, multi-faceted and expanding role for which they had minimal training, little organizational support, and a lack of access to sufficient time and resources to do their job effectively. By using the voice-centred relational method of data analysis in this feminist study, a pathway has been created that links the challenges described by the NUMs to the construct of organizational power. This pathway further illuminates the oppressive nature of healthcare workplaces.

Several authors suggest that in order to understand the legacy of the past, nurses need to consider the cultural, societal and political influences on their role and stop playing the same games (Clare, Jackson & Walker 2001; Girvin 1998). I believe that this suggestion should also apply to NUMs. Unless nurses themselves wield their political strength and demand change, the status quo is not likely to change. Speedy discussed this problem back in 1987, suggesting that nurses need to challenge organizational assumptions that oppress them by wielding political power and demanding a higher status role. However, Speedy acknowledges that this aim cannot be achieved unless nurses collectively fight to gain more power. It is my contention that an enhanced awareness of the influence of traditional nursing images on the NUM's current role may encourage the participants in this study to challenge the powerlessness of their role. A greater awareness may also reduce their tendency to blame themselves for their inability to cope with the

overwhelming and conflicting demands placed on them. The three readings undertaken in this chapter have assisted in uncovering aspects of the working lives of these NUMs that have further addressed the purpose and aims of the study.

The last section of this chapter presents a focused discussion of my reactions and responses to the NUMs' stories. This reflective stage, which as discussed previouslyis an integral part of feminist research (Brown & Gilligan 1992), includes a reflective account of the entries I made in my journal regarding my meeting with each NUM and my observations about the setting of each interview. I will link my perspective to the analysis of the NUMs' stories and to the literature reviewed in Chapters Two and Three.

6.6 The researcher's perspective

As a nurse listening to nurses' stories, I found that I could not help but empathise with them, as I too have had similar experiences of oppression, although not as a NUM. In my analysis of the data using the four readings, I have presented a relational approach to the participants' experiences, feelings and thoughts, which has exposed how the construct of power flows through the conflicts and challenges they face. As well as providing an analysis of the participants' stories, in a feminist study, it is also important to ask who is listening as well as who is speaking (Gilligan 1982). Therefore, as the listener, I will now present my reflections about, reactions to and observations of the NUMs' narratives as another source of data.

Let me start by saying that my overall reaction to all the NUMs' stories was one of concern and sympathy for their difficult role and indignation on their behalf that so much was expected of them. I believe that their stories overwhelmingly show that they are undervalued, overworked and unheard within the context of the Australian public healthcare system. I was angry that their contributions to the delivery of quality healthcare are not acknowledged, rewarded or valued by their employer. A broader concern was the obvious lack of recognition for caring as a core value and function of nursing. I also admired the NUMs' fortitude and sense of humour in dealing with their challenging and sometimes overwhelming role. Finally, I felt very privileged

that they agreed to share their experiences, thoughts and feelings with me. I must acknowledge that my reactions and responses to the NUMs' stories contributed to the way in which I have presented the data. It was important to me to that I gave the participants a voice, by presenting their stories as an accurate reflection of their working lives. I believe that I have achieved this in the data analysis chapters by providing excerpts from their stories, clearly differentiated from, but interwoven with, my interpretation of them.

Several feminist authors have indicated that careful observation of the social environment of participants can yield valuable information about the power structures in which they are located (Dendaas 2004; Lyons & Chipperfield 2000; Marx 2001). So, as well as recording in my journal my overall responses to the NUMs' stories, I also made observations about the NUMs' working environment and uniforms that further illuminate the construct of power within their working lives. The following section focuses on my observations of the NUMs' working environment.

6.6.1 The researcher's perceptions of the NUMs' working environment

Initially, when I started recording my impressions of the NUMs' workplace in my journal, I was just being thorough by recording non-verbal information about their environment. At first I did not consider this information to be of any particular significance, other than situating each NUM into a visual as well as an auditory landscape. The reason I did not initially link the NUMs' working environment to the construct of power is that as a nurse who has worked in a wide variety of public hospital environments across two Australian States I just accepted the environment as a normal part of the fabric of public hospital life.

It was only when I reviewed the feminist and management literature and discussed the interviews and journal entries with my PhD supervisors, one of whom is not a nurse–academic, that I realised that my observations provided further evidence of the NUMs' lack of access to the structures of organizational power already heard in their stories. Kanter (1977) describes power as consisting of both formal and informal aspects, both of which are embedded in work roles. Evidence of the level of power embedded in a role is

reflected in the working environment of the incumbent. Schein (1992) talks about artefacts, and indicates that these are representations of the values and assumptions that form the basis of an organizational culture. I found that when reflecting on the NUMs' working environment, I became aware of the visible indicators of their lack of access to organizational power.

As stated in Chapter Four, of the twenty participants who were interviewed, four were telephone interviews, and two interviews were in my office, leaving fourteen interviews conducted face-to-face in the NUMs' working environment. Out of these fourteen participants interviewed face-to-face, five did not have a private office, in that they either shared office space with others or were allocated a small amount of workspace in a communal multipurpose room. Of the remaining nine participants who did have an office, I noted in my journal that they all lacked adequate office equipment, space and privacy. All nine offices were small and cluttered, three had no window and lacked ventilation. Furthermore, some of the offices were obviously created by converting hospital spaces, such a cupboards, into small narrow workspaces. Two of the offices looked as if they were still doubling as storage spaces for hospital or cleaning equipment, with one office having mops, buckets and brooms standing in the corner. Three offices were also used to store the personal belongings of nursing staff.

All of the NUMs' offices looked shabby, in that they had mismatched and chipped furniture, frayed curtains and carpets, older style computers and a lack of storage space, evidenced by the fact that in a number of the offices papers were stored in cardboard boxes on the floor. Perhaps because the NUMs are nurses, like me, none of them commented on their shabby offices or old computers. Yet Kanter (1977) indicates that access to appropriate resources, such as space, time and equipment indicates one's level of organizational power. Similarly, as stated previously, Schein (1992) describes these resources as artefacts, which are the visual evidence of the values and assumptions about work roles held by an organization. Sandberg (2003) suggests that a 'lousy desk location' threatens perceptions of power, the author referring to both the worker's self-perceptions and the perceptions of others. Thus, a worker's space, standard of furniture and resources play an important role in communicating one's status and power within an

organization (Denton 1991; Ettorre 1995; Hofstede 1994; Pristin 2004). In this study, the working environment of the participants sent a strong visual message about their powerlessness.

As discussed in Chapter Four, Kanter (1977:166) theorises that formal and informal organizational power is needed to 'get the job done'. A lack of resources and visible symbols of power therefore play a significant role in limiting a worker's access to power. Kanter's (1977) theory helped me to understand how the construct of power is embedded in the NUM's role. However, I was still bothered by the impact that the image of nursing had on the participants, as the findings showed that the majority of the participants identified themselves primarily as nurses, and as discussed by a number of authors, nurses are in positions of little power or authority (Speedy & Jackson 2004). I reflected on how the traditional image of nurses limits the NUMs' access to organizational power, based on the literature discussed in Chapter Two. I felt that the NUMs' nursing identity, which was evident in their stories, was also communicated via their environment and uniforms.

6.6.2 The researcher's perceptions of the NUMs' uniforms

As well as recording in my journal observations about the NUMs' working environment, I also recorded information about how they were dressed. Again, at the time I did not think this was particularly relevant to the study aims. However, a comment by Speedy and Jackson (2004) regarding the visible power embedded in clothing choices led me to reflect on how clothing is a part of image, and therefore can communicate a person's power and status. Most of the NUMs in this study wore the corporate uniform required of staff employed by NSW public hospitals. This uniform consists of a combination of blue and white, with a choice of trousers, skirts or dresses, some are patterned and some are plain, all carrying the area health service logo. The choice of which combination to wear is up to the individual, as they pay for the uniform. The trouble is that other classifications of employees wear very similar uniforms, so that it is difficult to differentiate between catering staff cleaning staff, or nurses.

However, medical and senior administrative staff do not wear uniforms. Medical staff can generally be seen in operating theatre clothing, called

scrubs, or business style clothes. Similarly, senior administrative staff wear business style clothing, rather than a uniform. I reflected on whether wearing a uniform might disadvantage these NUMs, as clothing is a visible indicator of power (Schein 1985; Speedy & Jackson 2004). Maybe they would be seen as more powerful if they dressed for success, as described in some management literature (Aroch 1996; Solomon 1986).

In fact, Solomon (1986:20) suggests that 'clothing is laden with symbolism that provides information about social and occupational standing'. However, I wondered if the NUMs might experience increased inner conflict if they stopped dressing as a nurse, because of their strong nursing identity. Furthermore, if NUMs did not dress as nurses this might create distance between themselves and their patients and nursing staff, although as mentioned, the uniform worn by the NUMs no longer identifies the wearer specifically as a nurse. Thus, the generic nature of NSW Health Department uniform also works to disempower nurses generally. It is interesting to note that Pearson et al. (2001) suggests that nurses are required to wear uniforms because health services feel that if clothing choices were left up to nurses, they might make inappropriate choices. In contrast, medical and administrative personnel are not subjected to the same dress requirements. Therefore imposing uniform requirements on nurses is another way of embedding oppression and subservience into nursing roles.

I see the NUMs' workspace and uniforms as closely linked to Kanter's (1977) theory of organizational power, because these are visible symbols of how the construct of power is embedded in work roles. When my observations are combined with the findings from the NUMs' stories, it is obvious that the participants lack access to the structural determinants of organizational power. As well, they experience overwhelming responsibilities and a lack of preparation and support for the role. Thus, the NUMs' stories reflect how embedded assumptions about nurses' roles impact on their level of organizational power (Diers 2004; Buresh & Gordon 2000; Sullivan 2004). As well as exploring the construct of organizational power, I pondered on the comments made by some of the NUMs about a lack of voice, when asked why they agreed to participate. I reflected on the links between their comments about a lack of voice and the literature regarding the lack of media coverage

of nurses' opinions, discussed by Buresh and Gordon (2000). I believe that the NUMs' lack of power and voice can be explained using Kanter's (1977) theory, which acknowledges the complex interactions between gender, image and organizational roles.

Based on these findings I am convinced that unless radical organizational cultural changes occur in healthcare environments, it is unlikely that these NUMs will ever be taken seriously as managers within the healthcare organization. Therefore, the value of conducting a feminist study into the NUMs role has been reinforced. The implications of these findings will be further discussed in Chapter Seven.

6.7 Conclusion

In this chapter the NUMs' stories have been explored from three different perspectives, based on Readings Two, Three and Four, as suggested by the voice-centred relational approach to data analysis (Brown &Gilligan 1992). By using this method, the participants' stories have revealed their sense of self as nurses, the limiting nature of many of their working relationships, and their powerless role within their employing organization. In a feminist study such as this, where one of the overarching aims is to explore the construct of power, both data analysis chapters have exposed the impact of a nursing image on this group of NUMs. Collectively, the NUMs spoke of feeling overwhelmed by an ever-expanding and poorly resourced role, which translated into a lack of access to the structures of organizational power. As nurses, most felt unheard within their organization, particularly in the decision-making processes. Nevertheless, they tried hard to achieve all that was expected of them, while striving to stay true to the core value of nursing, which is caring.

The final section of this chapter was devoted to my reflections, based on my reactions to the NUMs' stories and observations I recorded in my journal regarding their workspace and uniform. I linked my observations of the NUMs' working environment and uniform to the findings from the NUMs' stories to demonstrate how these observations have further illuminated the construct of power in their working lives. The analysis contained in this

chapter addressed the purpose and aims of this study by providing further valuable information about the patriarchal nature of healthcare organizations, and the lack of power experienced by these NUMs. By considering the participants' experiences from these multiple perspectives, aspects of their working lives that may have remained hidden have been exposed. In the next chapter I discuss the findings and their implications for policy and practice.