REGULATING HOSPITAL SOCIAL WORKERS AND NURSES

REGULATING HOSPITAL SOCIAL WORKERS AND NURSES: DESKILLING AND RESISTANCE IN LEAN HEALTH CARE

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Abstract

Canadian hospitals continue to adopt private sector strategies in an attempt to improve efficiency, accountability and quality. One such mandated efficiency is a computerized psychosocial assessment for mental health patients known as the Resident Assessment Instrument–Mental Health (RAI-MH). This thesis uses the RAI-MH as the gateway into exploring how neoliberal or private sector strategies are used to penetrate hospital care work resulting in the regulation and restructuring of work practices. The RAI-MH requires professionals to input specified, closed ended data about patients simplifying and narrowing their practice in an attempt to govern, measure and fund what is "value added" in the patient/professional encounter. This qualitative study uses interviews with social workers and nurses to examine the competing tensions experienced by professionals as they strive to provide client-centred care in a culture that promotes computer-centred care.

My research findings reveal that the idealized portrayal of the 21st century knowledge worker is in sharp contrast to the realities faced by many increasingly standardized and "leaned-out" health care professionals. Social workers and nurses report that standardization leads to increasing surveillance. A few professionals comply with the increasing standardization or regulation but most found ways to resist while striving to maintain professional autonomy. As certain areas of work become standardized some professionals find ways to increase autonomy in other areas of their work. The findings reveal differences between those who engaged in work tasks outside of paid work hours (boundary crossings) and those who did not (boundary refusals).

Theoretically, this thesis contributes to the literature by illuminating the processes involved within the rapidly changing organization of hospital service delivery. Substantively, it adds to the literature on understanding the work of service providers and how they continue to find creative ways to resist the standardization process.

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Chapter 1

Introduction

1.1 Introduction

The frontline health care professions appear to be moving away from client-centred care to document or computer-centred care as public hospitals continue to adopt private sector strategies in an attempt to improve efficiency, accountability and quality. The continued scrutiny, by the government of health care spending, in a culture that promotes "austerity measures" seeps down to the frontlines of health care impacting professional practice and ultimately the care provided to patients. The drive to cut costs and increase accountability in the public sector appears to be as insatiable as is the drive for profit or surplus in the private sector. One of the strategies taken up in the Canadian health care system to meet these goals is the use of Information Technologies (IT's) which claim to help improve services provided to the public. I will argue computers are the machines/technology often used to push a neoliberal agenda through the restructuring and regulation of health care work. One such "efficiency" is the mandated use of a computerized psychosocial assessment for all mental health patients; the Resident Assessment Instrument – Mental Health (RAI-MH).

The goal of this thesis is to explore in what ways social workers and nurses are responding to the ongoing restructuring of public services in the current neoliberal climate. As the language and strategies of managerialism increasingly dominate health care, polices developed far from the frontline are shaping the daily practice of social workers and nurses. Key facets of that restructuring are policies and technologies

designed to standardize professionals' work in an attempt to contain costs and make professionals more accountable to hospital organizations. This study will focus on a particular instance of this drive to control work processes: the RAI-MH. How social workers and nurses respond to changes at the organizational, professional and individual levels requires further investigation.

Using the RAI-MH as the entry point into an examination of the widespread consequences of neoliberalism and the dominance of a pro-market agenda in health care has many advantages. The RAI-MH is a prime example of how neoliberal strategies are used to penetrate hospital work and other areas of the public service sector systematically resulting in the detailed shaping of work practices. This particular case has transferability to other care work sectors where the standardization of work is also being accomplished through structured assessments or a more computer-centred care agenda. For example, standardized, computerized assessments are becoming more prevalent in Community Care Access Centres, Children's Aid Societies and other community agencies.

1.2 When do I get to tell my story?

My research questions are informed by my experience working as a social worker in a large urban hospital and are borne of the concern that the remaking or reengineering of hospital roles directly affects the care provided to patients. My social work training and practice experience included narrative style psychosocial assessments. Guided questions were used to encourage the patient to tell their story and together we came up with a shared understanding and social work plan concerning what we could accomplish while

they were inpatients as well as a discharge plan to enhance transitioning back into the community. In 2005 the Ontario Ministry of Health and Long Term Care mandated that the computerized psychosocial assessment (RAI-MH) was to be completed on all psychiatric inpatients. The RAI-MH requires professionals to input specific, mostly close-ended, data. It was to be used as a multidisciplinary assessment tool as well as to determine funding. I suspect its use in constraining funding is likely its true aim.

The developers of the RAI-MH state it will reduce the administrative burden on clinical staff as it will become the one assessment tool used by all team members (Hirdes et al, 2002). During implementation of the RAI-MH I realized that the assessment was adding to my workload, not decreasing it as promised. As a result of this work intensification my initial assessment with patients was becoming increasingly shaped by the questions asked on the RAI-MH, with little time or impetus to ask other, more-opened ended assessment questions. This led to reflections on what it means to be a "good social worker" as the tension between striving to provide quality care and being viewed by the hospital as a "good employee" increased. On the one hand, the organizational rhetoric suggested the RAI-MH would result in better assessments and quality of service provided to patients, while on the other hand my experience was one where document or computer-centred care seemed to trump the focus on client-centred care. For example, during a time of significant work intensification I used a hard copy of the RAI-MH during an initial assessment rather than conduct my usual narrative interview. I began asking the RAI-MH questions and an eighty-six year old patient interrupted me and asked, "When do I get to tell my story?" She did not think that my asking a series of questions gave her the

opportunity or time and space to explain in her own words how she came to be sitting in my office.

We all have a desire, even need, to be understood by others and telling our stories is a way to put into context our experiences and how we arrived at this time in this place. This seems especially important for patients admitted to hospital for treatment of mental illness. As I attempted to respond to this new assessment or take it up as part of my social work role I became interested in how other professionals accepted, complied and in particular, found ways to resist its impact and yet remain employees of the hospital.

1.3 Objectives

By interviewing social workers and nurses, as well as reflecting on my practice experience, I will situate the context and findings of this study in several interrelated bodies of literature, including critical theory addressing neoliberalism, work organization, governmentality, and feminist theory. This study addresses a number of gaps in the literature relating to the competing tensions frontline hospital professionals experience as health care becomes leaner and workers are expected to become more flexible and elastic. In the manufacturing sector there is a substantial literature on the use of machines/technology in standardizing work, however, hospital work is less explored. Recent studies on Minimum Data Set (MDS) instruments, such as the RAI-MH, have reported on data obtained from patients' RAI-MH's. However, hospital professionals' experiences of restructuring through the use of computerized assessments, such as the RAI-MH, remains underdeveloped and under theorized.

This study also has pragmatic implications for professional practice and for work organization within hospitals going through change or restructuring. While this study uses one particular standardized instrument as the entry point to explore work intensification or the leaning out of health care, similar standardized tools and processes are being implemented throughout health and social services. This study will contribute to a broader literature due to its applicability or relevance to other areas of the public sector, as noted above.

In summary the goal of this study is to advance the knowledge in this area both theoretically and substantively. It will contribute theoretically by illuminating processes surrounding and within the rapidly changing organization of public service delivery, the consequences for the work of frontline hospital professionals and the wellbeing of citizens needing skilled support. Substantively, it promises to contribute to the literature on mental health services and in understanding the work of service providers and how they continue to find ways to maintain autonomy under neoliberalism.

Chapter 2

Literature Review

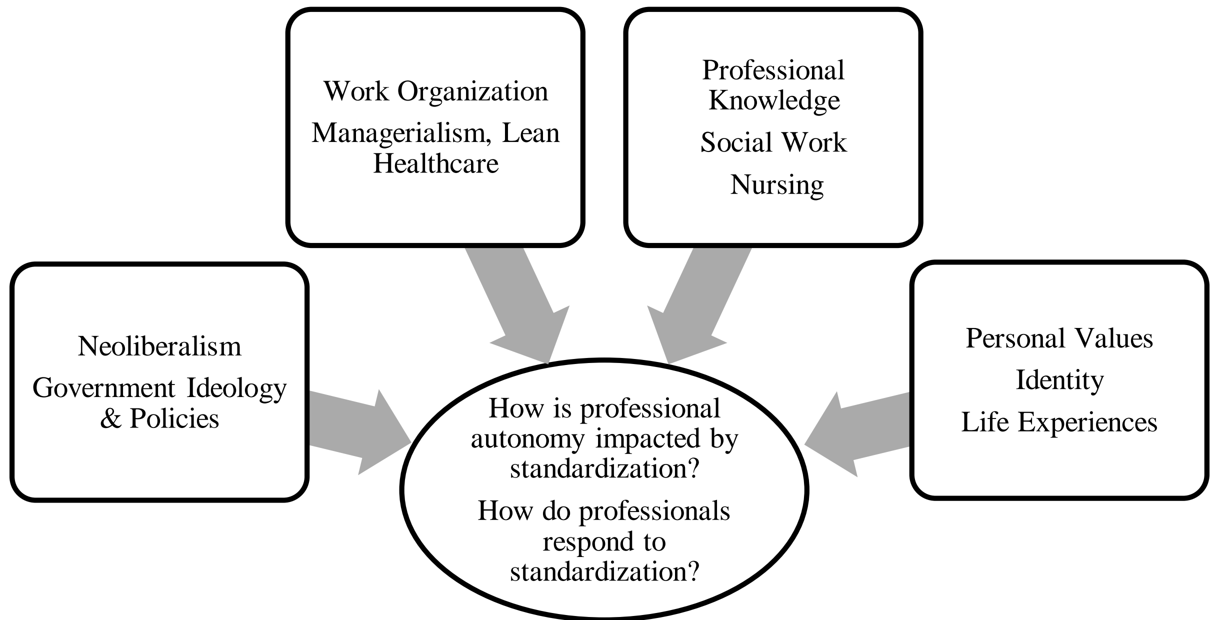
2.1 Introduction

As I began considering the many factors that influence the care work of social workers and nurses in hospitals I grouped the factors into four broad areas moving from the macro to meso to micro level; neoliberalism, work organization, and professional and individual values. These groupings represent the competing tensions experienced by professionals as they provide care to patients. While I list them as separate factors the linkages and intersections between them is the substance of this thesis.

My two key research questions are: 1) how are social workers' and nurses' autonomy and decision making impacted by the standardization of work processes; and 2) how do professionals' respond to neoliberal strategies such as standardization - with acceptance, compliance, resistance or a combination of these?

I developed a map in order to visualize the multiple, interconnected elements noted above. This map was useful in illustrating the relationships or linkages between these multiple competing tensions and was revised as the study progressed. Figure 1 offers a visual summary of the interrelated forces shaping social workers' and nurses' professional practice and of the research questions to be pursued in this study.

Figure 1. Competing tensions: Factors influencing social work and nursing practice and potential responses



To situate the research questions posed in the oval box, I will review four interrelated clusters of literature that the diagram embraces in this chapter: 1) literature relating to forces originating outside of the hospital professions which include neoliberalism, and government ideology/policy, 2) literature relating to work organization, including managerialism and lean healthcare, 3) literature relating to the ideological tensions within and between hospital professions, and 4) literature relating to the internal tensions individual hospital professionals may experience as they strive to practice in a way that aligns with their personal values.

2.2 The Impact of Neoliberalism on Public Health Care

The overarching influence of neoliberal ideology is widely debated within the literature including its impact on globalization, government ideology and government policy, as well as on the public's expectations for health care. The political, economic and social climate is one where neoliberal concepts permeate social welfare policies resulting in a restructuring and retrenching of the public services available to citizens (Harris, 1998, 2008, Aronson & Sammon, 2000; Connell, Fawcett and Meagher, 2009). Neoliberalism is defined broadly by Connell, Fawcett and Meagher (2009, p.331) as,

> "the project of economic and social transformation under the sign of the free market. It also means the institutional arrangements to implement this project that have been installed, step by step, in every society under neoliberal control."

Market influences or the dominance of the free market are an integral and well documented aspect of neoliberalism. Over the past few decades the rise in market influences on public services, hospitals and community social services has led to organizational and practice changes that have impacted the services provided to patients or clients as well as the daily work life of care workers (Gustafson, 2000; Globerman et al 2002; Lewchuk, 2002; Baines 2004, 2009; Beil-Hildebrand, 2005; Rankin & Campbell, 2006; McDonald, 2006: Pease, 2007; Austin, 2007; Armstrong, Armstrong & Scott-Dixon, 2008; Carey 2008; Connell, Fawcett & Meagher, 2009).

Neoliberalism has lucratively fashioned markets for things whose commodification was unthinkable in the past, such as water, body parts pollution and social welfare, argues Connell, Fawcett and Meagher (2009). The Australian authors refer

to this as the "colonization" of social life by the market and "under this regime private care becomes normative, and public health care becomes the residual system, the second best choice for those who can't afford the real thing" (Connell, Fawcett & Meagher 2009, p.332).

While health care in Canada is not based on the accumulation of profit, it has adopted private sector concepts and strategies such as standardization, benchmarking, performance management, continuous quality improvement and the managerial control of workers via computer surveillance (Gustafson, 2000; O'Neill 2007). The dominance of neoliberalism has led to some hospital professionals defining their practice contributions in market or private sector terms. For example, counting the number of patients seen daily by a professional seems to be more important to the hospital organization than what actually occurs during the face-to-face contact, while the importance of reducing length of stays may lead to early discharges and a revolving door scenario. Rather than caring professionals, social workers are often viewed as risk managers or handmaidens to physicians, hospitals and patients, ensuring service is provided quickly and smoothly despite "the messiness of patient's families" (Heimer, 1997, p.156). However, shortened length of stays, in psychiatry specifically, often deny social workers the time to help resolve patient's "messy" or complex issues and increases the probability they will be readmitted (Segal, 1999).

Neoliberalism, and the concepts and strategies from the private sector that are integral to its proliferation, is considered gender neutral by its supporters but this is strongly disputed by its detractors. Neoliberalism, the state and institutions are gendered

and the ideal of the gender neutral, entrepreneurial worker who reaches the highest levels of neoliberalized organizations is usually male (Connell, Fawcett & Meagher 2009; Acker, 2009). Additionally, while women workers dominate almost all areas of the public service sector those in high level positions are usually male. Joan Acker (2009) argues that the "unencumbered", "disembodied" ideal workers who rise through the "glass ceiling" are usually white males. This is true in Canadian health care where women are estimated to make up 80% of the workforce (Armstrong & Laxer, 2000) but a fraction of upper management positions. Neoliberalism, the state and its policies reproduce gender relations, impacting workers through such strategies as performance management which emphasise male-associated "administrative and technical aspects of work rather than care and interpersonal relationships" which tend to be female-associated types of work. Not surprisingly this emphasis on technical over relational aspects of care work has the potential to impact the clients or patients experience of care (Connell, 2005; Baines, Charlesworth & Cunningham, 2013, p.3). I will argue the RAI-MH is a gendered or masculine technology that is predominately completed by women who make up the majority of social workers and nurses. I define masculine technologies as the tools, tasks or technical aspects of work (IT) which differs significantly from care work which emphasizes empathy, relationship building and social justice (Lindsay, 2008). If there is an ideal neoliberal subject then in what ways do we try and shape patients and hospital workers into neoliberal patients and workers through "governing at a distance" (Rose & Millar, 1992).

2.21 Citizens as Neoliberal Consumers

Neoliberal ideology has penetrated and narrowed public expectations of the state and the meaning of citizenship, positioning individuals as consumers purchasing services in the market place, rather than citizens entitled to universal benefits/rights. Additionally, the public has also been influenced to accept restructuring and other cost containment strategies as in their best interests as tax payers (Aronson & Neysmith, 1996; Baines, 2004; Clarke, 2004, 2007; Armstrong & Armstrong, 2008; Carey, 2008; Connell, Fawcett & Meagher, 2009). At times, the media portrays public service workers, including hospital workers, as overpaid and underworked while their wages and benefits are said to be excessive compared to private sector employees. This type of discourse is an attempt to promote a more marketized or private sector health care to the Canadian public (Armstrong & Armstrong, 2008; Baines, 2004).

Carey (2008) argues that within a political economy founded on profit, there is an inevitable tendency to objectify and commodify "consumers". I will argue that one of the ways this is achieved is by moving from traditional narrative assessments to computerized assessments, such as the RAI-MH, which requires professionals to fit patients into narrow categories. There seems to be a move away from the value of narrative or story telling in professional encounters or assessments with patients (Wilder Craig, 2007) and a move towards the need to demonstrate to the organization the "added value" (Nelson, 2004) social workers and other professionals bring to hospitals. The importance of "added value" leads to a focus on assessment and discharge planning driven by the organizational goal of reducing length of stays of complex patients and cost containment (Aurebach,

Mason & LaPorte, 2007). This fits well with concepts and strategies from lean healthcare management which will be examined in detail in the next sections.

The psychosocial assessment is steeped in a narrative tradition in which clients have the opportunity to tell their stories and contextualize their problems both currently and in the past (Wilder Craig, 2007; Campbell & Gregor, 2002). The invitation to tell their stories often helps clients gain insight into their situations, highlighting their strengths as well as illuminating strategies for moving forward. Professionals thus base their assessments and subsequent interventions on knowledge of the complexity and particularity of clients' struggles. This pattern of practice is increasingly disrupted by the introduction of standardized assessment tools in health and social services – tools that simplify and narrow frontline professionals' practices in pursuit of organizational quests for efficiency. Equally disturbing, social work may encounter difficulties if it closely aligns itself with a scientific voice such as evidence based research and standardized assessments as this may result in a silencing of "the professions' collective wisdom and power" (Weick, 2000, p.396). For example, it is very possible that the RAI-MH could lead to the suppression of practice wisdom or practice knowledge as professionals attempt to adopt the science of structured assessments to meet organizational requirements and so gradually diminish the art of interviewing.

The use of structured assessments by nursing and social work in health care remains contested in the literature. Some academics suggest that structured assessments, such as the RAI-MH, are more efficient, will lead to improved quality of care for patients, provide a more accurate funding formula and permit the collection of patient data that can

be used for research purposes (Hirdes et al, 2002; Gray et al, 2009; Martin et al, 2009). Other academics highlight the perils of categorizing individuals who use the health care system and the potential negative impact on professionals (Campbell & Gregor, 2002; Rhodes et al, 2006; Ohayon, 2006; Cowley, Mitcheson & Houston, 2004).

A similar instrument to the RAI-MH is used by health visitors/nurses in the U.K. and it is argued this tool has the potential to further medicalize the nurses' role where an epidemiological focus leads to a prioritizing of biomedical facts (diagnosis, disease patterns or spread) while the client`s subjective experience is selectively ignored (Cowley, Mitcheson & Houston, 2004). The authors suggest the structured assessment used encourages the asking of closed ended questions to determine the essential "facts" of the case, the topics covered are controlled by institutional/ministerial requirements, and the extent to which it allows clients to participate in defining their own needs is debatable. Prior to the implementation of structured assessments the health visit was "agenda free". Health visitors provided a universal service focused on support and prevention and the building of a therapeutic relationship was a crucial part of the service. This model enabled support to reach the most vulnerable and isolated in society, according to Cowley, Mitcheson & Houston.

Other research also highlights the potential negative impact on relationship building by once again postulating that structured assessments are designed to meet the organization's goals around diagnosis and provision of services (commonly used today to justify the restriction of services rather than their provision) rather than being client driven (Gustafson, 2000; Rhodes et al, 2006; Campbell & Gregor, 2002). It is also argued

that the potential remains for professionals using structured assessments to work in partnership with clients, using their professional judgement, to assist clients in thinking about needs they had not considered and thus remain focused on client needs rather than only on bureaucratic procedures (Crompton et al, 1998: Sawyer, et al, 2009**;** Cowley, Mitcheson & Houston, 2004). It may be speculated on the one hand that the U.K. health visitor's assessment and the RAI-MH have the potential to create a disembodied professional underutilizing their professional knowledge and critical thinking skills while on the other hand it is an opportunity for resistance as professionals use their skills to find the "leaky parts of the system" (Clarke, 2004) or to exploit spaces or gaps in policies or technologies/assessments to obtain funding and services for clients. Asking social workers and nurses their experience with the RAI-MH opens up a discussion on how patients are viewed by the hospital organization and by social workers and nurses and the tensions between the two.

2.3 Work Organization: The Dance between Control and Autonomy

Work organization and the introduction of new philosophies and strategies to improve labour output and increase profit, or as is the case in public services to control labour and contain costs, is an ongoing project. With regards to the public sector the current "cult of efficiency" (Stein, 2001) is such that "efficiency frequently supersedes quality indicators" (Globerman, White & McDonald, 2002, p.275). The push for cost containment through organizational restructuring and regulation along with the adoption of private sector

strategies, such as those from Taylorism (classic standardization) to the Toyota Production System (lean strategies), seems to have reached new highs.

There is a substantial body of literature from the clerical and manufacturing sectors (Braverman, 1974; Thompson & Smith, 2009; Thompson, 2010), and to a lesser extent from the community social service area (Baines, 2004; Ferguson & Lavallette, 2004; Carey, 2008) that argues the standardization of work has the potential to lead to a loss of autonomy, deskilling, exploitation and alienation of workers. However, others commenting on the knowledge economy suggest work in a post-industrial economy will lead to an era of upskilling for workers (Florida & Martin, 2009). Rather than discussing the exploitation of workers, Florida and Martin, refer to harnessing the creativity of workers to remain globally competitive and their views align in many ways with lean healthcare management.

Carey (2007, 2009) in his study of community social workers, known as care workers in the UK, found that restructuring and regulation has led to deskilling. Additionally, on the surface it may appear that upskilling is occurring especially with the introduction of new Information Technologies (IT's), but these new skills are often learned quickly and ultimately lead to further deskilling. Carey (2007, P.104) states in practice some upskilling may lead to,

> "covert deskilling, in which new skills lead to regular engagement with
> a series of practically mundane tasks which are ultimately detached
> from professional roles."

Social workers in Carey's study indicated they did not consider these new skills as real social work. It can be argued that the RAI-MH requires upskilling as professionals are

required to learn how to complete it and yet similarly to Carey's experience, the RAI-MH may lead to further deskilling as new workers will be trained in the RAI-MH but may not gain the valuable experience of how to complete a full narrative style assessment. Carey (2003) fears the predominant role of social work will become the collection of raw data for the state. Carey's voice joins those of other academics who use labour process theory to understand how neoliberalism and New Public Management control and contain costs in the community social service sector by decreasing worker autonomy through standardization and performance measures (Baines, 2010a; Baines & Cunningham, 2011; Baines, Charlesworth & Cunningham, 2013).

The studies by Malcolm Carey and Donna Baines and her colleagues, while notably contributing to the debate on labour process theory by applying it to social work and social service work, unfortunately do not give enough attention to the tendency towards deskilling within the managerialised labour process. Additionally, the authors' work fails to consider fully the complex relationship between control and autonomy, especially in today's high performance or lean workplaces. I will illustrate how the tension between control and autonomy is played out by examining the stories told by social workers and nurses.

2.4 Lean Healthcare Management: Using Less to do More

Organizations will continue to implement the latest human resource or work organization management strategies in attempts to improve the bottom line. Additionally, health care professionals will incorporate the latest medical research to improve the care provided to

patients. Organizational change is an ongoing process and multiple organizational changes may occur within a similar time frame. The blending of lean with other organizational developments has been found in the UK where lean principles are interwoven with other reforms as policy makers, managers, clinical leaders and management consultants promote their projects (Waring & Bishop, 2010; Radnor, Holweg & Waring, 2012). This variation is likely much different from the purer lean strategies observed in the Toyota Production System.

Shortly after the RAI-MH was mandated by the Ministry of Health and Long Term Care this particular hospital, and others in Canada, began the adoption of lean healthcare management. The RAI-MH, in many ways, fits nicely within a leaned-out health care system that emphasizes accountability, efficiency, quality and the elimination of waste. Organizational change is complex and professionals are expected to readily adapt to ongoing restructuring as multiple strategies from various sources are implemented. Including a literature review on lean healthcare management is important as this is an ongoing, perhaps never-ending, project that will continue to impact professionals' work more deeply as time passes. Lean healthcare is located within larger debates connected to the standardization of clinical practice and the reshaping of professional boundaries (Waring & Bishop, 2010).

Radnor, Holweg and Waring (2012, p.364), based on the work of Womack and Jones (1996), state that lean,

> "seeks to reconfigure organizational processes to reduce waste and enhance productivity based upon the application of specialist analytical tools and techniques coupled with creating a culture of continuous quality improvement."

Lean healthcare management may have negative consequences on the public provision of care work and is little more than a repackaging of Taylorism for 21st century consumption, sold by private consultants/businesses to public health care organizations. Lean extends or adds to Taylor's scientific management philosophy or the standardization of work through strategies such as value mapping and Continuous Quality Improvement. Analyzing lean healthcare management further illustrates the complex relationship between control and autonomy and subsequently work intensification. In the following sections I will, 1) provide a brief overview of the origins of the Toyota Production System in manufacturing, 2) highlight leans appeal to health care management in a climate of austerity, 3) describe how lean has been taken up in health care, 4) illustrate and critique international and local lean projects, 5) discuss leans impact on managers, physicians and other professionals, and 6) leans impact on patient care.

2.41 The Origins of Lean Management

Lean management originated in the Japanese car industry, specifically the Toyota Production System. The goal is to provide a quality product the customer wants, in a timely manner at a reduced cost. The Institute for Healthcare Improvement (2005, p.2) indicates, "lean means using less to do more." While Jones and Mitchell (2006, p.3) state, "Lean is a tried and tested methodology for improving the way work gets done." This idea of improving work processes in order to increase profit and extract surplus labour is not a new phenomenon. I will provide a brief overview of the history of work organization as it pertains to lean management.

Frederick Taylor, in the late 1890's, developed scientific management, which included techniques such as, time study and the standardization of the work process in factories. Frank and Lillian Gilbreath (1912), who were associates of Taylor, introduced process charts, a focus on non-value-added elements and the elimination of waste in the work process. They are also credited with introducing the psychology of motivation. Henry Ford in 1910 introduced the continuous system of flow for manufacturing cars and mass production. The Ford system was eventually challenged for its reluctance to adapt quickly to customer demands (new models, multiple colours and so forth).

From 1949 onwards the Toyota Motor Company, under the direction of Taichii Ohno and Shigeo Shingo, incorporated Ford's ideas on process flow, Taylor's ideas on standardization, and the Gilbreath's ideas on process charting and eliminating waste, into an approach referred to as the Toyota Production System. These were supplemented with ideas related to customer defined value in products and services, replacing mass production with small lot production (eliminating the batch and queue system used by Ford and enhancing quality at the point of production – known as Just-In-Time Production) and finally viewing the knowledge of the worker as a source of future quality improvements. Later quality circles and workplace teams evolved. By the 1980's various U.S manufacturers had adopted the Toyota Production System principles with reported success (General Electric, Omark Industries, Womack et al 1990).

The term "lean manufacturing" was coined in the book "The Machine that Changed the World" which describes the history of automobile manufacturing (Womack et al, 1990). Lean was adopted in other areas of manufacturing sectors and eventually the

for profit service sector. More recently lean management has been adopted into the health care sector.

2.42 The Appeal of Lean to Health Care in a Climate of Austerity

Over the past few decades the Canadian government has moved away from a Keynesian economics towards a neoliberal ideology that promotes a market driven economy. Transfer payments from the federal to provincial governments for public services, such as health and education, have been significantly reduced (Stanford, 1998) along with the push for governments and public services to act like businesses, leading to cost containment and an increase in for profit health care services (Armstrong & Armstrong, 2009). Additionally, creating a more flexible public sector labour force who will more readily accept precarious employment (Armstrong & Armstrong, 2008) aligns with the philosophy of lean management. This hospital site has privatized some hospital services already and will become a PP3 (Public-Private Partnership) when it moves into its new building in early 2014.

Health care has become a commodity and its services have been subject to commodification (Armstrong & Armstrong, 2008) and McDonaldization (Austin, 2006) in pursuit of cost effectiveness and control over work processes which at times seems more important than client-centred care. Organizational pressure to reduce lengths of admissions leads to an emphasis on discharge planning, resulting in patients continuing their recovery in the community with the support of family, friends or no one, as community resources become increasingly limited. This rapid discharge and

commodification of patients appears acceptable in a climate of austerity where hospital CEO's who fail to balance their hospital's budgets may be reprimanded or fired.

Since approximately 2002 lean management has been infiltrating health care in the US, UK and Canada (IHI, 2005; Varkey, Reller & Resar, 2007; Proudlove, Moxham & Boaden, 2008; Fine, Golden, Hannam & Morra, 2009; Snyder & McDermott, 2009; NHS Institute for Innovation and Improvement, 2012). Lean advocates suggest Canadian health care organizations have been asked to do more with less and lean offers organizations the tools to work smarter, reduce waste, while empowering workers (Fine, Golden, Hannam & Morra, 2009).

2.43 How Lean Has Been Taken up in Health Care

The three main quality management strategies recently utilized in health care are: Six Sigma (Define, Measure, Analyze, Improve, Control) with a focus on reducing process variability; Lean Processes (Value Stream Mapping, 5 whys) with the goal of improving process flow and eliminating waste; and the Institute for Healthcare Improvement's (Plan-Do-Study-Act) to set goals, establish measures and test changes. Each conceptualizes work organization and improvement in different ways but all have the ultimate goal of improving the efficiency and quality of health care provision. While these models are presented separately it is suggested that they may be combined into a single strategy to find the "operating sweet spot" (Martin, 2007, p. 28; IHI, 2005; Koning et al, 2006; Martin, 2007; Varkey, Reller & Resar, 2007).

Lean language, such as flow, value-added services, excellence, and reducing waste, have rapidly become buzz words in hospitals. Lean language was used by many of the participants in my study. The adoption of lean in any given workplace requires the taking up of not only specific tools that help formulate problems and solutions but also embracing a new language and culture. The Institute for Healthcare Improvement (IHI), (2005, p.17) emphasizes,

> "the importance of creating an organizational culture that is ready and willing to accept lean thinking. Without a receptive culture the principles of lean will fail."

Lean experts agree the main challenge in implementation is the resistance of leaders and frontline workers in accepting a significant change in culture, and so, it is vital that a culture that is receptive to lean thinking be a primary goal (IHI, 2005; Martin, 2007; Varkey, Reller & Resar, 2007). Some authors' note that the scepticism of staff is to be expected as lean is the next in a long line of initiatives that have been tried and failed (Fine, Golden, Hannam & Morra, 2009). It is stated that lean requires buy-in from all levels of an organization, from the CEO to frontline staff, and this requires financial resources for training, implementation and ongoing initiatives (Kaizen Institute, 2009).

The hospital organization in my study began pursuing excellence or lean strategies several years ago. Senior managers were trained by experts in lean from the US, graduates from business programs were hired to work for the Quality Improvement Department at the hospital, and later lower level managers, including social work, began receiving lean training. Continuous Quality Improvement committees and the use of lean language was implemented. An example of a mantra used by managers at this hospital is

that patients should receive the, "right care, in the right place, at the right time, all of the time (reliability)" (NHS Institute for Innovation and Improvement, 2013). This mantra was used when discussing patient flow through the hospital system. Participants in this study paraphrased lean mantras such as when one social worker stated the pressure from the hospital is to "do more, do it better, do it with less and add some research to it."

According to Kaizen (2009) lean is challenging to implement and sustain and therefore should be treated as a long term commitment by an organization. Interestingly, it is recommended that the way to challenge the inevitable resistance from staff is to do value maps of the current and future states of the organization's culture through tools such as cultural surveys (Kaizen Institute, 2009). Additionally, these surveys suggest the importance of decreasing the negative connotations of some lean terminology that is associated with ruthless efficiency, by using softer, more appealing language like "pursuing excellence". The hospital where this study took place has conducted cultural surveys with staff over the past few years. The pro-lean literature, notes that it takes five years for an organization to become lean (Kaizen Institute, 2009, Fine, Golden, Hannam & Morra, 2009). Ironically, according to Sawchuk (2009), five years is also the length of time Frederick Taylor suggested for Taylorization to take hold in a factory.

Lean management has become a mini industry in itself with the creation of private businesses acting as consultants to public sector organizations such as hospitals, community clinics, the pharmaceutical sector and the educational sector. Lean is often presented as a mystical process that requires the hiring of experts or "lean wizards," from private sector management consultants, to implement change and train staff (Fine,

Golden, Hannam & Morra, 2009). Some authors argue that this may result in the magical benefits of lean disappearing after the experts leave (Fine, Golden, Hannam & Morra, 2009).

The socialization of frontline professionals into a culture of lean is through membership in Continuous Quality Improvement committees and also via the implementation of these Continuous Quality Improvement projects by all staff. At this hospital site some frontline professionals or what the organization refers to as "informal leaders" were recruited to participate in the Continuous Quality Improvement committees along with managers. While frontline professionals may not have been formally trained in lean they have been socialized into lean by managers and "informal leaders" and so the culture and language of lean has been established at this organization. In their ethnographic study of the leaning out of a UK operating room, Waring and Bishop (2010) noted how a group of professionals quickly became converts to lean. This group embraced the philosophy, language and practices of lean becoming caught up in the activities of value mapping, timelines and spreadsheets or the rituals of lean.

As noted earlier the time frame to become a lean organization is five years (Kaizen Institute, 2009, Fine, Golden, Hannam & Morra, 2009). The CEO of the hospital I studied first introduced the hand washing policy after consultation with Toyota consultants in 2009, which makes 2013 the fourth year of this lean process (at the time of writing). The stated goal in 2009 was to reduce infection rates from super bugs and lower the level of inpatient infections. The CEO stated to the media that Toyota's expertise was not health care but on how to increase standardization, decrease variability and reduce the

waste of time (The Hamilton Spectator, April 17, 2009). While the CEO reported he had been working with Toyota for the previous 18 months the timing of his interview with the media was during an outbreak of super bug infections at local hospitals. Lean was first introduced to the research participants through the implementation of the hand washing policy. Fear tactics to gain public and employee support paved the way for the introduction of significant organizational change, including cultural change.

Currently there are various lean projects at both the corporate level and through the program-based Continuous Quality Improvement committees at the hospital studied. The Institute for Healthcare Improvement (IHI), located in Massachusetts, Boston, US, has a website that promotes lean in health care through conferences, seminars, education, White Papers, success stories and so forth. They list a number of lean projects as well as White Papers on how to implement specific lean strategies in the health care sector. I recognized several that were or are currently being implemented at this hospital. They include: Healthcare Associated Infections (hand washing), Patient Flow, Falls Prevention, SBAR (standardized communication practice), Rapid Response Teams and Medication Reconciliation to Prevent Adverse Drug Events.

No one would deny that these are all areas in which the staff, patients and the public would like to see improvements, but I question the use of scare tactics around patient safety and the inefficiencies or waste in public health care as a means to initiate changes. For example, when the Toyota hand washing policy was introduced the process was as follows: the education of staff regarding the new initiative; and then the near-constant surveillance of staff. Staff's and visitor's hand washing behaviours were

observed, monitored and recorded by fellow employees. This permitted statistics to be gathered in order to compare differences between wards or programs as well as between employee groups (doctors, nurses, social workers). These statistics were regularly posted until hand washing rates improved sufficiently. Colleagues were instructed to tell their peers to hand wash if they failed to do so and report them to managers. Eventually the majority of staff complied and monitored themselves. These monitoring and surveillance strategies were similar to the ways in which the RAI-MH was implemented. Labour process theory indicates that even in increasingly standardized or controlled workplaces employees will find ways to resist. In this instance, some staff continue to wear their engagement rings or nail polish (it is suggested they increase infection rates), both of which are forbidden in a lean hand washing environment.

Womack and Jones (2003) identified five principles of lean thinking. Firstly, define value which is determined from the standpoint of the customer. Secondly, identify all steps in the value stream and ask the team to identify wasted steps which are then eliminated (Appendix A) lists the types of waste identified in health care). Thirdly, the product should continuously flow through value added steps. For example, does the patient flow through the service or are they held up (bottlenecks) at different points of the process as they move from triage in the ER, to admission, to discharge.

Fourthly, the product should be pulled through the process; let the customers pull value towards them from the next upstream activity. For example, rather than the traditional approach of pushing clients into a waiting area after registration a lean strategy would have staff who have just finished preparing a bed move the patient from the

waiting room to the bed to ensure the bed does not remain idle or empty. This is referred to as "pulling patients along in their journey" rather than pushing patients from one queue to another (NHS, Institute for Innovation and Improvement, 2013). Interestingly using the term journey appears very client-centred and much softer than saying patients are being pulled through the value stream in order to improve efficiency and reduce waste and costs.

Fifthly, pursue perfection to continuously reduce the time needed to serve the customer. The initial future state is implemented and standardized. The workers are encouraged to continually look for improvements that can be implemented and so continue to reduce waste or idle time (Lummus, Vokurka & Rodeghiero, 2006; Fine, Golden, Hannam & Morra, 2009; Varkey, Reller & Resar, 2007). Training documents emphasize "the patient's journey" and that generally variation "is caused by the way we work" and should be eliminated (NHS, Institute for Innovation and Improvement, 2013). This hints of blaming the worker; if workers where more efficient then the patient's journey through the hospital would be smoother.

Health care organizations use scare tactics and moral rhetoric around patient safety and satisfaction. For example, by frequently referring to the large number of medical errors and that hospitals who adopted lean have greatly reduced these numbers (IHI; Varkey, Reller & Resar, 2007; Ben- Tovim, Bolch & Martin 2007; Kaizen Institute, 2009). Or that lean improves quality from the patient's perspective, enables prioritization of tasks, utilizes standard tools to improve the process, increases efficiency and reduces waste, work can be divided into manageable pieces, empowers employees, increases face-

to-face contact between patients and frontline staff, and reduces health care costs (Institute for Healthcare Improvement, 2005; Varkey, Reller & Resar, 2007; Kaizen Institute 2009). I challenge some of these claims below.

The original aim of my study was to explore the restructuring of work through the standardization of psychiatric assessments. However, as research participants described their experiences at work they used lean language and described how their work was impacted due to the pressures to have patients flow efficiently through the system. Subsequently, tensions were experienced around discharge planning. For example, a social worker told the story of a fragile patient with little family support who was given a firm discharge date by the team (in one week). However, pressure from "upstream" or a lack of beds for new admissions, resulted in the team discharging her later that day. This was prior to the agreed upon date and before all the community supports where in place. The social worker informed the patient of the change and she became visibly upset by the "quick discharge" as she felt unprepared to leave that day. The social worker stated she worried that the patient would commit a minor crime in order to be readmitted to the hospital as soon as possible.

The first health care waste listed in Appendix A is overproduction with examples that include duplicate charting, multiple forms with the same information and asking for the same information repeatedly. I will give examples from the research participants regarding the duplication of information; the same information is collected, recorded and stored in various places. I will also highlight the inability of IT's to communicate with each other which compounds this problem. While lean advocates may encourage the

elimination of this kind of waste the reality is that in large organizations multiple change projects often occur simultaneously and may work against each other.

2.44 Lean Projects in Healthcare: International to Local

The literature on quality improvement has more recently focused on the lean management successes in the US, UK, and Canada. Varkey, Reller & Resar (2007) describe a study reporting reduced wait times due to moving from a batching of patients to continuous flow through a clinic, reduced supplies in carts to those most frequently used, so that fewer instruments are sterilized each month. It is claimed the clinic saved $7.5 million in 2004 by using lean techniques. Merriam (2004) claims a community orthopaedic clinic discovered a bottleneck in the recovery room and by reducing recovery times from 90 to 60 minutes was able to provide five surgeries per day instead of four without additional capital or staff costs. Roberts (2004) reports lean was used to reduce Emergency Room wait times. However, this means more patients are seen over the course of a shift which results in work intensification for professionals. While Roberts claims this reduced the stress on patients and staff they do not comment on how this decrease in stress was determined.

Bushnell (2002) indicated a multi-speciality clinic reduced the wait times for appointments and the wait times in their clinics. It is claimed this reduced the stress on physicians who disliked the ebb and flow of patients throughout the day. What about the other staff members? Snyder and McDermott (2009) report a small rural hospital in the U.S. reported success in improving supply availability, patient flow through the ER to

discharge and improving real time electronic charting after the adoption of lean principles. A health care organization called ThedaCare, which includes three hospitals, reported success with lean as determined by a $3.3 million savings in 2004. They also claim they reduced medication distribution times to individual patients from 15 minutes to 8 minutes and a reduction by 50% in the time taken by staff to complete paperwork. Once again efficiency through increasing work intensification for employees.

Fine, Golden, Hannam & Morra, (2009) reported on a Canadian study of five hospitals (four in southern Ontario and one in Saskatchewan) that implemented lean. All five reported the experience a success, reporting decreased emergency wait times, decreased patient length of stay, improved operating room usage, more radiology procedures per time period and better infection control outcomes. Likely much of the improvement was due to increasing workloads for employees.

Value Stream Mapping is the main tool used to graphically display the entire process of service delivery to determine what is value-added and what waste is. A value map is created at the beginning of the project (the current state), workers generate ideas for improvement, and then a value map for the future state is developed. Employees are encouraged to continue to suggest value-added steps or improvements to the process on an ongoing basis (Lummus, Vokurka & Rodeghiero, 2006).

I experienced lean firsthand while working in a surgical program where referrals had increased significantly. Staff expressed their concerns about work intensification to the manager. The manager arranged for the Quality Improvement Department to meet

with the team. The Quality Improvement Department staff held business degrees and were trained in lean management.

At these meetings we developed a current value stream map illustrating the flow through of patients and then created a map of a future state. As I participated in these meetings I observed the skill with which the lean advocates extracted the knowledge and creativity of the team to come up with a more efficient future map of the clinic. While undoubtedly process changes were needed due to the rate at which the clinic was growing, my colleagues seemed unaware of the potential to continue to increase workload for themselves. Several times I stated that even with the proposed changes that would allow the clinic to operate more efficiently, the rate of referrals suggested we still needed to hire more staff, especially administrative staff. I was informed each time by the manager that an increase in staff was not currently on the table and the goal of these meetings was to improve the flow through the clinic by finding ways to increase efficiency and have the clinic run more smoothly for patients. The lean advocates did not respond to my comments about increasing staffing levels.

While performing their usual work roles clinic staff now came up with solutions and implemented them resulting in a spike in workload. With the changes staff were able to "pull" more patients through the system than previously. The employees' creativity and practical actions clearly benefited the program and organization but did not necessarily benefit the worker as the outcome was increased productivity without an increase in wages.

What is regarded as waste, wait or idle time in lean terms may provide opportunities for workers to reflect, build therapeutic relationships (slow time) or to socialize with each other which is an important aspect of job satisfaction. For example, the process may be so lean that there is little need for staff to speak with each other and thus decreasing opportunities to socialize and support one another during the work day. This may increase the likelihood of burnout or compassion fatigue. I left the clinic during the implementation of the changes and so did not see the project to completion. But then again a lean project never reaches completion as a stated goal of lean is to continue to pursue perfection.

Chapter six of the thesis will discuss in more detail some of the tensions or what I refer to as "the dance" between standardization/control and worker autonomy. I will illustrate how some professionals attempted to increase autonomy and variation in their work role by participating in Continuous Quality Improvement committees or special projects, leading to the extraction of their creativity/knowledge and extra work with no increase in pay or promotion. In essence these professionals, or "informal leaders", perform tasks previously completed by managers without the title or financial compensation. One professional expressed her frustration at being recognized by her managers for several years as an 'informal leader" and yet as she had no formal management or supervisory experience (a title) she had failed to secure a management position within the hospital (and no increase in wages or benefits that might recognize her additional labour).

While there has been a recent surge of research on the implementation of lean in health care, there remains a scarcity of studies examining its impact on staff. This will be explored in the following section.

2.45 Lean's Impact on Managers, Physicians and Frontline Professionals

There is a lack of high quality evidence supporting lean management strategies in health care (Joosten, Bongers & Janssen, 2009). The authors noted that a research bias seems to exist with favourable results highlighted and other results minimized. While the authors believe lean has the potential to improve health care delivery they caution that methodological and practical considerations must be taken into account otherwise lean will be superficially adopted, add to existing resistance by workers and ultimately fail. They argue studies to date have been overly positive, focussed on operational concerns, (the tools used to implement lean), and fail to take into account or pay attention to "sociotechnical dynamics" which results in scepticism and resistance on the part of workers. Additionally, there are 'sociotechnical" aspects that are unique to health care, and specifically to mental health, where there is a risk of interference with the delicate therapeutic relationship and increased work stress and burn out of professionals (Joosten, Bongers & Janssen, 2009).

There is a scarcity of literature on the effects of lean on frontline health care staff. Some of the research articles reviewed reported improved staff and patient satisfaction but do not state how the researchers came to these conclusions. The study of five Canadian hospitals who reported successful outcomes with lean indicate they did include

semi-structured interviews as part of the methodology. They report interviewing a CEO, directors of quality/patient safety, a director of a clinical programme, a senior project manager and a designated lean coordinator (Fine, Golden, Hannam & Morra, 2009). However, it appears they neglected to interview frontline professionals and patients who are most directly impacted by lean initiatives to explore their experiences.

Lean is intended not as a top down approach but rather as a bottom up approach. Managers take on the role of facilitator, teacher or enabler rather than director or problem solver. It is the role of frontline staff to improve care processes while the manager's role is to improve and develop the workforce by creating an environment where interaction between team members leads to better performance than what could be achieved by individual team members on their own (Joosten, Bongers and Janssen, 2009).

Managers play a major role in the functioning of a team and the research participants in my study commented on the positive or negative impact of specific managers. More generally, many of the social workers and nurses commented on the changing roles of managers whereby responsibilities traditionally held by supervisors or managers were downloaded onto frontline staff. On the one hand this may be viewed as empowering, increasing autonomy, upskilling and increasing the participation of workers, on the other hand it is clearly a downloading of managerial responsibilities without financial compensation. Professionals who are already feeling the consequences of work intensification may limit their contributions in such meetings for fear of additional workload. Or they may refrain from overtly critiquing work processes in case they are tasked with coming up with, exploring and following through with potential solutions.

The use of champions in UK health care settings increases the potential for frontline professionals to be drawn or co-opted into management and leaderships roles, suggests Waring and Bishop (2010). I will discuss the role of RAI-MH champions and provide examples of the downloading of managerial responsibilities onto frontline staff without financial compensation. Standardization may result in a tendency towards deskilling with a decrease in autonomy but there also appears to be avenues that permit upskilling and increased autonomy for some workers. Deskilling and upskilling both have the potential to lead to work intensification, exploitation of the workers knowledge and creativity and future job losses.

Physicians are near the top of the hierarchy in health care and have more autonomy than other professionals. This may be due in part to the professional status they hold as well as the Canadian fee for service system of payment. This means, in some ways, they are much more like self-employed workers than waged employees of the hospital. The literature shows that physicians were found to be resistant to lean or slow to engage in the lean process due to how they are financially compensated (Fine, Golden, Hannam & Morra, 2009). Fee for service means they are not paid if they attend lean training/meetings. Suggested solutions to physician resistance includes the hospitals paying the physicians to make it worth their time and/or picking an issue that was a key concern of the physicians and deliver successful results to encourage future participation (Fine, Golden, Hannam & Morra, 2009). Ironically, if fee for service physicians realized the potential of lean to increase the number of patients seen by them (and so increased payment) they might be more motivated to participate in the lean meetings. As an

observant insider I witnessed the ways physicians were given the message that if they are not willing to support change initiatives they always have the option of resigning, as the organization is fully committed to moving forward with lean changes (Personal Communication, 2009).

In the UK the leaning out of operating rooms resulted in physicians and other clinicians fearful that standardization may lead to a loss of clinical skills and more time spent on paper work prior to the surgery (additional check lists). A few months later many staff had returned to previous practices in the operating room, with the typical view that what seemed a good idea in theory was difficult to put into practice (Waring & Bishop, 2010).

Staff are often initially concerned that the outcome of lean will be job losses. The importance of reassuring staff there will be a "No-Layoff Policy" is critical to the success of lean, reports the Institute for Healthcare Improvement (2005). They state,

> "People will more fully engage in improvement work if they are not worried about improving themselves out of a job."

Fine, Golden, Hannam & Morra (2009) describe a hospital in Windsor, Ontario, whose staff where fearful lean would result in job losses. The hospital established the core rule "no jobs are lost because of lean" and this provided the freedom for the staff to initiate creative solutions to eliminate waste. ThedaCare (US) reported after lean implementation they were able to redeploy staff to other areas and thus saved the equivalent of 33 full-time staff positions. Additionally, redeployment is framed in terms of staff moving to meet the needs of patients (IHI, 2005). It is further claimed with staff redeployment there

is an inevitable decrease in real jobs, through attrition due to retirements or resignations, as improved productivity means there is no longer a need to replace them. Despite the reframing used by ThedaCare, Virginia Mason and other health care organizations in the US, the end result over time is less nurses and other staff being employed by the organization – staff cuts, and work intensification for those who remain.

Martin (2007) states, "lean thinking does not mean working harder but working smarter" which may sound very appealing to an already stretched thin workforce but I would argue at some point in the striving for continuous quality improvement and perfection a tipping point will result in work intensification and dissatisfaction among workers. According to Joosten, Bongers & Janssen (2009) lean can result in making jobs too simple or repetitive which will lead to employee resistance and anxiety. The authors address physicians' work and suggest that work for them can remain attractive and motivating if work that has become standardized and repetitive can be given to less highly trained professionals. The result ensures physicians are freed up to deal with more complicated patients. In essence they are referring to the deskilling hypothesis were some jobs are upskilled while others are deskilled.

Lean's success is intricately woven with the workers' knowledge and their willingness, or lean's coerciveness, in extracting this knowledge to further the goal of perfection in the work process. However, it is likely that this will ultimately result in standardization, deskilling, work intensification and future job losses for many workers. The Institute for Healthcare Improvement (2005, p.15) state that ThedaCare continues to

work towards a culture where continuous improvement is a, "never ending journey, relying on the organization's most important attribute: the brainpower of its staff."

Sewell (2005) states managerial control is not just concerned with physical labour but also extends over knowledge work. Managers would like to ensure they tap workers' full cognitive potential even if it means increasing worker discretion in some areas. This permits workers to provide organizations with solutions to workplace problems or eliminate waste in lean terms. This still requires disciplinary mechanisms by management. While management may use the language of empowerment, commitment and team work the worker is still being exploited whether it is their physical or cognitive labour that is being referred to. It is argued that even during the time of Frederick Taylor there was manual or physical aspects to labour as well as cognitive aspects that were exploited (Thompson & Ackroyd, 2005).

The way work is organized, whether referring to Taylorism or lean, inevitably shapes worker's behaviour. Lean advocates state lean is not concerned with influencing the professional content of clinical encounters and will result in more time for clinical relationships or face-to-face contacts (Ben-Tovim, Bolch & Martin 2007). However, this assumption is challenged. A US consumer survey found 40% of Americans feel the quality of health care has worsened in the past five years and consumers attributed medical errors to workload, stress/fatigue of health care workers (74%), too little time spent with patients (70%) and too few nurses (69%) (Snyder & McDermott, 2009). While the authors argue this supports the introduction of lean I would contend that lean's tenet of eliminating all waste through continuous improvement will inevitably lead to less

frontline staff, work intensification and thus more stress and dissatisfaction among health care workers and less face-to-face time between patients and frontline staff.

It seems that with Continuous Quality Improvement what is considered value-added, and therefore not waste or idle time, will continue to be influenced by austerity measures to cut or contain costs. While lean may have some aspects that promote worker wellbeing, such as, extensive training and alleged respect for workers and patients, these are only a pleasant by-product of the pivotal goal of higher productivity and quality (Joosten, Bongers & Janssen 2009). Additionally, while the five principles of lean places customers, value and waste reduction at the centre, it is at expense of working conditions for most employees.

2.46 The Impact on Patient Care

Neoliberal approaches value audit and accountability within the public service sector. It is easier to realize these goals when work becomes more standardized (Carey, 2008; Ferguson & Lavallette, 2004; McDonald, 2006). The drive for standardized measurable outcomes shapes professional discretion, practice models and clinical judgements. For example, the use of Evidenced Based Practice or Best Practices, aligns with neoliberalism, standardization and lean in health care. Standardized practice models have been developed and implemented in many areas of health care. They include Medication Algorithms and Care Pathways. The provision of psychotherapy in a more structured and standardized format with short times frames is in line with managed care models in the US and the public provision of psychotherapy in Canada.

Teghtsoonian (2009) suggests that group Cognitive Behavioural Therapy (CBT), for psychological problems, supports the ideals of neoliberalism, as providing this therapy in a *group* format is more cost effective than providing it on an *individual* basis. Evidence from the research literature has found that *group* CBT is as effective as *individual* CBT. The measurable outcomes or scores using psychological tests shows depression/anxiety symptoms improve equally whether the *group* or *individual* format is used. Drawing on my years of practice experience as a CBT psychotherapist I would argue that *individual* CBT is more likely to result in therapy that also addresses structural issues and the link to depression than *group* therapy mainly because of time constraints involved in group work. It is possible for some professionals to continue to be focused on client-centred or a more holistic approach to psychotherapy. However, the ability to resist becomes more challenging as practice becomes more constrained due to work intensification, audit, accountability and the push to see increasing numbers of patients daily.

Lean's principle of adhering to what the customer wants and needs is disputable. It is argued that patients want an accurate diagnosis, appropriate treatment without mistakes and wasted time (Fine, Golden, Hannam & Morra, 2009). However, I would question the impact on the relationship with health care providers, especially in mental health. For example, a study on lean in the U.S. stated wait times in a family practice were reduced as patient flow was improved by changing the expectations and behaviour of patients. Rather than seeing their family doctor, patients were encouraged and trained to be willing to see other doctors in the practice, if their GP's flow of patients was too long, while another GP had some idle time. Patient's inflexibility was discouraged and

flexibility was rewarded. This process benefited GP's as it helped reduces the ebb and flow of patients or idle and busy times, thus improving profit margins and physicians' stress. The biggest concern reported in the study was how to "educate", or perhaps they mean convince, patients of the overall benefits of the new system. The article did not state explicitly if there was patient resistance to the changes. Perhaps patients desired an ongoing therapeutic relationship with the same physician rather than the possibility of seeing a different physician each time they went to the practice. This study reported it successfully achieved goals that pleased the physicians, but does not discuss the experiences of patients or the other staff at the practice and whether they were pleased with the changes.

Recently, lean approaches have been adopted locally in Emergency Rooms and wait times have been reduced. The time spent with health care professionals was also reduced. Work processes in the ER have been linked to specific time frames (likely through value stream mapping) (Personal Communication, 2009). Hopefully this speeding up of work for ER physicians and nurses will not result in burnout or compassion fatigue for staff and more importantly impact the care provided to patients. Decreasing wait times is a worthy aim and when statistics are cited to the public that confirms this, it viewed as the result of a successful hospital initiative. However, I would ask at what cost to staff, patients and the therapeutic relationship?

Waring and Bishop's (2010) UK study of lean operating rooms illustrates staff frustration and resistance to value stream mapping with designated time frames to complete tasks. Acts of resistance included graffiti on process maps/charts. Handwritten

comments included "Fairy Tale; Work of Fiction" and where it was written "30 seconds for patient check" someone had written "staff need more than 30 seconds, what we need are more well trained and motivated staff". The literature on the concept of a "workaround culture", or a pre-given time frame for an encounter with restructuring of Ontario public service or welfare work (Sawchuk, 2009; Lewchuk, 2002) is also useful when looking at hospital work. In both sectors the unpredictability of a client's or a patient's life and their needs may challenge standardized work processes and time frames. As mentioned earlier this often results in the exploitation of workers as they try to continue to meet their clients/patient's needs.

An extreme example of the removal of the human connection is an Ontario pilot project called PACE (Patient Automated Care Experience system). It is a self-service machine, similar to an ATM, used to register patients. The patient swipes their health card. The process takes less than 10 seconds and so reduces patient registration time by 95% and thus improves productivity and work flow (No name, Healthcare Quarterly, 2006). Armstrong and Armstrong (2008) sum up this up accurately when they state that a computer cannot give a warm smile. Are we gradually eliminating the human element in the health care sector in an attempt to contain costs? What is next?

2.47 Just-In-Time and Just-Enough-Nursing

The Just-In-Time philosophy is "providing what is needed, when it's needed, in the quantity needed, on time, every time" by pulling products and services downstream in a continuous flow (Zidel, 2006, p.31). Jimmerson (2004) suggests waste can be reduced in

health care by focusing on inventory and the overstocking of supplies from linens to drugs. While Just-In-Time strategies may work in manufacturing it may not work in health care, especially when it comes to medical supplies. Just-In-Time production may prove more difficult and risky in health care due to the unpredictable volumes during infection outbreaks or natural disasters. For example, during the 2003 SARS outbreak a Just-In-Time inventory, of masks and other infection control inventory, may have led to the supply being unable to meet the demand.

Armstrong and Armstrong (2008, p.114) describe "just enough nursing" whereby managers schedule barely enough nursing time/shifts to meet patient needs. The authors report this results in work intensification leading to an increase in the injury and illness rates of nurses which are already higher that the rates for police officers and construction workers. As hospitals become leaner restructuring permits more of a Just-In-Time philosophy when it comes to scheduling staff. At this hospital site there has been an increase in part-time nursing positions leading to these nurses often working for more than one employer at a time in order to obtain a sufficient income. This allows the hospital to give these part-time nurses a minimum number of shifts but have a large pool of them available should they need to schedule them in. The hospital also moved to a centralized pool for casual, temporary nurses referred to as the Nursing Resource Team. This pool of precarious nursing positions (RN and RPN) allows managers from different wards to draw from the pool of nurses, as they need them. The research participants stated their wards often drew on this pool of precarious workers on a daily basis. This resource pool aligns nicely with lean health care principles as it sounds very like a ready source of

labour that in some ways might be referred to as Just-In-Time nursing at no extra cost to the hospital should this extra staff not be needed.

2.48 Taylorism and Lean

The control of work processes through strategies such as lean is not a new phenomenon. It is argued that there is a "seemingly endless morphology of Taylorism" as capital continues to respond to changing contexts, technologies and resistance (Sawchuk, 2009, p.7 &13). Additionally, Taylorism is inextricably linked to capitalism or neoliberalism. It is further argued, by Sawchuk, that Taylorism is an ever evolving process to address worker divergences within organizations. Sawchuk states Total Quality Management (TQM), and I would add lean strategies in general, are attempts to ensure the compliance or cooperation of workers similar to other work organizational models since the days of Taylor. Additionally, TQM, and lean, may be argued to be an extension of Taylorism and not a departure from it. Sawchuk argues that just as there was resistance to Taylorism originally, there will always be opportunities for resistance from workers. Sawchuk (2009, p. 13) reminds us that in the time of Taylor and today there exists,

> "the virtually endless capacity of workers' learning to push back, to attempt to re-collectivize and re-appropriate elements of their work."

The research literature from the manufacturing, community and public service sectors demonstrate that as managers strive to find new ways to reorganize or restructure work in order to control workers so too will workers continue to creatively find ways to resist

(Ackroyd & Thompson, 1999; Aronson & Summon, 2000; Thomas & Davies, 2005; Clarke, 2004; Carey & Foster, 2011).

Waring and Bishop (2010, p.1333) state that "Lean is the current fashion in health care" and they remind us that the purer form of lean, that is observed in manufacturing, is not easily transferred into health care. Additionally, other factors or competing voices are seeking to be heard when it comes to health care reform. These include the voices of policy makers, managers, clinical leaders and management consultants.

The future of health care reform also needs to include the voices of frontline professionals and most importantly patients. It is those who are most vulnerable in society who use a higher proportion of health care services. This makes sense given the connection between income and health or the social determinants of health (Armstrong & Armstrong, 2008). Patients with complex life situations may not fit into an eight or ten minute slot when being assessed in the ER, or may not fit neatly into the categories in the RAI-MH. Health care is less predictable than manufacturing as a patient encounter may take longer than expected. Professionals have the opportunity to look for and exploit the gaps in policies and practices, so that health care is more client-centred, rather than a one process fits all as lean would suggest, given its aim of having designated time frames for tasks or the care work provided by health care professionals.

Armstrong and Armstrong (2008, p.142) state that health care is primarily about social justice and reforming health care is a struggle over power and equity. Additionally, the struggle is between "solidarity, community, equity, compassion" and "individual rights to sell, purchase, and consume based on market principles and profits". Who

decides what is value-added in our health care system, lean consultants or managers, government accountants, individual patients or are wider collective beliefs about values the fundamental issues?

I have outlined above factors that influence social work and nursing practice at the at the macro-level (neoliberalism) and at the meso-level (work organization-managerialism, lean healthcare) and now I will review the literature in terms of the more micro-level elements that play a role in hospital care work. This will include literature relating to the ideological tensions within and between hospital professions as well as literature concerning the internal tensions individual hospital professionals experience as they strive to practice in a way that aligns with their personal values.

2.5 Professional Knowledge in Social Work and Nursing

Tensions exist between, as well as within, nursing and social work as they strive to secure their place in hospitals. Labour process theory suggests that standardization leads to the potential for job insecurity and thus inter-professional tensions or "turf wars" between workers may arise (Braverman, 1974; Baines, 2004; Carey, 2009). In contrast, lean healthcare management suggests that employees need not fear job losses and offer reassurance that as work becomes more efficient surplus resources (staff) will be moved to other areas of the hospital where more resources (staff) are required (Institute for Healthcare Improvement, 2005; Fine et al, 2009).

Social work and nursing share a similar location in that they are considered gendered work, they are in a subordinate position to medicine, their respective literatures

reveal tensions in practice and professional insecurity, and both are thrown together in the division of labour to process patients through a system that values economics over care work. While both professions are being pushed to evaluate their roles on the basis of measureable outcomes, I would suggest that social work is in a more marginal position within hospitals, compared to medicine and nursing, therefore this drive has the potential to impact social work practice more significantly. Additionally, given the current emphasis on rationalization, the survival of hospital social workers is almost exclusively dependent on outcome-based research to highlight their "value added" role (Davis, 2004; Nelson, 2004). This thesis explores whether the implementation of standardized tools, such as the RAI-MH, leads to hospital professionals solidifying their professionalism and place within hospitals alongside the other professions or advances professional insecurity and inter-professional tensions.

Differences between the social work and nursing professions may help explain potential variability in research participants' responses to the standardization of work and in particular their responses to computerized assessments such as the RAI-MH. Medicine and nursing are health professions while social work is an allied health profession sometimes viewed as an extra service available to patients, on an as-needed basis, rather than an essential service in hospitals. Nursing is closely aligned with medicine as both perform concrete medical procedures connected to the patient's body whereas social work focuses on the social or "messy" aspects of patient's lives and emotions which are often linked to access to services or social justice issues. It might be speculated that nursing is under more pressure than social work to become closely aligned with medicine and

science. Evidence Based Practice (EBP) or Best Practices are about standardizing practice based on current research and is an area where this alignment might also be explored. Some view EBP and Best Practices as a way to be seen as more professional and scientific or as a way to legitimize the position of various health professionals alongside the medical profession, while others argue EBP decreases autonomy and clashes with a client-centred approach to care (Traynor, 2000; Winch, Creedy & Chaboyer 2002; Geanellos, 2004; Pickard, 2009; McDonald, 2006; Bates 2006; Teghtsoonian, 2009). EBP focuses on measuring and comparing outcomes and the standardization of work practices based on narrowly defined "scientific research". This quest for legitimation and job security may encourage the shaping of practice so that what can be measured becomes what is valued (Davis, 2004; Nelson, 2004; Tilbury, 2004). However, the therapeutic relationship, especially in mental health, is of great importance to both nursing and social work. However this is an aspect of work that is very difficult to measure in positivist terms.

I suspect that given the organizational rhetoric around the RAI-MH, nursing may be more likely to accept its use and more importantly the value assigned to it by the organization and the provincial government. I wonder whether professional insecurity leads some nurses (and social workers) to suspend or put on the back burner their critical thinking skills at times and readily accept standardization (e.g. RAI-MH) and EBP despite it at times being at odds with client centred-care. However, it is also possible that the nurses will "break the rules" and practice in ways that conflict with EBP and Best Practices (Furber & Thompson, 2006).

Life experiences and professional education have been found to play a significant role in shaping public sector workers practice (Hoggett, Mayo & Millar, 2006) and community social workers (Carey, 2008). For some social workers, social justice is a priority while for others advancing their professionalism within an organization alongside or on an equal footing to other professions is important (McDonald, 2006). I would speculate something similar may occur in nursing where some nurses believe the path to increased professionalism is through alignment with medicine and the organization while for others maintaining an autonomous practice is the priority. The RAI-MH provides a gateway into exploring factors that come into play when similarities and differences between social workers and nurses are observed. I will explore if there are generational and educational differences in how social workers and nurses respond to restructuring and regulation of their daily practice. Will newer graduates who have been educated and socialized in a different historical context than more senior professionals who have experienced the restructuring and increased regulation over the past few decades respond differently to the RAI-MH and other regulations?

The literature illuminates the social structuring of worker resistance; for example Casey (1995) identified how gender, race and age play a role in the kinds of resistance strategies taken up by employees. Women were more likely to practice covert resistance strategies, such as avoidance of team meetings, in contrast to men who were more likely to engage more overtly by vocalizing their critique of the organization (Casey, 1995). Lumby (2009) takes this a step further and argues that those who have fewer resources (financial, social and cultural) are more likely to succumb to identity projects in

organizations and have more difficulty resisting due to their designation as "other". I believe that much is to be learned by exploring how social workers and nurses with varying levels of experience, of different genders, races and classes, respond to standardization of work both at the substantive and theoretical levels given the similarities and differences between them noted above.

2.6 Personal Values and Identity

Identity, including personal values, beliefs and life experiences in influencing professional practice and the potential responses to changing work processes is an important consideration. Race, gender and class are aspects of identity that may also impact work, social status at work and resistance, as was noted above (Casey, 1995; Lumby, 2009). Hoggett, Mayo and Millar (2006, p.782) suggest that for many public sector employees, working in this sector is not so much a "career choice but rather an expression of who they are" and thus is intricately linked to life histories, values and identity. I suspect the role of identity is crucial when looking at hospital work as it will help to explain not only the kinds of work people are drawn to (Hoggett, Mayo & Millar, 2006), but also how they respond to practice dilemmas (Thomas & Davies, 2005; Aronson & Sammon, 2000; Brown & Crawford, 2003; Clarke, 2004; Carey & Foster, 2011) and the tensions that may arise when values clash with an organization's priorities and identity project (Casey, 1995; Alvesson & Willmott, 2002; Ball, 2003; Rose et al, 2006).

The literature suggests that individuals do not like to hold inconsistent thoughts or ideological tensions and strive to find ways to bring their thoughts and behaviours into alignment (Festinger, 1957; Casey, 1995), to resolve ambivalence. This will lead to acceptance, compliance or resistance to organizational changes, according to Casey (1995). This attempt to bring the self and corporate self into alignment may not always be at a conscious level. Frontline hospital professionals are faced with daily dilemmas as they try to manage the tension between being viewed as good employees by the organization and practicing in a way that supports personal and political values or being a good social worker or nurse. For example, social justice is an important value for many social workers which may come into conflict with an organization that values shortened length of stays, especially given since social work's major role in discharge planning.

It has been suggested that men in caring roles emphasize the technical aspects of their work compared to women who tend to stress caring or the therapeutic relationship (Lindsay, 2008, Baines, Charlesworth & Cunningham, 2013). The majority of social workers and nurses in hospitals are women and given the social construction of gender roles (Aronson & Neysmith, 1996; Cormon & Luxton, 2007) it seems likely that they may struggle to find ways to align managerial goals that stress accountability and performance measures, via the RAI-MH or other standardized aspects of the work process, with their personal values around caring for others. This study will explore the strategies professionals use to continue to strive to meet the needs of patients in increasingly regulated work sites. The RAI-MH provides the opportunity to look at

moments of tension between providing client-centred care and document/computer-centred care.

2.7 Responses to Restructuring and Regulation: Comply, Accept, Resist

Social workers' and nurses' responses to the RAI-MH and the standardization of their assessments are likely to vary depending on the relative influence of their professional and personal values and the organizational values or priorities of the hospital or employer, as noted above. According to Casey (1995) their responses may include acceptance, compliance and resistance,

Resistance is conceptualized and articulated differently in different bodies of literature and is in a continuous process of development. In manufacturing it is characterized as soldiering (Taylor, 1947) and misbehaviour (Ackroyd & Thompson, 1999), while in the public sector it is articulated variously as resistance (Thomas & Davies, 2005; Aronson & Sammon, 2000), subversion (Clarke, 2004) and deviance (Carey & Foster, 2011). Resistance encompasses acts or practices, recalcitrant attitudes and emotional responses that challenge organizational policies or required practices (Carey & Foster, 2011). There are those who focus on collective approaches to resistance (Collinson, 2005; Carey, 2008; Acker, 2009) while others explore the importance of micro level or individual resistance strategies (Aronson & Sammon, 2000; Clarke, 2004; Thomas & Davies, 2005).

Within managerialism and a culture of performativity, it is possible to comply with an institution's procedures and also be resistant to those procedures at the same time

(Thomas & Davies, 2005; Powell & Gilbert, 2007). Clarke (2004) argues the opportunity for subversion occurs in the gaps between policy and practice. Additionally, employees are not merely robots but will find ways of "surviving, negotiating, accommodating, refusing and resisting" (Clarke, 2004, p.159). Barnes & Prior (2009, p.191) question whether subversion is "…necessarily even *(a)* conscious act deliberately intended to undermine a particular purpose or outcome of public policy."

It has been suggested that as values are closely linked to gender, employers in the social services sector depend on their predominately female workforce responding to or resisting managerialism with altruism, self-sacrifice and the valuing of social justice in order to continue to meet the needs of their clients despite reduced resources (Baines, Charlesworth & Cunningham, 2013). In contrast, Carey and Foster (2011) suggest deviant practice is taken up for various reasons and not necessarily altruistically motivated. Additionally, Carey and Foster found that deviant social work was not automatically linked to a commitment to epistemological or professional based ideologies such as radical social work, anti-oppressive practice, service user participation and so forth, but rather to personal feelings or rationalizations. I am particularly interested in how social workers and nurses resist in practice, through not only actions but thoughts and feelings as well, and what, if any, is the link to personal and professional values and identities. This study will explore the specific and yet underdeveloped area of the experiences of hospital professionals as they negotiate managerialism including if, and how, they resist the reengineering of their roles.

To understand the impact of neoliberalism I will situate my research by drawing on the following critical frameworks and researchers: labour process theory (Braverman, 1974; Thompson & Smith, 2009; Thompson, 2010), feminist theory on care work (Aronson & Neysmith, 1996; Baines, 2004, 2009; Corman & Luxton, 2007), feminist organizational theory (Acker, 2009; Sabelis et al, 2008; Benschop & Doorewaard, 1998; Lindsay, 2008), governmentality (Foucault, 1997; Rose et al, 2006; Brown & Crawford, 2003) and performativity (Ball, 2003; Clarke, 2004, 2007; Gibson, 2012; Powell, 2012). My theoretical approach will be discussed in more detail in chapter three. These critical frameworks or literatures will be used to situate and illuminate the impact of the increasing regulation of work in health care. Once again my two key research questions are: 1) how are social workers' and nurses' autonomy or decision making impacted by standardization of work processes; and 2) how do professionals' respond to neoliberal strategies such as standardization - with acceptance, compliance, resistance or a combination of these?

2.8 Outline and Overview of the Thesis

I have divided the thesis into eight chapters. The first chapter is an introduction that describes how the mandatory implementation of the RAI-MH led to changes in my professional practice and work intensification. This restructuring and regulation of my work led to reflections on what it means to do good social work and also be a good employee. Chapter Two begins to explore the context in which social workers and nurses practice their professions within a public sector that is becoming increasingly more

regulated and standardized. An overview of the competing tensions (from the macro to meso to the micro level) that come into play as social workers and nurses go about their daily care work is situated in the research literature along with my key research questions.

In Chapter Three I will situate the area under study in a theoretical framework and use this framework to deepen the understanding of hospital care work. Theoretical literature from outside of hospital work will be drawn on as well as empirical literature within the area of health care. Critical theory that draws on labour process theory (Braverman, 1974; Thompson, 2010) will be presented as a basis or underpinning to explore work organization in hospitals that are increasingly adopting private sector strategies. Aspects of more contemporary theories such as governmentality (Foucault, 1997) and performativity (Ball; 2003; Lumby, 2009; Powell, 2012) will be used to enhance or augment more traditional theory, as I delve into the role of values and identity processes whereby some workers appear to engage in self-surveillance resulting in a governing of the self in order to be viewed as "good or excellent" professionals/employees. This chapter will also draw attention to the dearth of research on the impact of IT's as a tool to standardize professional work in this particular segment of the workforce further demonstrating the need for this study.

Chapter Four will present the study site, including the origins of the RAI-MH, this study's research design, the advantages and disadvantages of my insider position and discuss in some detail the constructivist grounded theory method used. I will also highlight the challenges I faced as I tried to uncover the tensions in values and identities

as well as ways the social workers and nurses engaged in resistance which were not always stated or at a conscious level.

Chapters Five through Seven will include the findings and analysis of the study. The themes emerging out of the study will be explored, connected to existing literature and suggestions for new interpretations will be presented.

Chapter Five compares traditional narrative style psychosocial assessments with computer mediated assessments and examines the neoliberal forces outside of the professions that shape how work is practised and documented on the frontline. I argue this narrative tradition has been increasingly disrupted by the introduction of the RAI-MH which simplifies and narrows professional practice in an attempt to govern and measure what is "value added" in the patient/professional encounter. Social workers and nurses challenged the accuracy of the RAI-MH as well as critiqued the ways in which the instrument forced patients into narrow or inadequate categories. I will illustrate how health care policies and procedures lead to patients at times being viewed as sources of data and how social workers and nurses, are assigned to shape ill, messy, unruly, non-compliant individuals into neoliberal patients who move through the health care system in an efficient and timely manner.

In Chapter Six I will report on the ideological tensions arising in health care as hospital organizations continue to readily adopt strategies developed in the private sector in an effort to standardize and control frontline care work. Labour process theory and governmentality is used to explain work organization in hospitals. I will explore concepts such as deskilling and upskilling adding to the debate in the literature by showing how

social workers and nurses are responding to increasingly standardized workplaces. This will include a discussion on the competing tensions between control and autonomy, especially in high performance or lean workplaces.

Chapter Seven will present findings that illustrate the internal tensions experienced by hospital professionals as they strive to find ways to practice good social work or nursing in increasingly prescribed, overly regulated, highly controlled workplaces. The findings and analysis will be situated in the tension between organizational, professional and personal values. The ways in which social workers and nurses resolved these tensions will be discussed to uncover which values were prioritized and why. This will lead to my highlighting the concept of pretending which I will argue was a strategy used unconsciously and consciously by social workers and nurses as a way to continue working in progressively more neoliberal workplaces. Exploring values leads to an exploration of work-home boundary crossings and refusals as well as social workers and nurses as rogues and outliers. Taking gender and age into consideration I will underline the changes that appear to be occurring in how work is viewed and valued by younger social workers and nurses compared to their older more senior colleagues.

Chapter Eight is the concluding chapter and I will pull together the major themes emerging from this thesis study and link them to wider academic debates. I will provide reflections on the implications of this research study and in particular how social workers and nurses may respond to the restructuring of their frontline practice as neoliberal principles, policies and procedures, seek to determine, shape and count what is "value added" in care work. Further, implications for clinical practice will be discussed in the

context of the education and the mentoring/supervision of new social workers and nurses as well as for current frontline professionals. Implications for further research and conclusions are discussed.

Chapter 3
Theoretical Tensions: Negotiating Theory, Research and Practice

3.1 Introduction

My research study is deeply rooted in my practice experience as a social worker in a hospital. I became interested in this area of research following the implementation of the RAI-MH and my subsequent struggle over what it means to do good social work in an organization whose values and priorities diverged further from mine. As I considered my theoretical framework for this research study I wanted to remain grounded in my practice experience. I take a critical social work approach to practice that is informed by various theoretical frameworks including critical theory or structuralism, as well as feminism, but I wanted to be open to the possibilities that other theoretical approaches might also shed light on my practice problem. This chapter will include a theoretical framework that seemed to fit for me as I tried to make sense of my specific area of interest and how various theories offered insight into different aspects of my research.

Though most of my social work practice is rooted in Marxist-influenced, critical, umbrella approaches such and structural social work or anti-oppressive social work, several authors have noted that insights from postmodernism and poststructuralism provide useful ways to address many of the complex issues facing social work practitioners in contemporary contexts. In particular, issues of power, control and culture have been framed within postmodernism and poststructuralism in ways that help shed light on the dilemmas social workers face in a world that is increasingly diverse and multi-layered in terms of populations and social problems.

Modern, poststructural and postmodern theories have been richly debated in the

social work literature and beyond. Their particular ontological and epistemological perspectives, lead to different understanding of how power, control and resistance are articulated in the workplace (Thomas & Davies, 2005b; Exworthy & Halford, 1999). Clarke (2004) suggests that rather than get into binary conflicts such as culture versus structure or modernists versus postmodernist, it is more useful to be open to contradictions or a "thinking in tension." This type of approach is used in this thesis. I consciously draw on a number of theories that do not meld together seamlessly. Rather than trying to resolves these tensions, I hold on to them loosely, letting them highlight important aspects of work reorganization in the context of managerialism and lean production.

Of particular importance in this thesis, I explore how these different theoretical approaches address control, autonomy and resistance, in order to help me understand how work continues to be restructured and re-regulated in health care organizations and how this redistributes control and autonomy, while simultaneously fostering various forms of resistance. Work organizations are complex and limiting an analysis of a large organization to one approach or paradigm will result in an incomplete picture (Thompson & McHugh, 2009). Paul Thompson and David McHugh (2009, p.436) go on to refer to Stephen Ackroyd and his colleagues, (2005, p.14) who state that social scientists need to "move beyond single units of analysis and to understand organizations at multiple levels – building theory across individual and work groups, establishments, firms, institutions…" as the complexities of human behaviour require different "modes of analysis."

Mark Exworthy and Susan Halford (1999, p.129) noted variations in findings when studies on the topic of professional-managerial relationships are compared to each other. They argue that this is the result of using different frameworks or focusing on different dimensions of the professional-managerial relationship, often without the researchers explicitly stating which framework or paradigm they are working from. Exworthy and Halford suggest an analytical framework that encompasses a three-dimensional analytical approach operating in a non-hierarchical relationship with each other. Each dimension may be used separately or jointly by researchers thus showing the differences between them and also what connects them to each other. In brackets I have indicated how I will apply each dimension to my study: 1) abstract – which would include ideological and conceptual aspects (*theories critiquing neoliberalism*); 2) collectivity – which focuses on institutional and organizational aspects (*theories critiquing managerialism*); and 3) individual – which looks at the interaction between and within professional groups and professionals (*theories exploring identity & values*).

The balance of this chapter will discuss concepts from various critical theoretical approaches and the ways they explain control, autonomy and resistance at work. The discussion will proceed thusly: 1) drawing on social work literature, I present the theoretical approach I will use to blend theoretical approaches; 2) my problem or incident from practice will be explained using Dorothy Smiths (1974) ideas on documentary reality; 3) a structural perspective using labour process theory will illustrate how control and autonomy exist in the employment relationship; and 4) issues of control, autonomy and resistance will be theorized using the poststructural and postmodern concepts of

governmentality and performativity. I will conclude the chapter by acknowledging that during this thesis there will be deliberate moments of slippage between theories in order to provide a fuller picture of the work of social worker and nurses in hospitals.

3.2 A Theoretical Approach from Social Work Practice

I am particularly interested in what social work theories have to say about combining structural and poststructural or postmodern theories, their connection to social work practice which is often in the contested space of control and empowerment when working with marginalized individuals or groups. It has been argued that critical or radical social work research and other social justice social work theory in the past often failed to offer frontline professionals substantive or practical ways of addressing practice concerns (Carey & Foster, 2011). Carey and Foster (2011) state that this is, in part, due to these theories' inability to offer "street level" or local, small scale suggestions for resistance that can be applied by frontline social workers. Some scholars interested in social work theory have turned to postmodernism to address these gaps (Fook, 2002; Pease, 2002; Healy, 2000; Rossiter, 2000). Many of these authors have blended the Marxist-informed, critical tradition with postmodernism in what is referred to as critical postmodernism or postmodern critical theory, depending on whether postmodernism is subordinated under critical theory or vice versa (Casey, 1995; Mullaly, 2002; Fook, 2002; Pease, 2002; Fraser, 2005). Jan Fook and Bob Pease suggest that incorporating postmodernism into critical theory offers new ways of conceptualizing power, and responding to, resisting or challenging power, especially when addressing current neo-liberal politics and policies.

Paul Stepney (2009, p.18) drawing on the work of Bhaskar (1978) refers to the blending of Marxist-informed and postmodern theories as critical realism. Critical realism is,

> "sensitive to the multiple realities of subjective experience, but views these within the context of dominant social structures and emergent conditions." (Stepney, 2009, p.18)

Stepney (2006, p.1289) argues further that critical postmodernism,

> "offers practitioners a means for critical engagement with the issues that lie at the root of injustice and exclusion, to develop a more emancipatory approach, whilst resisting pressure for enforcement and control."

Stepney (2006) and Fook (2002) argue that the neoliberal project not only shapes but makes it more difficult to change dominant power structures. The authors also suggest that critical postmodernism is a way to invigorate structural theories by highlighting the importance of social context (the external structures) and values (the internal thinking). Stepney (2006, p.1302) provides concrete suggestions for how this blended approach can be taken up by social workers in practice. Below, I list Stepney's four point guide along with how I have adapted it to fit with my research problem (in brackets).

1) Identify a critical incident from practice (*my problem-the RAI-MH- a documentary reality).*

2) Analyse the incident from a structural perspective by placing it in a theoretical and global context (*neoliberalism & labour process theory*).

3) Using critical postmodernism reflect and re-theorize the incident via the deconstruction of the narratives of oppression using different frameworks to suggest alternative realities (*governmentality, performativity*).

4) Reconstruct and recreate new more emancipatory strategies and processes for change (*social workers' and nurses' responses/resistance to regulation of their practice*).

3.3 An Incident from Practice: The Problem

Initially my interest in this topic was framed in terms of looking at the RAI-MH as a text or document that shaped professional work practices and given this it makes sense that I was drawn to Dorothy Smith's (1974, 1987, 2005) work on documentary realities and institutional ethnography. More recently, Campbell and Gregor's (2002) work on how texts used by nurses shape the nurse-patient relationship, as well as the work of Mykhalovskiy and McCoy (2002, 2006, 2008) who both conduct health research, helped me to begin to problematize the "incident" in my practice that can be used as an entry point to understand the multiple layers of policy and practice that shape the everyday context in which the work of hospital nurses an social workers takes place.

Dorothy Smith's (1974, p.257 & 259) writings on "the social construction of documentary reality" illustrate the importance of texts as they "mediate relations" between individuals in ways similar to how Marx suggested commodities mediate relations among people. Ruling practices or technologies use texts as a central method of governing or ruling. A documentary reality is produced through firstly, the "social organization of the production of the account" and secondly through the "social organization of its reading (and interpretation)". As a text, such as the RAI-MH, becomes an invisible part of daily routine, organizing practices, priorities and resources. Using the RAI-MH as the entry point or gateway into looking at work organization, I was able to examine the daily practices of social workers and nurses and to make visible how their

work is governed far from the frontline by texts. Reorganizing work practices shapes the relations between nurses and social workers and texts and between them and their patients. This leads to patients' experiences or stories being reduced into a series of unconnected bits and bytes of data, converted into funding algorithms that make sense to government accountants. The questions on the RAI-MH bear little connection to the lived experience of the patient or the ultimate use to which the data is applied. Smith cautions there is a danger that such organizational practices as it leads to individuals being viewed as objects in the relations of ruling, or as I will show later, being seen as sources of data or data.

In her examination of psychiatric practices, Smith (1974) noted the patient is defined in terms relevant to psychiatry and the information that contextualizes the patient becomes invisible when it is rendered into reports constructed by observers (nurse, social worker, psychiatrist). Even though nurses (and social workers) may have good intentions, they are still a part of the oppressive relations of ruling and they may be actively involved in this without being aware that they are (Campbell & Gregor, 2002 p. 43). While the importance of the patient's voice has increased, with the mental health service user movement, as my data will show, under the RAI, the patient's experience or context continues to be "rendered invisible" by governing techniques that view patients in terms of funding algorithms. Understanding the RAI in institutional ethnographic terms shows that completing the RAI-MH is not only as an individual, routine, mundane, work task but an economic and political activity, and as such a practice of power.

Social work and nursing has for the longest time been implicated in the creation of

texts, often called case notes, assessments and/or patient charts, which hold particular control over service users' lives, particularly, marginalized citizens. Within social work there has been an "electronic turn" (Garrett, 2005) with a swing away from a narrative to a database way of thinking and operating which emphasizes collecting raw data to assist with governing (Parton, 2008; Carey, 2003). Narrative texts give depth by drawing on sociological and psychological theories which have been replaced by surface explanations to measure risk and allocate resources (Parton, 2006) creating a "data double" or virtual client (Haggerty & Ericson, 2000, p.611). Similarly, nursing has been implicated in creating texts and check lists in order to assess or evaluate patients (Rhodes et al., 2006). With the introduction of MDS instruments in nursing homes nurses and personal support workers (PSWs) use these tools in assessment and care planning, often failing to provide individualized care plans, and in doing so are seen to undermine the quality of the care provided to seniors (Kontos et al., 2009; Colon-Emeric et al., 2006; Dellefield, 2006; Casper & O'Rourke, 2008).

Some social workers and nurses may welcome such tools as they believe they will improve the quality of their assessments and enhance their professionalism (Robinson, 2003; Rhodes et al, 2006). Associated with the introduction of managerialism and strategies to cut costs, some authors argue that these tools do not inevitably erode professional discretion as discretion can still be undertaken when professionals can develop a critical stance towards these developments and find ways to resist managerial demands (Aronson & Smith 2010; Moffatt, 1999; Healy, 2000). For example, professionals often have the opportunity to resist by manipulating what is entered into

databases. Some authors note that data is often entered in ways aimed deliberately at safeguarding or increasing staff levels (Pithouse, 1998). As will be discussed in later chapters, the data collected for this thesis shows this type of outcome.

Dorothy Smith's work on texts helped to contextualize or problematize how texts created far from the local site can shape the daily work of social workers and nurses. I am also interested in exploring further the relationship between control and professional autonomy and labour process theory provided an opportunity to explore this in some depth.

3.4 A Structural Perspective: Labour Process Theory and Neoliberalism

Work organization is effected by global forces, political economy and national institutions (Smith & Meiksins, 1995). The state is one of the most central of these institutions. The state's policies, in turn, are enacted by public institutions such as health care, education and the justice system (Jessop, 2000; Foucault, 1997). Offe (1984, p.153) stated, "while capitalism cannot coexist with, neither can it exist without, the welfare state". This paradox can be seen today as capitalism continues to be dependent on aspects of the welfare state, specifically, its key role in the social reproduction and the use of government policy to "create flexible, enterprising workers suited to a global, knowledge based economy" (Jessop, 2002, p.168).

The welfare state has been radically restructured over the past few decades in advanced liberal regimes (Epsing- Anderson, 1990); the outcome is a more residual welfare state (Baines, 2004; Carey, 2008; Connell et al.., 2009). Many critical researchers

continue to comment on these changes and their impact on service delivery and work organization in countries such as Canada, (Aronson & Neysmith, 1996; Aronson & Smith, 2009; Campbell & Gregor, 2002; Baines, 2004; Rankin & Campbell, 2006; Armstrong & Armstrong, 2008), the U.K. (Harris, 1998; Clarke, 2004; Carey, 2008), Australia (McDonald, 2006; Connell et al.., 2009), the U.S. (Fraser, 1989, 2005; Acker et al, 2010) and internationally (Baines et al.., 2012; Baines, Charlesworth & Cunningham, 2013).

The restructured welfare state in most of these countries includes the adoption of pro-market, non-market strategies and strong support for a minimalist, residual welfare state. Through these complex processes, clients, work and workers are produced for the for-profit sector as the middle class seeks alternatives to narrow and inadequate public services for which they increasingly not entitled and workers lose jobs in the shrinking public sector (Baines, 2004). Examples of how this plays out in the Canadian hospital sector includes: Public Private Partnerships (PP3's) to build new hospitals in which ancillary services are privatized and patients at the point of discharge are encouraged to use the private sector to provide nursing or psychotherapy services due to a scarcity in public services (Armstrong & Armstrong, 2009; Personal Communication, 2009). These neoliberal pro-market, non-market strategies are highly gendered as they disadvantages women as service users, workers and volunteers (Baines, 2004). As jobs move to the private sector they may continue to be filled by women but at a lower rate of pay than their public sector counterparts. This is also happening in health care with the building of PP3 hospitals.

Labour process theory (LPT) draws on Marxism to address the central relationship between capitalism and work. LPT also uses "analytical and empirical tools" which connect the workplace to wider social or political systems (Shalla, 2007; Thompson & Smith, 2009). Due to its ability to link everyday work to the economy, LPT's framework is helpful in studying work in more traditional Taylorized workplaces, as well as in lean and high performance workplaces. LPT proved to be a valuable approach in my research study area as the RAI-MH is a standardized assessment and a funding tool that narrows and routinizes work and links neoliberal agendas of cost saving in public services with the everyday practices in health care.

Studies exploring the standardization of public sector work, include teaching (Ballet et al., 2006), probation (Fitzgibbon, 2008), nursing (Rhodes et al., 2006), community or non-profit social work (Baines, 2004, 2006) and state social work (Ferguson & Lavallette, 2004; Carey, 2009). While some workplaces are more standardized than hospital social work and nursing, I will argue LPT can still be used to explain recent trends in hospitals, especially with the implementation of computerized, psychosocial assessments (RAI-MH). LPT provides a way to fill a gap in critical research in work, namely, the experiences of hospital workers using the RAI-MH and the potential to decrease autonomy.

At the core of LPT is an examination of the employer- employee relationship and in particular the indeterminacy of that relationship (Thompson & Smith, 2009; Belanger & Edwards, 2013). For example, control and autonomy are in tension as hospital organizations seek to control and gain surplus labour power (work intensification and

surveillance) and workers try to maintain professional autonomy over how to use their time. Since Braverman's (1974) seminal work there has been an abundance of literature supporting, contesting and advancing this approach. I will use Thompson and Smith (2009) and Thompson (2010) to briefly highlight aspects of LPT history and current thoughts as it relates to my study.

Braverman (1974) presented a critique of Taylor's scientific management model in manufacturing by comparing it to the standardization of clerical work. Braverman states that through Taylorism work processes are standardized and workers experience deskilling, alienation, exploitation, decreased autonomy and so the degradation of work, while management extends their capacity to exert control over the labour process.

During the 1980's, the second wave of LPT, academics elaborated the concept of deskilling, and the relationship between control and resistance. For example, Burrawoy (1979) raised the important question of the role of consent in the employment relationship. Burrawoy (1979, p.77) stated,

> "twentieth century Marxism has too often and too easily reduced wage labourers to objects of manipulation; to commodities bought and sold in the market; to abstractions incapable of resistance…."

Workplace relationships involve contradictory elements including, co-operation and conflict and engagement and alienation (Sawchuk, 2008). Over the course of a number of decades now, LPT has been debated and pushed in new directions which, many argue, led to, "a more nuanced, textured and dynamic understanding" of the capital-labour relationship (Shalla, 2007, p.4). One aspect that has remained consistent, though, is the notion that the indeterminacy of the employer-employee labour relationship is such that

the employer attempts to extract surplus labour while the worker finds ways to resist (Thompson & Smith, 2009). After considerable debate, deskilling began to be viewed as a tendency rather than a law of capitalist development in society. As Thompson and Smith (2009, p.262) note, the core theory of LPT refers not to the inevitability of deskilling but to,

> "the tendency for competition between capitals to result in pressure for cheapening the costs of labour and the continual transformation of labour power. This may or may not create pressures to replace skilled workers with less skilled."

In short, the goal of capital is profit whether that is through cheapening the costs of labour through deskilling, or retaining skilled labour, or moving into other industries which have more skilled labour (Thompson & Smith, 2009).

Braverman was also challenged during the second wave of LPT for not including gender and race analyses and in the 1980's feminist researchers (Cavendish. 1982; Pollert, 1981; Westwood, 1984) began looking at work organization to examine gender issues and continue to do so today (Baines, 2004; Baines, Charlesworth & Cunningham, 2013).

The third wave of LPT took place at the end of the 1980's and the beginning of the 1990's with the arrival of the "cultural turn" or the rise of postmodernism in academia. This led to an emphasis on identity and consumption as the service sector expanded and ideas regarding emotional labour and aesthetic labour where put forward. In a post-Fordist world, or in the new economy, LPT was in a more defensive mode theoretically as it attempted to hold its ground (Thompson & Smith, 2009; Thompson,

2010). Around this time there was a shift to lean organizations in manufacturing with team working, IT's, flexibility, implied upskilling or a broadening of skills as work organizations transitioned into the new economy. LPT academics began focusing on critiquing these claims with the realities observed in lean workplaces (Thompson & Smith, 2009; Thompson, 2010). Initially, the Toyota Production System (TPS) was seen as presenting an opportunity for a better future for manufacturing workers. It was thought to be a more humane way of organizing work as it encouraged worker involvement and empowerment, compared to the monotonous, hard work of Fordist manufacturing (Beale, 1994; Womack, 1990). However, the reality for many workers in TPS plants was health and safety concerns, an intensive pace of work, understaffing and rigidly standardized jobs (Graham, 1995; Lewchuk & Robertson 1996; Rinehart et al, 1997).

Lean has been referred to as "Fordism on amphetamines" or "management by stress" with work intensification resulting in increased risk for physical and verbal abuse in the social services sector (Baines, 2004). While it appeared that lean strategies increased worker autonomy and discretion, LPT academics revealed the "dark side of lean" in manufacturing by highlighting the "softer controls" used by lean management; increasing worker identification with the company and CQI teams (Thompson & Smith, 2009; Thompson, 2010). Lean's success is intricately woven with workers' knowledge or creativity and their willingness, or leans coerciveness, in harnessing this knowledge to extract surplus labour which seems more like an extension of Taylorism rather than a departure from it (Sawchuk, 2009). While a few beginning studies are emerging in the literature that take a critical stance towards lean healthcare management, this study will

contribute to the literature from the perspective of social workers and nurses in the hospital sector.

Thompson and Smith (2009) suggest that current LPT addresses the rise of generic softer skills (rather than technical) valued in work organizations, particularly the service sector: communication, adaptability, cooperativeness and team skills. LPT has taken into consideration and addressed the "cultural turn" through exploring ideas such as seduction, surveillance and self-discipline in workplaces and the understanding that identity rather than labour may be the site of indeterminacy (Thompson & Smith, 2009, p.921). Additionally, work organizations need to move beyond Taylorism and Fordism in high performance workplaces in order to harness initiative and innovation through Continuous Quality Improvement and so forth. Lean or high performance workplaces may lead to increased responsibilities; extra work or projects and this increases the likelihood that work spills over into home time. This was evident in my study where the push for increased autonomy led to increased responsibility and extra work from Continuous Quality Improvement committees or other projects. This is complex as some social workers' and nurses' sought out opportunities to be on Continuous Quality Improvement teams and so in some ways consented or agreed to further exploitation.

As a high performance worksite, hospital care teams reinforce the connections between smaller groups of workers and create distance from workers in other areas of the hospital. Hospitals also seem to be encouraging the blurring or breakdown of specialized roles or skills held by various professions. At the hospital site examined in this study, various disciplines are encouraged through *program* management, rather than the

discipline-specific management of the past, to view themselves as part of their small team rather than align themselves with others in their discipline across the hospital. There is also the subtle encouragement to break down traditional roles when nursing is encouraged to complete social work tasks or vice versa. This is discussed in chapter five when I describe the Most Responsible Clinician model and how it impacts job roles. These practices may increase efficiency but they also may lead to feelings of job insecurity and promote turf wars between health care disciplines as budgets and staff wages are constrained and cutback.

LPT is useful in analyzing many aspects of health care work but does not adequately address the inter-professional tensions arising between associated professions such as nursing and public health *(or nursing and social work in hospitals)* as they struggle for control over work activities, (Carey, 2009). My research illustrates that the deskilling/upskilling debate is further complicated by Continuous Quality Improvement committees and other strategies used in lean or high performance workplaces that permit professionals to gain more autonomy and upskilling (leading projects) and yet they are simultaneously further exploited as they are not reimbursed for this extra work. Poststructuralists and postmodernists taking up the concepts of governmentality and performativity add a fuller description of how and why the role of identity and values is important, especially with regards to gendered caring work in hospitals.

Ackroyd and Bolton's (1999) study with UK nurses found work intensification but not Taylorism. The authors of this 1999 study stated that nursing jobs had not been redesigned, as managers did not have the knowledge to change and control nursing work,

there were no controls over output or quantifying performance measures and the variation in patients' needs did not lend itself to the standardization of work processes. Additionally, they found no evidence of grade dilution: the ratio between qualified nurses and auxiliary nurses was increasing in favour of qualified nurses. Ackroyd and Bolton (1999) asserted that professional autonomy was such that managers would not risk conflict with the nursing profession. Similarly, Belanger & Edwards (2013) recently stated that while there is rationalization and monitoring of nurses in UK hospitals, they did not see Taylorism, due to the high degree of autonomy within the nursing profession.

I agree that nurses have more autonomy than other work sectors, such as call centres, but I dispute the assertion that nursing work is not increasingly standardized and I will show the tensions between management and professional autonomy is increasing. Similar to Cooke's (2006) study examining the ways nurses are managed, I will show that managers are requiring more documentation due to concerns about risk and patient complaints. I will illustrate how the RAI-MH standardizes the assessment of patients in mental health and that assessments are an important aspect of nursing and social work practice. Additionally, RN's in my study indicated grade dilution is occurring as the ratio to RN's and RPN's is increasing in favour of RPN's and PSW's in hospitals. I see lean as an extension of Taylorism, which I will argue in chapter seven, and as such will give some examples of how lean management strategies in hospitals leads to other aspects of work becoming more standardized as well. Lean or high performance workplaces use "softer methods" to control work processes rather than traditional Taylorism. Lean draws workers into using their own creativity to lean out their work and while it may use

responsible autonomy the goal of lean, similar to Taylorism, is to increase output through work intensification.

It has been suggested management use strategies of direct control, based on scientific management principles, with workers who are poorly organized, less skilled and working for firms in highly competitive product markets (Freidman, 1977 & Childs, 1984 in Thompson & McHugh, 2009). While the strategy of responsible autonomy is used with well-organized workers with more controls over the labour markets and these workers are also treated as more central to the organization (Freidman, 1977 & Childs, 1984 in Thompson & McHugh, 2009). Responsible autonomy acknowledges the drawbacks of worker resistance and the advantages gained from worker cooperation and involvement (Freidman, 1977 & Childs, 1984 in Thompson & McHugh, 2009). While Thompson and McHugh acknowledge the simplicity of these distinctions, they are helpful in identifying the tension management may find themselves in, as they seek to control labour to ensure profitability, while also requiring workers to be motivated and cooperative. This tension between control and autonomy appears to be playing out in hospital nursing and social work, with management encouraging the standardization of work processes, and at the same time promoting autonomy through lean strategies, such as increased responsibilities and team work. I explore this in my study and show how professionals respond to tensions such as these.

Some of the social workers and nurses in my study where on Continuous Quality Improvement teams, however, it is debatable how much autonomy they had on these teams and I will argue there is an increased potential for self-exploitation. Workers may

have an increased workload and seemingly more responsibility but reliance on Taylorism or hierarchical control usually results in a top down approach. It seems the team is encouraged to work on certain projects and come up with particular suggestions for change. Townsend (2007) discusses management's use of teams to gain control and maximize labour output, as opposed to teams providing workers with more control over aspects of their work, and concludes the two are not mutually exclusive. Different workers have different experiences working on teams and there are also differences between workplaces and within workplaces as would be expected, Townsend argues, teams with greater control over decision making have the potential to improve the working lives of employees. Townsend did not discuss the impact of gender on teams or traditional hierarchical work organization. Benschop & Doorewaard (1998) conclude that team based models do not lead to more equality or empowerment for women than traditional hierarchical or Taylorist based models.

LPT does not fully explain or account for the self-exploitation observed in some of the research participants. Some of the feminist literature suggests this kind of exploitation is the result of the social construction of gender and the way many women identify with the traditional role of caring, inside and outside the home, and in unpaid and paid labour (Aronson & Neysmith, 1997; Corman & Luxton, 2007). This strong identification with caring may result in exploitation at work were some women work more hours than they are paid for, often contributing personal resources to their workplace and tolerating violence at the workplace in ways that many men do not (Baines, 2004, 2006). Women working at a highly restructured Ontario Disability

Support Program office described feeling an obligation to provide good service to clients despite their own exploitation at work. It appears self-exploitation is the purest form of exploitation (Lewchuk, 2002). Despite the self-exploitation of some of the nurses and social workers in this study, as will be discussed later in this thesis, they do seem to have a limit.

As fruitful as LPT is in offering a significant perspective of work under neo-liberalism I would contend there is a gap when it comes to hospital caring work, especially with the more recent implementation of the RAI-MH and other standardized work processes resulting from lean health care management. Hospital organizations have changed significantly since Ackroyd and Bolton's (1999) study that found work intensification but not Taylorism. LPT may be complimented by using other theories or approaches (Thompson & McHugh, 2009), especially to explain more fully hospital nursing and social work. I would contend the addition of poststructural and postmodern theories such as governmentality and performativity will enrich the explanation of work in the public sector, especially hospital nursing and social work. Thompson and McHugh (2009, p.427) suggest that "a purely structural analysis, even where it allows for human action and resistance, fails to get sufficiently inside those routine everyday experiences in which people react, adapt, modify and consent to work relations". Given this, the usefulness of poststructural and postmodern theories will be addressed in the following section.

3.5 Re-theorizing the Incident: Poststructuralism and Postmodernism

There are theoretical tensions between those who favour a materialist or a modern approach which emphasizes social structure, structural locations, top-down power and dominant ideology and those who prefer a postmodern approach, which stresses the importance of culture, agency, subject positions, localized power and discourse (Pease, 2007, p.4). Poststructuralists and postmodernists challenge modernity and approaches that seek answers through meta theories promoting meta projects, as the way to transform the social world, by arguing reality is much too complex to be explained by universal explanations or truths (McDonald, 2006; Crompton, 2006; Gilbert & Powell, 2010). This section will add to the discussion on labour process theory by re-theorizing control and autonomy as it relates to the employer-employee relationship when concepts such as governmentality and performativity are explored.

3.51 Governmentality

Earlier I touched on governing when I discussed Dorothy Smith's (1974, 1987, 2005) views on texts and how they are used to shape professionals' practice. This helped me to situate my problem with the RAI-MH. I want to further expand on this by introducing Foucault's (1997) concept of governmentality and Rose and Millar's (1992) views on governing at a distance. I am particularly interested in how control and autonomy, or power and discretion, are expressed to give a more nuanced picture of the employment relationship, by exploring how identity or values impact the expression of multiple subjectivities. Firstly, I will discuss governing through the surveillance of professionals in

an attempt to create neoliberal or enterprising professionals (and patients). Secondly, I will explore discretion which occurs in the same space as surveillance and thus allows for the expression of resistance by professionals (and patients).

Gilbert and Powell (2010) argue that in order to examine social work today we need to move away from the idea of a monolithic, all-powerful state, to reveal neoliberal tactics and strategies of governing that regulate and shape the daily lives of citizens, states. Gilbert and Powell suggest Foucault's (1977, 1978) analysis of power reveals that power is relational, such that in a relationship both individuals (social worker and patient) may exercise power and discretion, or resistance. Additionally, this suggests power may be only partially successful depending on the context/relations and this uncertainty leaves open gaps or spaces in which resistance or challenges can occur.

Michel Foucault argued that governmentality should be "understood in the broad sense of techniques and procedures for directing human behaviour", (1997, p.82) and so to govern, "is to structure the possible field of action of others" (1982, p.221). It is through governmentality that professionals or experts, (such as social workers and nurses), act as agents for the government by using different techniques and strategies (RAI-MH). Gilbert and Powell (2010) also use Fournier (1999, p.285) to describe welfare professionals as, "both the instrument and the subject of government, the governor and the governed." Rose and Millar (1992) use the term "governing at a distance" to describe the shaping of behaviour far from the local site. The neoliberal strategies or technologies used to do this include, audits, benchmarking and budgets (Rose, O'Malley & Valverde, 2006).

Rose, O'Malley and Valverde's (2006, p.101) state that some professions such as accountants, insurers, managers, and psychologists are "gray sciences" or "minor professions" and I would add social workers and nurses to this list. Those in the "gray sciences" are implicated in the mundane strategies used to govern, due to their role carrying out strategies on behalf of the government. Governing from a distance, through the managerial technologies of bed utilization programs and care pathways, which prioritize efficiency, was shown to impact clinical nursing (Rankin & Campbell, 2009). Rankin and Campbell reported that health informatics enabled benchmarking which then put pressure on nurses to discharge patients after a standardized length of stay, specific to a particular diagnosis and not a particular patient. This led to nurses subordinating their professional judgement regarding patient care and discharge dates. Instead, efficiency was prioritized and discharge decisions made in a business like way. It was only in extreme circumstances that nurses advocated and intervened to delay discharges, as nurses were expected to ensure a discharge proceeded smoothly, as determined by benchmarks and so forth. In chapter four I will discuss the various ways professionals actually complete the RAI-MH and thus will illustrate how governing from a distance plays out in the day to day work of social workers and nurses as they work with patients. A couple of nurses emphasized the importance of efficiency and reported this is why they complete the RAI-MH with the patient present. Discharge was the other key area that tensions were experienced by social works and nurses as they told stories of the constant pressure to discharge in order to open up beds, resulting in patients who, in their opinion, where discharged too soon.

In my study it was the social workers and nurses who assess psychiatric patients, rendering their lives into categories in the RAI-MH, in order to determine funding. Consequently, their work was more easily controlled through standardization and surveillance. Parton (2008, p.11) reports that social workers have become information processers and are now aiding in the governing of clients through computers rather than through relationships. Social workers and nurses are also subject to performance management, often using information obtained from IT's, to ensure they are good neoliberal or enterprising professionals.

The "gray sciences" perform the business of government. What is measured will influence what type of work is considered valuable (value-added) and so performed. Work not measured will be viewed as less valuable by managers and consequently by some workers. Counting something makes it important and not counting aspects of practice makes them invisible even if in practice they are very important, such as the therapeutic relationship (Tilbury, 2004). Workers striving to be seen as good employees or to ensure job security may change their work behaviour to meet performance indicators that are valued by managers.

Foucault's description of Bentham's panopticon is useful in exploring how the 'gray sciences", (social work and nursing), are shaped, controlled, monitored and so governed by the state. Bentham's panopticon describes the ability of the tower in prisons to keep prisoners under constant surveillance and thus ensures the efficient expression of power as individuals are keenly aware they are constantly monitored. Ultimately, this results in them monitoring themselves (Foucault, 1979; Chambon, 1999; Moffatt, 1999). I

will show how the IT panopticon potentially prioritizes what aspects of caring work are considered valuable by the organization. IT brings the panoptic gaze right into work processes (Zuboff, 1988; Sewell & Wilkinson, 1992; Moffatt, 1999). IT's are increasingly being used in the surveillance of workers and service users (Garrett, 2002, 2005; Gilbert & Powell, 2010). I will illustrate this process, from the mandatory implementation of the RAI-MH by the government to self-surveillance. It seems the spread of IT's in the public sector is such that they cannot be avoided and refusing to participate is not really an option, but resistance and subversion are always potential responses (Garrett, 2002, 2005; Fleming, 2005; Gilbert & Powell, 2010). Governing strategies that shape neoliberal professionals and patients will be discussed and analysed in some depth in chapters four and five as well as the ways in which social workers and nurses find spaces or gaps in which to resist.

In order for governing to be successful discretion needs to be part of the equation. Individuals need to have some freedom for this type of governing to work (Rose et al, 2008). The control of employees (and citizens), is in tension with the appreciation that employee motivation and commitment are also important. Given this, it is advantageous to shape employees (and citizens) or in other words have them choose to behave in ways that are desirable to the employer or the state, in the hope resistance will be decreased. Advanced liberal governments' use of freedom as a strategy, results in what Foucault (1997) refers to as "technologies of the self". Freedom is complex and is not about being in opposition to government but rather having some level of individual choice, autonomy, responsibility and so the obligation to maximize your life (Rose et al, 2006).

Gilbert and Powell (2010, p.14) report that, "discretion provides a paradoxical space for the operation of power, both enticing resistance and inviting surveillance." Additionally, the dance between discretion and surveillance will continue to be the subject of ongoing revisions in social work practice. The authors state that,

> "discretion is a political activity that occurs in the context of uncertainty and complexity necessitating negotiation while highlighting localized and relational aspects of power." (Gilbert & Powell, 2010, p.14)

The ways in which professionals use their discretion to engage in acts of resistance, either by applying or not applying rules, or working in the gaps between policy and practice will be discussed in a later section in this chapter.

Governmentality is a very useful analytical tool in exploring hospital social work and nursing under neoliberal governing as it helps to make visible forms of power and the implementation of strategies that allow governing at a distance. Neoliberalism seeks to reconstruct individuals into entrepreneurial workers and consumers. Rose (1999, p.141) argues that,

> "All aspects of social behaviour are now reconceptualised along economic lines – calculative actions undertaken through the universal human faculty of choice".

This focus on the individual is a shift away from the collective rights of citizenship, both in accessing services in the welfare state and in workplaces, where the emphasis on the individual is a move away from the collective solidarity suggested by citizenship and unions. The assembling of the neoliberal or entrepreneurial professional will be discussed further under performativity.

3.52 Performativity

The term performativity is used by Stephen Ball (2003) and Judith Butler (1993) differently and I will use it in both senses. Firstly, I will discuss Ball’s research with teachers, which draws on the work of Lyotard (1984), by highlighting the impact of performance measures on professionals. Secondly, I will use Butler by drawing on the idea that individuals take on the identity of professional (or rogue or outlier) through the repetition of the acts of being professional.

The rise of performance measures or performativity is associated with globalization, neo-liberalism, the importance of efficiency, the rise of a more dispersed state, and the contested relationships between welfare, the state and citizenship (Clarke, 2004). Performativity is a method of governing whereby employees’ behaviour is shaped through the implementation of targets, indicators, evaluations and benchmarking or comparisons (Ball, 2003; Rose et al, 2006; Powell & Gilbert, 2007). For some this is an opportunity to show they are good employees, or enterprising professionals, while for others it leads to tensions and resistance (Rose et al, 2006; Ball, 2003; Gibson, 2013). Faegerstrom’s (2006) research on nurses, describes the tensions over, being or not being a good nurses, or the strain of meeting inner demands to provide good care or the external demands around performance. Faegerstrom indicates these tensions may lead to burnout and absenteeism.

The concept of performativity developed out of Judith Butler’s (1990, 1993, 1998) work on gender. Butler (1993, p2) suggested that identity may be constructed in and through action or performativity and asked for an,

> "understanding of performativity not as the act by which a subject brings into being what she/he names but rather as that reiterative power of discourse to produce the phenomena that it regulates and constrains"

The restructuring of public services is an attempt to redefine the workforce or colonize "the self" and therefore this "turn to the self" is an identity project mediated through managerialism (du Gay, 1996; Costea et al, 2008). Performativity pressures may impact a worker's identity and relations with others (Ball, 2003). Ball's work with teachers laid out how teachers were encouraged to strive for excellence, improve productivity, and be competitive. This diverges from traditional beliefs such as, professional judgement, cooperation and caring for children. This same process operates in hospital where health care professionals may view their practice as worsening, according to professional and personal values, but succeeding in terms of performance requirements. I will explore the importance placed on performance statistics by some managers in order to be viewed as a "good" social worker or nurse.

Research often portrays health professionals as being in conflict with New Public Management, however, Brown and Crawford (2003, p.67) found many community mental health professionals "had become self-regulating "deep managed" subjects under a largely hands off management regime". They argue in some work environments where deep management has been achieved, "surface management" (traditional supervisory techniques such as evaluation and surveillance of work tasks) is less likely to be required. Moreover, "deep management" is a "masterful feat" by managerialism. Additionally, this "deep management" or "governing of the soul" (Rose, 1990) is facilitated by, having a

professional ideology of caring, as well as policies which emphasize values and excellent client care. It is suggested the reorganization of health care at local and national levels leads to professionals adhering more closely to their professional identities when they feel under threat. Given this, workers identify more closely with caring work and their caring identities at these stressful times (McDonald, 1999; Brown & Crawford, 2003).

The performativity literature asserts that organizations exploit workers' values, beliefs and desire for recognition through the organization's identity project. This is a deliberate strategy accomplished through a "discursive colonization of the employee self" by the employer to extract as much surplus labour as possible and encourages teams and workers to discipline themselves (Casey, 1995, p.159; Alvesson & Willmott, 2002; Thompson & McHugh, 2009). This "cultural engineering" project is an attempt to shape workers' identity and thus decrease resistance but also recognizing other factors come into play in the formation of identity (Alvesson & Willmott, 2002; Alvesson & Karreman, 2004). Resistance may be decreased but not eliminated. This helps explain why despite some workers engaging in self-exploitation, through over identification with the organization or their caring profession, it is still necessary to use bureaucracy or "surface management" in order to control those who resist "cultural engineering. Lumby (2009) argues that those who have fewer resources (financial, cultural, and social) are more likely to succumb to identity projects.

Professionals in organizations need to meet multiple demands and do so by adopting different context specific roles so that there is always "some degree of fluidity and uncertainty around expectations" and "this myriad of sites for performativity contains

potential for resistance" (Powell, 2012, p.68). Additionally, performativity does not occur in isolation but is relational (with managers, or other professionals or clients), as well as complex, indeterminate and open-ended. Powell (2012 p.70) suggests that accepting identity as discursively constituted, but fluid, uneven and unpredictable, will facilitate our understanding of multiple identities. Additionally, it is therefore possible that in different situations individuals experience tensions arising from their multiple subject positions. In my study there were many examples of social workers and nurses holding multiple subject positions during the interviews depending on the context, situation or relationship they were describing. At times they were risk assessor, advocate, supporter, caring professional, enterprising professional and covert or overt dissident. This notion of multiple subject positions also helps me make sense of some of the contradictory comments and actions made by them over the course of the interviews. On the one hand, some insisted they provided client-centred care and that the RAI-MH did not influence their practice, and on the other hand their practice stories sometimes indicated otherwise. Given this, their engagement in resistance or in "pretending" to deal with these contradictions or tensions was understandable.

Gibson's (2013) study with Australian nurses analysed the ways in which an enterprising nursing subjectivity was developed through nursing vision statements, and job descriptions that emphasized characteristics adopted from the "market" (innovation, creativity, responsibility, accountability, productivity/efficiency) over traditional nursing qualities (respect, honesty, integrity): caring was considered an outcome rather than a key nursing value. Gibson (2013, p.98) also found that nurses in management positions "had

more clearly taken up an enterprising subjectivity", especially with regards to the business of bed management. This enterprising subjectivity seemed to be diluted when it came to nurses on the ward. Gibson thought this was due to role location and ward culture. Ward nurses were in relationships with patients and families and sometimes found themselves in conflict with organizational values when it came to discharge. Similar to Gibson, my study explores tensions in personal, professional and organizational values, and in what ways, and to what extent, social workers and nurses take up an enterprising subjectivity in order to meet performance measures. When do they use discretion and resistance?

Ball (2003) gives a gender neutral analysis of performativity whereas Baines and her colleagues (2012, p.363) argue that performativity "is a highly gendered process, building on and reflecting gendered expectations of ones self and others." There is an extensive feminist literature on caring work that includes gender roles drawing women to this type of work, discusses their exploitation and self-exploitation, so that women can continue to meet the needs of their clients in a residual welfare state (Aronson & Neysmith, 1997; Baines, 2007; Cormon & Luxton, 2007; Baines et al., 2012). Men moving into caring work provides an opportunity for gender comparisons. Men were found to have clear cut boundaries between work and home while women were more likely to blur this boundary by engaging in unpaid labour (Baines, 2006). Men preferred the more technical or masculine parts of work while women identified strongly with the relational or caring aspects of work (Lindsay, 2008; Baines, Charlesworth & Cunningham, 2013). I view the RAI-MH as technical aspect of work or a masculine

technology and wonder if it is taken up differently by women and men. I will explore boundary crossings and refusals to see if there are gender differences.

Connell, Fawcett and Meagher (2009, p.334) state that New Public Management strategies have led to "“flat” organizational structures and generic skills". This move to "fractual organizational logics" results in departments, managers, and individual workers functioning like mini businesses held accountable at each level. Individual workers are expected to follow a profit making logic and are held accountable through performance management (Connell, Fawcett & Meagher, 2009). This supports Clarke (2004, p.121), who describes the shift from professional identities to organization centred identities: the organization/department "seeks to become the "point of identification, loyalty and commitment" to such an extent that professionalism becomes "suspect" and "distracts" from the organization/department. Social workers (and nurses) are not blank slates with managerialism creating an entrepreneurial public sector worker: the New Public Management discourse is often "contested, manipulated, adapted, perverted and sometimes internalized and adopted" (Hoggett, Mayo & Millar, 2006, p.768).

This section discussed the governmentality and performativity literature, including how it specifically relates to social work (Powell, 2012) and nursing (Gibson, 2013). I have illustrated that governing requires a dance between power and discretion. One of the strengths of the concept of performativity is its complex understanding of power and discretion which challenges arguments often made about Foucault's earlier work as conservative with individuals as docile subjects (Powell, 2012). Powell (2012, p.71) states that,

> "it becomes possible that the docile, industrious and resistant subject can occur within a single individual providing for different performances in different areas of life"

The literature on labour process theory, governmentality and performativity discuss the dynamic relationship between control and autonomy or power and discretion and so highlight potential opportunities for resistance.

3.6 Reconstruct and Recreate Emancipatory Strategies: Practice Responses

The responses of social workers and nurses to the standardization of their work is of particular interest in my study, especially the ways in which they resist the regulation of their work. Resistance is richly discussed in the literature. There are those who favour a more modernist approach that emphasizes collective resistance, often through unions or social movements (Collinson, 2005; Acker, 2009; Carey, 2008). As Carey (2008, p.359) states, individual approaches to resistance such as those postulated by postmodernists,

> "offer no coherent attempt to *confront* neoliberal reform. In contrast, real or tangible forms of change would require the support of more substantial individual, group or wider collectivist ideological forms of resistance from within the social work labour force (including the academy) – something which has at times been promised, debated, and discussed, but rarely delivered in practice."

There are other theorists who lean towards a postmodern approach that stresses micro level or individual resistance (Aronson & Sammon, 2000; Clarke, 2004; Thomas & Davies, 2005; Barnes & Prior, 2009). Barnes (2009, p.191) suggests that neoliberal policies leaves gaps or spaces that become sites of potential subversive action or resistance. Additionally, Barnes does not,

> " identify subversion as heroic, revolutionary or necessarily even conscious acts deliberately intended to undermine a particular purpose or outcome of public policy." (p.191)

The tendency to see power as monolithic and oppressive is challenged by Judith Butler as she asserts that power operates through subjects or individuals and to further complicate things this then means that "resistance is always contaminated by the power it resists" (Fleming, 2005, p.53). Butler (1998, p.2) illustrates the complexity of power when she states, "power is not simply what we oppose but also, in a strong sense, what we depend upon for our existence and what we harbour and preserve in the beings that we are."

With the "cultural turn" labour process theory academics' views on resistance has expanded to include many forms of resistance. Control and resistance are in a reciprocal relationship; both are dynamic given that control changes to address resistance and resistance changes to adapt to changing control systems. Given this dynamic, Ackroyd and Thompson (1999) mapped out organizational misbehaviour while still acknowledging the importance of collective action. Misbehaviour includes four dimensions of appropriation, working time (time wasting, absence), working effort (soldiering, effort bargaining), the product of work (perks, pilferage) and identities (joking rituals, class or group solidarity). Within each dimensions are examples of practices that are an attempt to improve autonomy. Ackroyd and Thompson (1999, p.55) further state that "Interests and identities are not opposites and they reciprocally and discursively form one another".

Labour power has two components or indeterminacies referred to as "effort power" and "mobility power" (Smith, 2006). With "effort power" we are reminded that just because an employer hires a worker this does not automatically mean that

labour/work is guaranteed. In other words, the capacity to work is within the worker and the employer needs to find ways to extract labour (such as managerialism). With "mobility power" the worker decides where and for whom she works and the employer can choose whether they continue to need her labour/work (Thompson & Smith, 2009). This furthers our understanding of the uncertainty or indeterminacy of the employer-employee relationship and so the dance between control and autonomy. This adds to my understanding of social workers' and nurses' responses to the regulation of their practice. They may seek ways to regain autonomy and also have the option of leaving the organization and looking for work elsewhere. As fruitful as LPT research has been in explaining resistance in a variety of sectors more research is needed to explore hospital social workers and nurses given their unique role as state employees, the gendered aspects of their work and the increase in standardization or regulation.

Thomas and Davies (2005) remind us resistance is a risky business for workers as it could potentially result in limiting careers or job losses. There is a possibility that micro resistance may still be considered a political project that may lead to broader organizational change, especially if social workers and social work managers are resisting policy changes (Thomas & Davies, 2005; Clarke, 2004). Thomas and Davies contend that engaging in micro resistance does not mean workers cannot be a part of more overt, collective forms of resistance. It is not an either or choice but rather being strategic as to which strategies a social worker uses, and why, and when.

Power is relational, or the product of human interactions, and with power there is discretion, this means any interaction has the potential for resistance (Powell &

Hendricks, 2009). As I illustrated earlier the reason that professionals, such as social workers and nurses, remain important in our society is in part due to their autonomy or discretion, which implicates them in the governing of others who need managing or reassembling into neoliberal patients. Subsequently, it is through technologies of governing that the state acts to constrain or limit a professional's autonomy. Within this complex circuit of power relations opportunities for resistance will arise requiring us to remember that "not all resistances are productive, progressive or transformative" (Rose, 1995; Clarke & Newman, 1997; Clarke, 2004, p.159; Powell & Hendricks, 2009; Powell, 2012). Thomas & Davies (2005, p.687) state,

> "Resistance is understood as a constant process of adaption, subversion and reinscription of dominant discourses. This takes place as individuals confront, and reflect on, their own identity performance, recognizing contradictions and tensions, and in so doing, pervert and subtly shift meanings and understandings."

Powell and Gilbert (2007) argue that on one hand it may be possible to be the consummate professional social worker, while on the other hand to be a radical political activist. The authors are making the point that even within a culture of performativity it is possible to comply with an institution's procedures and also be resistant to those procedures at the same time. People are not robots and will find ways of "surviving, negotiating, accommodating, refusing and resisting" (Clarke, 2004, p.159). In my findings chapters I will analyze the many resistance strategies social workers and nurses engaged without seriously jeopardizing their jobs which suggests they are also meeting the managers and the organizations performance expectations. The holding of multiple subjectivities helps to explain why, and how, this is possible.

3.7 Conclusion

Stepney's (2006) model or four point guide was useful in helping me explore how different theoretical approaches can be drawn on or synthesized when looking at work organization in hospitals. In particular, I used labour process theory, governmentality and performativity to examine how control/power and autonomy/discretion are exercised when social work and nursing work in hospitals is standardized using the RAI-MH.

John Clarke (2004, p.119) reminds us that despite a more dispersed state, through technologies of governing, the state or government continues to have centralized power and highly conditional autonomy is given to organizations; it is expected they will conduct themselves in a business-like manner. Additionally, the government's method or mode of operation gives autonomy or the freedom to manage conditional on competitive success (or containing budgets in hospitals). Clarke contends that one of the dangers in the concept of governmentality is viewing the state as decentred to such an extent that it may limit our thinking on centralized power and governance. Clarke agrees with Jessop (2000, 2002) that there are concerns with

> "meta-governance - the governing of governing..the state remains a significant issue – both as the organizing force for meta-governance and as the legitimating agency through which most governmental strategies have to pass to become authorized"

This suggests a need for both structural and poststructuralist approaches when examining neoliberalism and Clarke states that neoliberalism is unfinished, uneven and unstable, and the glue that holds it together is managerialism.

I have explored the usefulness of labour process theory, governmentality and

performativity and illustrated ways they complement and fill in gaps of the other when examining hospital work. It seems taking an eclectic approach is most beneficial to me. Thompson and McHugh (2009, p.437) go as far as to argue that complementarity is often more feasible than synthesis when theories such as these are used in the examination of power and control in work organizations. Additionally, the authors suggest the benefits of choosing a middle ground between positivism and relativism, namely critical realism; both social structures and the meanings actors give to their situation are acknowledged. In this thesis there will a telling of different tales (Ristock, 1998) and deliberate "slippages" (Dehli, 2008) as I move or navigate between structuralist and poststructuralist epistemologies. In presenting the findings and analysis of social work and nursing work in restructured and regulated hospital organizations I will view the tensions and the slippages between theoretical approaches as an opportunity to add to the conversations in the literature.

Chapter 4

Methodology and Research Design

4.1 Introduction

This chapter will focus on the ways in which my epistemological stance influences my research questions and consequently the research design most suited to explore this area under study. The research design and methods used will be discussed along with what constitutes good qualitative research. The Resident Assessment Instrument – Mental Health (RAI-MH) will provide a point of entry for understanding how the clash between past work practices and new managerialist technologies are experienced and negotiated by social workers and nurses seeking to provide good care to patients.

4.2 Critical Research

Epistemologically I locate my work within the critical social sciences utilizing aspects of Marxism, feminism and poststructuralism (Braverman, 1974; Thompson, 2010; Smith, 1987; Fraser, 2005; Acker, 2009; Foucault, 1997). Critical theory analyzes individuals' or groups' experiences in order to understand social structures and subordinated forms of knowledge. It aims to uncover or make visible power and inequality while suggesting ways to respond to or resist injustices with the ultimate goal of social transformation. Critical literature that focuses on the neoliberal restructuring of public services (Aronson & Neysmith, 1997; Baines, 2004, 2009; Carey, 2007, 2008; Connell, Fawcett & Meagher, 2009) and on work organization (Braverman, 1974; Thompson & McHugh, 2009; Casey,

1995; Acker, 2009) in particular, offers conceptual and methodological guidance for this study.

Feminist theory (Smith, 1987, 2005; Acker, 2009) is used to gain critical insight into the gendered processes at play and in particular the tension between "feminine" care work which traditionally relies on narrative and experiential ways of understanding and assessing people's distress and the current trend to utilize what may be considered "masculine" technologies (Lindsay, 2008) and I would include standardized computer assessments. Feminist theory highlights the importance of taking a particular standpoint or position during research which challenges the myth of the absent researcher or neutral knowledge building and promotes reflection and transparency on the part of the researcher. Reviewing my epistemological location is important as it provides clarification as to why I formulated the research questions in this particular way and why I selected the research design outlined below.

4.3 Qualitative Research

Given the research questions concern with social workers' and nurses' actual experiences in hospitals and how they attribute meaning to enforced changes to their practice, a qualitative research design which incorporates a grounded theory approach is clearly indicated. There are many methods and approaches that fall under qualitative research and even within grounded theory there is variation, therefore, I will define and discuss the specific processes I used in this study.

Denzin and Lincoln (2008, p.4-5) offer a broad definition of qualitative research as a,

> "situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible ….. They turn the world into a series of representations, including field notes, interviews …and memos to the self. .... researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them".

As noted above the interpretive framework or paradigm I bring to this study is situated in the critical theories of Marxism, feminism with a measure of postmodernism. This type of approach is referred to as critical postmodernism (Mullaly, 2002; Fook, 2002; Pease, 2002, Stepney, 2006). The research strategy I employed was grounded theory and the method for collecting data was interviews. These will be described in more detail below along with the particulars on how the data was analyzed.

4.31 Grounded Theory

Glaser and Strauss's (1967) promoted qualitative research arguing that grounded theory offers a systematic method for social science inquiry. Since then the specifics of grounded theory have been contested. While Glaser and Strauss (along with Corbin) later moved in differing directions their standpoints remained infused with positivism and its objectivist foundation. To avoid the rigidity of positivism this thesis adopts a constructivist grounded theory approach. It is postulated by Charmaz (2003, p. 250) that constructivist grounded theory,

> "takes the middle ground between postmodernism and positivism and offers accessible methods for taking qualitative research into

the 21st century".

Constructivist grounded theory encourages a focus on experiences from the standpoint of those living it which results in multiple viewpoints rather than the search for a single reality (Charmaz, 2003). Similar to a constructivist approach my aim was to include the multiple voices and views of social workers and nurses.

Bulmer (1979, p.667 in Charmaz, 2004) argues that Glaser and Strauss' "tabula rasa view of inquiry is open to serious doubt". Glaser and Strauss suggestion that researchers refrain from reading the literature until after categories have been developed is challenged by constructivists. The development of categories necessitates an understanding of sociological concepts "without being wedded to them" as this allows for a "delicate balance between possessing a grounding in the discipline and pushing it further" (Charmaz, 1990, p.1165). Additionally, sensitizing concepts allow researchers to attend to "central issues" without them merely reproducing the same concepts. My study developed out of my lived experience as a hospital social worker and my reading of the literature over the past decade. Existing concepts in the literature or sensitizing concepts shaped my initial research interest in pursuing a thesis in this area and in developing my research questions. My entering the research as a blank slate was neither a possibility nor a position I desired to begin from. I agree with Charmaz (1990, p.1171) that grounded theory analysis is enhanced by the clarification of the researcher's epistemological stance and by linking back to existing literatures.

Constructivist grounded theory allows the researcher to take up a flexible position along a continuum between objectivist and constructivist grounded theory (Charmaz,

2003). With a constructivist stance the researcher recognizes, firstly, that the strategies used may be flexible rather than prescriptive, secondly, the focus on meaning pushes rather than constricts our understanding, and thirdly, using grounded theory strategies does not necessarily result in the researcher taking the positivist stance postulated by early grounded theorists (Charmaz, 2003, p. 251). I tend more towards a constructivist than objectivist stance on this continuum. This more flexible, open approach to grounded theory aligns more closely with my methodology at both the more practical and theoretical levels.

4.32 The Marginality of Qualitative Research in Health Care

The marginalization of qualitative research in some academic disciplines has been discussed by Charmaz (2008). I would suggest something similar occurs in medical research and at the clinical level where the positivist or quantitative paradigm dominates. The superiority of "gold standard" research studies or randomized clinical trials that emphasize validity, reliability, randomization, statistics and objectivity is strongly promoted and endorsed within health care research. The marginalization of qualitative research became apparent while conducting this study when physician colleagues asked what my hypothesis was along with what statistical measures I would use in analysing the data. Physicians use and value "gold standard" research while nurses and social workers also use and respect qualitative research methods.

This marginalized position may be viewed as an opportunity to move research away from established positions, break down barriers and move boundaries. Additionally,

this permits researchers to present as close a view from the inside as a researcher can get as opposed to the view from the outside traditional held and valued by quantitative research (Charmaz, 2008). This "view from the inside holds possibilities to gain fresh ideas and new understandings", according to Charmaz (2008, p.15). I attempted to follow Charmaz's (2008, p. 16) suggestion and with curiosity delve deeply into participants' experiences and their making meaning of their experiences and I faced the uncertainty and ambiguity of this research process as my findings and analysis emerged.

Prescriptive data collection methods are not required by grounded theory. Methods for data collection range from interviews to photographs but grounded theory does suggest strategies that will assist in data collection, analysis and theory development. Grounded theory may be broken down into the following steps, according to Charmaz (2003, p.251),

> "a) simultaneous collection and analysis of data, b) two-step coding process, c) comparative methods, d) memo writing aimed at the construction of conceptual analyses, e) sampling to refine the researchers' emerging theoretical ideas, and f) integration of the theoretical framework".

This will be described below, but first, a description of the study site and the focus of my research; the Resident Assessment Instrument-Mental Health (RAI-MH) which is the particular case of standardization or technological strategy being studied and the particular hospital selected to be the study site.

4.4 Study Sites

The study sites are the actual Resident Assessment Instrument-Mental Health (RAI-MH) computerized text and the hospital site where the social work and nursing interviews were conducted.

4.41 Resident Assessment Instrument-Mental Health (RAI-MH)

The RAI-MH is the point of entry into work processes of central interest to my study. This section provides an explanation of its origins and implementation. The RAI-MH originated in the development of Minimum Data Set (MDS) technologies in the U.S. The U.S. Omnibus Budget Reconciliation Act, 1987, mandated the U.S. federal government develop a comprehensive system to assess and evaluate all nursing home residents and out of this MDS instruments evolved. Nursing homes are required to complete a MDS on each resident to assess care outcomes and allow comparison with other homes (Lum et al, 2005).

The inter RAI consortium was established in 1992 and consisted of about 50 clinicians, researchers and administrators from 25 countries. This not-for-profit group's goal was,

> "the assembly of accurate clinical information in a common format within and across service sectors and countries enhances both the well-being of frail persons and the efficient and equitable distribution of resources." (Fries et al, 2003 In Hirdes et al, 2009).

The RAI-MH was initially used in long term care and expanded into home care, inpatient mental health and community mental health, forensics and so forth, with 10 core items and then optional items to suit particular populations or settings (Appendix B). Inter RAI

consists of a network of researchers in over 30 countries who state they are "committed to improving health care" with the goal of promoting "evidence-based clinical practice and policy decisions" (www.interrai, 5/2/2012). The RAI-MH was "designed to support care planning, outcome measurement, quality improvement and case mix based funding applications" (www.interrai, 5/2/2012).

In 2005 it was mandated by the Ministry of Health and Long Term Care in Ontario as the basis of the Ontario Mental Health Reporting System and thus became part of daily clinical practice for many hospital based social workers and nurses and appears to be gradually expanding to hospital mental health outpatient services. When initially introduced to frontline staff it was described as a multidisciplinary assessment that would decrease workload and would be used in research to improve quality. Its role as a funding formula was downplayed but over time its importance for funding and allocating resources, including staff positions, has been ramped up.

In 2011/12 the data from the RAI-MH will be used to determine funding. Data collected and inputted by staff is used to develop a SCIPP (System for Classification for In-Patient Psychiatry) algorithm,

> "that can be thought of as an accounting process by which clients …. are grouped with relative weights that represents costs and staff resources needed for their care … comparing our SCIPP values with those of facilities in our peer group" (Training Document, n.d.).

While all sections of the RAI-MH influence the SCIPP value some sections or questions impact funding significantly. These are section Q where the mental illness is diagnosed and in other questions that assess risk and independence. Hirdes et al (2009, p.5)

describes RAI's "powerful capacity to compare caseload complexity and service responses between facilities, regions and nations" and will "require significant investment by governments".

The use of MDS instruments continues to grow; in long term care (Rahman & Applebaum, 2009), palliative care (Brandt et al, 2006), intellectual disabilities (Martin, 2005), forensics (Seto, Harris & Rice, 2004) and so forth. While the validity, reliability and usefulness in clinical care of MDS tools continues to be contested (Hirdes et al 2002; Lum et al, 2005; Teresi & Holmes, 1992; Ouslander, 1994; Crooks et al, 1994; Mor et al, 2003; Mor, 2005; Simmons et al, 2004; Piven, et al, 2006; Rahman & Applebaum, 2009).

The RAI-MH is a computerized, psychosocial assessment that has approximately twenty sections. It requires health care providers to input specified, close ended data and produces a resulting care plan. In some sections there is limited space for nurses to input narrative. While standardized assessment tools are increasingly used in a range of public services, the RAI-MH is used to not only standardize work processes but also to determine hospital funding. This clearly links it to an efficiency/cost containment agenda and thus makes it an especially rich focus of study.

4.42 Hospital Site

The social workers and nurses were recruited from an urban hospital in Southern Ontario with a large inpatient and outpatient mental health program. While this qualitative study will be conducted in a hospital, or as Sandelowski and Barroso (2003, p. 784) refer to it as

the "real world" rather than the "artificially controlled and/or manipulated conditions" in a laboratory, it is argued that the findings may be transferable or applicable to similar settings or contexts. Findings from qualitative studies may have transferability or fittingness to other contexts depending on the similarity or congruence between the environments (Lincoln & Guba, 1985). Both the study site (urban hospital) and the case under study (RAI-MH) have broad and beneficial transferability given the similarity of contexts with other hospitals as well as other public services where standardized assessments and processes are used to regulate work. For example, many hospital services are being restructured as lean strategies from the Toyota Production System are being adopted to standardize work with claims of increased efficiency and cost containment. Transferability is one criterion to assess the quality of qualitative research. Towards the end of this chapter other criteria will be reviewed.

4.5 Sample and Recruitment

The goal was to recruit approximately twenty social workers and registered nurses (RN's) who completed the RAI-MH as part of their practice. I subsequently interviewed seventeen participants; eleven social workers and six registered nurses. One participant was male and two were from racialized populations. All of the social workers had undergraduate degrees half of whom had Masters of Social Work degrees. Two of the registered nurses had university degrees and the other four had college diplomas. With regards to experience five of the six nurses would be considered senior while half of the social workers were also senior with lengthy practice experiences. Due to the small

sample size some details have been moderated or modified in the findings chapters in order to protect the participants.

As this type of study is emergent the number of participants was approximate. However, the aim was to continue interviewing until saturation was reached or in other words until new data fit into existing categories. The approach to sampling was purposeful and included both snowball sampling and theoretical sampling strategies with the possibility of conducting second interviews and/or member checks, as needed.

Social workers and nurses were chosen as the hospital had assigned them the responsibility to complete the majority of the RAI-MH. The nurses completed the majority of the assessment and social workers the next largest number of sections (five). The psychiatrists completed one section on diagnosis. While occupational therapists completed one or two sections on some wards but not at all on other wards.

Qualitative studies are typically in-depth "with careful attention to detail, context and nuance" and have relatively small sample sizes which are selected purposefully (Patton, 2002, p.227). Purposeful sampling is a type of nonprobability sampling where the participants are selected on the basis of the researcher's judgement about which ones will be most helpful or information rich for a particular subject under study (Babbie, 2004; Patton, 2002). Participants were drawn from social workers and nurses who worked in acute, tertiary and outpatient settings in an attempt to gather information from various settings within the mental health program of the hospital.

A grounded theory approach typically utilizes theoretical sampling which is defined as,

> "sampling on the basis of the emerging concepts, with the aim being
> to explore the dimensional range or varied conditions along which

the properties of concepts vary" (Strauss & Corbin, 1998, p.73).

Theoretical sampling was used after I had developed categories as this provided the opportunity to refine my ideas through asking specific questions in an attempt to fill in gaps in my analysis and to further assist in theory development (Charmaz, 2003).

In the recruitment process, variation was sought with regards to social workers' and nurses' length of practice experience in order to include a mix of both newer and seasoned workers. As noted earlier, there may be generational differences in how they respond to standardization. The seasoned workers will have practiced before the RAI-MH was implemented while the newer workers will have been hired after mandatory implementation of the RAI-MH and thus their education and socialization or initial training at work will differ. It was speculated that responses, and specifically resistance, may be taken up differently or take different forms given social work's and nursing's differing knowledge bases. Where possible variation was sought with regards to gender and race as it has been suggested that these may also be factors in influencing how workers respond to organizational changes (Casey, 1995; Lumby, 2009).

I had more difficulty recruiting nurses than social workers. Social workers appeared to have more autonomy in that they could more easily schedule their work to allow for participating in an interview. Nurses reported having more difficulty leaving their wards in order to be interviewed and interviews often had to be rescheduled a few times as a result of mainly coverage issues and occasionally emergency situations arising on the ward. RN's reported difficulty participating in interviews as a minimum of one RN had to be present on a ward at all times. Due to a reduction in the number of RN's on

wards and an increase in RPN'S over the past several years the ability to leave wards even for breaks particularly on weekends can prove difficult for some RN's. While I was flexible as to the time and place of interviews only one RN from a ward requested she be interviewed on her unit after indicating she had difficulty leaving the floor. I also offered to conduct interviews before and after shifts or on days off and this was declined. The composition of the participants seemed somewhat representative (in terms of age, gender and ethnicity) of the make-up of social work and nursing professionals in the mental health program at the hospital.

Practically, participants were recruited in a manner that allowed those interested to initiate contact with me in order to ensure that their participation was voluntary. The Professional Practice Leader at the hospital sent an email to staff. The email included a Letter of Information (Appendix C) outlining the purpose of the study, expectations of participants and information on how to contact me if they wished to explore participation in the study. The email requested staff pass on this information to other potential participants. This snowball strategy proved very useful given the difficulty recruiting nurses. Social workers interviewed where asked at the end of the interview to inform nursing collegues about my study and those interested in participating where contacted initially by email. A snowball sampling strategy was built into the method to allow for the recruitment of key participants with rich information and thus allow greater depth into the area under study (Patton, 2002). Those who came forward were contacted and given the Participant Information and Consent Package (Appendix D) to review and ask questions

about before deciding whether to give written consent. Following written consent the research interview was started.

4.6 Data Collection

Interviews were arranged at times and places that were convenient, safe, comfortable and selected by the participants. Participants all chose on site interviews in offices or meeting rooms close to their places of work. One nurse specifically requested an interview on her ward due to her inability to leave the ward during her shift. Participants were informed their personal identifiers would not be used. They would be assigned a number and any information obtained in connection with this study that could identify them would remain confidential and only disclosed with their permission or as required by law. While every caution was taken to avoid participants being identified they were reminded that they may be identified by the views they expressed and therefore they could choose their level of participation. Participants were informed they could withdraw from the study at any time. None withdrew from the study and some expressed the usefulness of the interview in helping them think more critically about their practice.

Interviews were recorded and transcribed verbatim with the participant's permission. Interviews were in-depth, active, conversational and approximately one hour in length. This was an interactive process where I asked the initial participants open ended questions using the more structured interview guide (Appendix E). The interview guide is composed of broad, open-ended questions that were designed to explore the participant's experiences and opinions on the RAI-MH. However, I showed flexibility in

my responses so that the interviews were conversational rather than rigid or forced (Fontana & Frey, 2008). I agree with Scheurich (1997, p.62) who states that interviewing is not a process by numbers technique but rather is "persistently slippery, unstable, and ambiguous from person to person, from situation to situation, from time to time". Data gathering followed an iterative process whereby themes and or issues identified in earlier interviews were incorporated into later interview guides and explored in later interviews (Glaser & Strauss, 1967).

Grounded theorists begin with general research questions, rather than a fixed hypothesis, which may narrow or change over the research project. These general, open ended interview questions may change or become more specific as categories begin to emerge from the data as the interviews progress. My initial interview questions were very broad, open ended and I started the conversation by asking which computerized assessments participants used, advantages and disadvantages and so forth. I quickly discovered that by asking how they used the RAI-MH in their daily practice, or the mechanics of how they completed it, led to rich stated and unstated data. As the study progressed new questions were added. For example, the impact of values in addressing tensions and dilemmas became apparent early on and I adapted the interview guide to include specific questions on personal, professional and organizational values (Appendix F).

Obtaining a description of how the RAI-MH is completed allowed the exploration of levels of acceptance, compliance and resistance even to some extent if a participant was not aware of their response on a conscious level (Cowley, Mitcheson & Houston,

2004). For example, if the participants reported they diverged from the prescribed method and the RAI-MH questions, this would shed light on whether they viewed the instrument as a checklist of questions to be closely followed or as a guide. I was interested in how tightly they controlled the initial interview with patients. Were patients permitted to answer in more depth than the RAI-MH required? Were patients allowed to tell their story? This will be discussed in detail in the findings.

I realized the exploration of values, identity and life experience as they relate to professional and organizational values may have proven challenging particularly if, as Barnes and Prior (2009) suggest, subversion or resistance is not always at a conscious level. Additionally, if I wished to explore not only acts of resistance but deviant attitudes and emotional responses this also may be problematic (Carey & Foster, 2011). Other researchers have managed this challenge by asking questions about life experiences and more specifically why the individual entered their profession, their personal and professional values and how these align with the organization's stated and unstated values (Carey, 2008; Hogget, Mayo & Millar, 2006; Brown & Crawford, 2003). I asked participants how they came to be in social work or nursing and what influenced their decision to enter these professions. I also approached the topic by asking them to describe times when they had little choice but to (or times they wanted to) ignore or bend the rules so they could do their job or do what is best for the patient (Furber & Thompson, 2006; Carey & Foster, 2011). Additionally, I asked if they ever left work troubled. Did they seek out colleagues to talk about troubles/concerns? What were these concerns?

It is suggested the language or "lexical choices" used by professionals during patient-professional interviews can provide insight into the beliefs and values held by them (Cowley, Mitcheson & Houston, 2004, p. 509). During the research interviews attention was paid to the participants' use of language in describing their practice and also the extent of and recognition of their use of the language or euphemisms of the organization. This may be a sign of acceptance of organizational values or a conscious strategic use of language on the part of the professional to manipulate the organization to gain credibility (Bates, 2006).

On a practical level during the interview I asked for and explored stories or examples, especially those that participants seemed reluctant to tell in an attempt to seek more texture, detail and complexity. I encouraged the exploration of ethical dilemmas or tensions in practice and how they resolved this in practice and within themselves. I was interested in overt statements made by the participants as well as what was unspoken implicit or unstated.

Interviews should preferably end on a more positive note (Charmaz, 2004) and I added specific questions in an attempt to do this. I asked the "miracle question"; if you had the power to change one thing at work what would it be? Towards the end of the interview there was a focus on their responses to tensions or dilemmas and I was concerned this may lead to a critique of their practice that left them feeling disillusioned. I hoped the "miracle question" would lead to areas participants thought was of primary concern to them but more importantly to what they might believe where possibilities for change or transformation on a more practical level.

Active listening, including listening for when silences occurred facilitated the collection of information at a more unconscious level. Silences are meaningful and "take different forms and serve various purposes" including when individuals are searching to vocalize thoughts on the edge of awareness, or someone may be indicating their voices have been silenced or censored by others/self-censored, be related to historical, social, cultural contexts, a way to resist dominant views and so forth (Poland & Pederson, 1998; Charmaz, 2002, p.306). Poland and Pederson (1998, p.293) emphasize the significance of silences in qualitative research when they state, "what is not said may be as revealing as what is said, particularly since what is left out ordinarily far exceeds what is put in".

The use of field notes and memo writing assisted me in remembering verbal and non-verbal behaviour or emotional responses to questions. For example, Furber and Thompson (2006) noted times when midwives whispered or talked in a quieter voice, spoke clearly and directly, were vague in their explanations but smiled at the same time seemingly inviting the researcher to probe further to clarify what they were saying. In this study eye rolling, hand waving and laughter were behaviours I observed in moments of frustration and tension.

4.7 Data Management and Analysis

I used qualitative data analysis (QDA) software, NVivo 9, to assist with the organization of the data. NVivo assisted in finding, categorizing and retrieving data faster than a manual search while the analysis of the data remained my role as the researcher (Charmaz, 2003; McLellan, MacQueen and Neidig; Liamputtong, 2009). McLellan,

MacQueen and Neidig (2003) give detailed instructions on how to transcribe and enter transcripts into QDA software to ensure robust data collection techniques. I transcribed the first few interviews and then gave detailed instructions to a professional transcriptionist who completed the rest of the interviews. I read each transcription while listening to the recording to ensure accuracy before entering the transcripts into NVivo 9.

Charmaz (2003, p.268) cautions us that QDA software appears to align well with objectivist grounded theory rather than a more constructivist approach and may "unintentionally foster an illusion that interpretative work can be reduced to a set of procedures". I did reread whole interviews and memos many times particularly when I felt overwhelmed by the volume of data and the various ways NVivo 9 could sort the data.

Searching across the data for themes using the constant comparative method facilitated this stage of the study (Glaser & Strauss, 1967; Strauss & Corbin, 1990: Strauss & Corbin, 1998; Ryan & Bernard, 2003; Charmaz, 2003; Liamputtong, 2009). It is suggested that the importance of a theme is determined by how often it appears, how pervasive it is across different types of cultural ideas and practices, and how people react when the theme is violated (Ryan & Bernard, 2003, p.2.). The data collection and analysis occurred simultaneously so that emerging themes could be explored in subsequent interviews. The constant comparative method is one where different participants experiences, views and so forth are compared, where data from the same participant may be explored over time, or by comparing incident with incident, or by comparing data

within a category and comparing categories with other categories (Glaser, 1978, 1992; Charmaz, 1983, 2003, p. 259).

Coding is the first step in data analysis and the researcher begins to define what the data are about by naming chunks of the data (Charmaz, 2006; Liamputtong, 2009). I used invivo codes as much as possible. These are the words or terms used by participants in an attempt to remain true or close to their intended views or meanings (Liamputtong, 2009). The codes developed at the beginning of data collection may change as we become immersed in more data (Liamputtong, 2009). Sinding (n.d.) suggests the following questions when beginning to code transcripts? What can we think of this being about? What is this? What does it represent? What do I see going on here? What are these people doing? What is happening? While Liamputtong (2009) suggests asking the following questions; what, who, how, when, how long, where, why, what for, and by which? It is also suggested the beginning stage of coding is an opportunity to examine the researcher's assumptions about the area being studied (Strauss & Corbin, 1990). I was open to finding, as have others (Sinding, n.d; Brown & Crawford, 2003), that an assumption of mine is challenged or debunked.

As analysis progressed several codes were incorporated under one category. The two analytical processes that contribute to moving codes to categories and concepts are constant comparison and continued questioning (Charmaz, 1990, p.1168). On a practical level I began coding by reading and listening to the interviews simultaneously and making initial codes onto the margins of the paper transcripts. Then I read through the transcripts in NVivo 9 and line by line began more detailed coding. This resulted in large

quantities of codes which through further analysis, in and out of NVivo 9, I began to develop categories and concepts or themes. At times when overwhelmed by the rich data I had collected I asked myself "What is the story the data are telling me?"

I engaged in memo writing to record my ongoing thinking and emerging questions during the research process. This is an opportunity for the researcher to engage in an ongoing discussion with themselves by noting down ideas, questions, what is explicit and implicit in the data and so forth. It becomes a record of the progression of analytic thoughts during the research process (Charmaz, 2003). As analysis progressed and I began to formulate ideas for writing and arranging the thesis. This led to my engaging in theoretical sampling and some member checks to fill in gaps in the data and my emerging analysis. Charmaz (2003) states the act of writing and rewriting is an opportunity to gain further insight into the data and during this stage I would return to the data and memos to further develop my thinking and analysis.

4.8 Ethics: Researcher Role

Ethical considerations are typically concerned with informed consent, the right to privacy and protection from harm (Fontana & Frey, 2008); issues dealt with in the institutional ethics process. This research obtained ethics approval from the hospital's Research Ethics Board. My ethical concerns here, however, are linked to my role as an insider. I believe it is possible to conduct good research in my current workplace as long as ethical concerns, specifically, my location as an insider, are carefully considered. Potts & Brown (2005) suggest there are insider/outsider tensions in all research relationships and this was indeed

my experience in the past when I conducted my MSW research study and currently with this PhD thesis. Insider positioning both enriches and complicates the research process and therefore requires particular attention in the recruitment, data collection and analysis phases of the study.

4.81 Recruitment and Data Collection

As an insider navigating and obtaining approval from the hospital's Research Ethics Board (REB), as well as gaining access to potential participants, was straightforward as an insider. I am known by most of the seven or eight managers and professional practice leaders whose signatures were required on the ethics application. The REB application also required an internal academic employee to agree to be the Principal Investigator. Fortunately, a work colleague agreed to take on this role. Research is an intricate and central component of this organization and my study was viewed similarly to other low risk projects that do not involve patients.

My location as a social worker results in knowledge of how the RAI-MH may influence practice. I also share a common organizational knowledge and language with participants. Institutional ethnographers would view this as a valuable position and suggest the significance of lived experience as well as value the ability to "recognize and analyze the relations of power within which you live and work" (Smith, 1987, 2005; Campbell & Gregor, 2002, p.16). However, I acknowledged that my intimate experience of the subject matter may result in me being unable to appreciate what is unique about the

participants, taking for granted a shared understanding and not push for further exploration (LaSala, 2003).

Whether insiders or outsiders, researchers enter into the field of study to explore the viewpoints and experiences of others and discover what the participants think is significant. Caution needs to be exercised and reflexivity is paramount so that we do not assume that we already know what is significant. According to Charmaz (2004), participants are often wrestling with making sense of their experiences and it is our role to grapple with them. This entails opening ourselves up to ambiguity and acknowledging we do not have all the right answers (even if I have worked in this area). The researcher should "embrace ambiguity, contradictions, and your bewilderment" as this is "a sign you are entering the phenomenon" and through this struggle "you may sense hidden meanings and gain a deeper understanding" (Charmaz, 2004, p. 981) Given my practice experience in this area and in this particular organization my acknowledging and accepting that participant's views and actions at times conflicted with my own was viewed as an opportunity to deepen my understanding and analysis. I also had opportunities to discuss these tensions with my PhD peers and supervisor.

In the recruitment and data collection phase I was mindful of power relations. The method of recruitment was an attempt to decrease the possibility participants would feel pressured to be interviewed. Participants seemed open to the process and only one, a social worker, asked prior to making a critical comment about the organization if her manager would hear the recording. Reassurance was provided and she then jumped into talking about a practice experience.

As a researcher I am in a position of power due to my knowledge of the subject under study, I developed the interview guides, I decided which voices are included or excluded and so forth. Being an insider may result in participants sharing more in-depth information or them withholding information. I was mindful of inter-professional tensions that may result in some nurses viewing me as an outsider. There was the possibility they may be hesitant to reveal any negatives associated with their discipline and may feel the need to protect their professional group. Only one nurse seemed more reserved when this topic was probed while the others openly offered their critique. Skill, sensitivity and reflection were required when participants brought up inter-professional tensions. I needed to examine my own practice experiences and assumptions. However, my location assisted me in "sorting out" and understanding differences in team members' perspectives" (Campbell & Gregor, 2002). I also recognized that it would be easy to slip into a "them and us" typology or categorization where the participants become the object of study rather than the institution and the implementation of computerized assessments.

Acknowledging the similarities between the participants was also important; they are mainly women doing care work in a lean or restructured health care system. This is where the literature on institutional ethnography is both appealing and helpful. McCoy (2006, p.109) states that when conducting research there is the danger of an unintended "analytic drift" occurring where the analytic focus moves from the institution to the informants. She further suggests this sometimes occurs when researchers gets caught up in the conflict between different informants' stories rather than focussing on the institutional relations that give rise to the conflict. I do not want the participants to be the

objects of the study and so I am wary that inter-professional tensions or conflicts may potentially lead to the institution or the current health care policies slipping from view. This study had the potential to shed light on the role inter-professional tensions or "turf wars" play in promoting "efficient and effective" business practices. In other words what are the organizational advantages to having a workforce with inter-professional tensions resulting in territorial practices? This will be discussed in the findings.

Another issue to negotiate was my degree of self-disclosure. On the one hand it is argued that researchers should avoid getting involved in real conversations where the researcher is in the position of answering questions or giving personal opinions on the topic of inquiry while on the other hand a feminist perspective is more likely to encourage such a conversation (Oakley, 1981; Berg, 2003; Fontana & Frey, 2008). As noted earlier, theoretically and epistemologically, I will use a feminist lens or standpoint and therefore tried to engage participants in conversations to access richer data. The extent of my self-disclosure during interviews varied depending on the interpersonal dynamics between the participant and me. The degree to which I shared my experiences of the RAI-MH was perhaps a riskier endeavour for me as an insider than it would be for an outsider. Behar (1996) argues the interviewer, writer, respondent and interview are not clearly separate units but are deeply entangled and I think this further underscores that self-disclosure may be at a different level in different interviews.

4.82 Data Analysis

Data analysis is another phase that requires reflexivity and self-examination and there was a particular need to do so given my insider positioning. It is during the analysis stage that researchers are arguably most vulnerable and they are especially open to criticism at this point (Mauthner & Doucet, 1998). Mauthner and Doucet, (1998, p.86) describe reflexivity and its significance in analysis by highlighting the importance of,

> "…reflecting upon and understanding our own personal, political and intellectual autobiographies as researchers and making explicit where we are located in relation to our research respondents. Reflexivity also means acknowledging the critical role we play in creating, interpreting and theorizing research data."

Taking a feminist perspective facilitated the privileging of participants voices while at the same time I engaged in a process of acknowledging and questioning my assumptions during data analysis and presentation of findings (Harding, 2003). I hoped to follow in Fine's (1992, p.220) footsteps and be a "self-conscious, critical, and participatory analysts, engaged with but still distinct from our informants".

Our location is neither simple nor static but is dynamic and changes depending on our current context (Absolon & Willett, 2005). During the research study at different times I was a student, researcher, social worker, colleague, peer, satisfied employee and disgruntled employee. The literature highlights potential difficulties when combining roles, for instance, of scholar and feminist, and how this may lead to a conflict if the researcher has a different political stance than the participants (Fontana & Frey, 2008). Being both a scholar and frontline social worker could potentially lead to issues, conflicts or dilemmas between some of the participants and me. However, this concern may also

lead to positive results such as the challenging or debunking of my assumptions (Gluck (1991; Sinding, n.d.).

My knowledge base is also dynamic based on previous readings of the literature and readings I am currently immersed in. A transformative research process requires that "opinions, thoughts, ideas and theories are in a constant flux" and so while it is important to state my location initially I must also be willing to revise this statement on an ongoing basis (Absolon & Willett, 2005). I remain confident I addressed the issues noted above through my being attentive and reflexive as well as by using the expertise of my supervisor, my committee members and my PhD peers.

4.9 Quality and Qualitative Research

My goal of completing a good research study led to my exploring how quality is determined by other qualitative researchers. Attempts to evaluate what may be considered good grounded theory research developed from early attempts to replicate the standards for rigor that came out of positivist research and concepts such as validity and reliability. Qualitative researchers continue to suggest guidelines for conducting quality qualitative research. Pope and May (2008) refer to Spencer et al's (2003) framework, on behalf of the UK Cabinet Office, following an extensive review of the literature and interviews with qualitative researchers. Four guiding principles are suggested that lead to eighteen appraisal questions for various stages of the research process: 1) contributory in advancing knowledge which is similar to the idea of relevance, 2) defensible in design by using a research strategy that addresses the research questions or objectives, 3) rigorous in

conduct through systematic and clear collection and analysis of data, 4) credible in claim by ensuring well-founded and plausible arguments.

The approach taken to qualitative research will influence what is considered criteria for measuring its quality (Patton, 2002). There are five broad perspectives, according to Patton; traditional scientific research criteria, social construction and constructivist criteria, artistic and evocative criteria, critical change criteria and evaluation standards and principles. Each has specific ideas about how to assess quality although there is overlap between these perspectives. I have outlined above my location as a critical researcher who leans more towards a constructivist stance than an objectivist stance when using grounded theory and this was taken into account when I consider the criteria for good quality research which is outlined below.

As a critical researcher my goal is to make visible power differences, to highlight how policies made far from the frontline have the potential to shape daily practice and the care received by patients. It is also important to identify potential change making strategies that frontline hospital workers may engage in. If my study achieves these things then it may be considered credible research from a critical change perspective.

Lincoln and Guba (1985) argued that constructivist research required different criteria than those from more traditional social sciences. They identified four components of trustworthiness; credibility, transferability, dependability and confirmability, thereby, ensuring the study has been conducted rigorously and increasing the likelihood credible findings will be produced. These would include the following methods; prolonged

engagement, triangulation, external checks on inquiry process, negative case analysis, member checking and audit trail (Lincoln & Guba, (1985).

Firstly, prolonged engagement refers to the length of time spent in the field of study and therefore the researchers understanding of the topic under exploration. I have many years of experience working in a hospital. I also conducted my MSW thesis in this area. I have spent many months interviewing participants to elicit the meanings underlying their experiences.

Secondly, triangulation is the use of multiple methods or sources of data and may include multiple perspectives as well as the use of different theories to analyze findings. I did examine documents including the RAI-MH, training materials, government and hospital policies to explore if they supported or contradicted participants' experiences of the RAI-MH. I captured different opinions of participants and also used different theories when analyzing the findings.

Thirdly, external check or peer review refers to discussions with individuals outside of the research to ensure data collection and analysis is rigorous and who may support and challenge the researcher. I had the opportunity to meet regularly with a small group of PhD peers as well as my supervisor and discuss my emerging analysis and obtained feedback from my PhD committee.

Fourthly, negative case analysis is facilitated by the constant comparison process and highlights data that does not fit with the rest of the data or seems to contradict the data. This helps to deepen preliminary analysis and theory building (Lincoln and Guba,

1985). In the findings I have highlighted negative case examples and further analyzed what they may illustrate by providing alternative explanations.

Fifthly, member checking involves sharing of preliminary findings with participants and soliciting feedback to check for accuracy or agreement. I did contact some participants to check whether I had captured specific experiences and views accurately. For example, I went back and asked about the concepts of outliers and rogues.

Sixthly, an audit trail consists of interview recordings, transcripts, field notes, memos, initial codes, NVivo searches, early drafts of writing throughout the research process and while mine are not as organized as they could have been they do show the progression of my thinking from the beginning to the end of the thesis process. However, while the above may be helpful in assessing the quality of research and are an aid to informed judgement they are not a set of rules or prescription to be applied to all qualitative studies (Spencer, 2003, in Pope & May, 2008).

Quality research needs to be relevant by adding to knowledge or by supporting existing knowledge (Pope & May, 2008). Additionally, while qualitative research does not claim to be representative by providing enough descriptive detail others can decide whether the findings may apply to other settings. This is similar to the concept of transferability and I discussed earlier why this study has transferability to other hospitals and other public services. The interviewer's skill is also an important component of trustworthiness and becomes readily apparent in the quality of interview transcripts (Kvale & Brinkmann, 2009). Reflexivity refers to an awareness of the ways the researcher and the research process have shaped data collection and analysis. During this

chapter I have attempted to provide clarity both in terms of my theoretical stance and my location as an insider.

4.10 Conclusion

In summary this chapter has highlighted my approach to the research study and made visible my particular standpoint or location as well as the theoretical paradigms that have influenced my selection of this research topic and my selection of a research strategy and method. I have discussed what is considered good quality qualitative research by others and my efforts to ensure this study was of good quality. Clearly, I am not a "tabula rosa" or blank tablet and I agree with Charmaz (1990, p.1170) when she states,

> "grounded theorists bring to their studies the general perspectives of their disciplines, their own philosophical, theoretical, substantive, and methodological proclivities, their particular research interests, and their biographies. They do not bring, however, a set of finely-honed preconceived concepts and categories to apply automatically."

Introduction to the Findings: Chapters Five to Seven

The following chapters, five through seven, will include the findings and analysis of my study. Themes emerging out of the study will be explored and linked to existing literature as well as presenting new interpretations or ideas. My key research questions are; 1) in what ways is professional autonomy impacted by the standardization of work processes, and 2) how are professionals responding to the restructuring and regulation of their work. The model in Figure 1 in the literature review presents three interrelated clusters of literature that will be examined along with the findings from this study. Firstly, influences from outside social work and nursing work which includes neoliberalism, government ideologies/policies, and work organization (managerialism, lean healthcare). These will be discussed in chapters five and six when I analyze how standardization may lead to firstly, the assembling of neoliberal patients and then secondly, neoliberal health care professionals. Finally, the internal struggles individual hospital professionals may experience as they strive to practice in a way that aligns with their personal and professional values as well as their responses to these tensions will be illustrated in chapter seven.

Chapter 5

The Assembling of Neoliberal Patients by Neoliberal Professionals

5.1 Introduction

Ideological forces outside of the social work and nursing professions influence and shape how care work is practiced in hospitals. I will make explicit some of the neoliberal strategies used in hospitals to govern social workers and nurses and highlight their role in reconstructing marginalized citizens or the assembling of individuals into neoliberal patients.

In this chapter I will use Dorothy Smith's (1974) ideas on the social construction of a documentary reality, as well as Michel Foucault's (1997) work on governmentality, to show how professionals and patients are governed. This expression of power often remains implicit and invisible to many social workers and nurses. I will complement the work of these critical theorists with recent empirical studies on Minimum Data Set (MDS) instruments, such as the RAI-MH, which are used to determine resource allocation in the US, UK and Canada.

Dorothy Smith's (1974, p. 257) emphasizes the central role documents play in "governing, managing and administration" in society. Smith suggests research should begin with people's everyday experience; being among participants at ground level, as opposed to what Smith (2008) referred to as the "14th floor effect" whereby sociologists or researchers look down from above on participants. I began my research as an insider whose questions about the RAI-MH remained unanswered by management.

Governmentality has been described more generally by Michel Foucault (1997, p. 82) as

> "techniques and procedures for directing human behaviour. Government of children, government of souls and consciences, government of a household, of a state, or of oneself."

The RAI-MH scripts and orders the activities of health care professionals by the "centre of calculation" (The Ministry of Health and Long Term Care). Social workers and nurses are involved in the "mundane business of governing everyday economic and social life" (Rose O'Malley & Valverde, 2006, p.101) through technologies such as the RAI-MH. Neoliberal policies, techniques or strategies have,

> "enabled the state to use various techniques to divest itself of its obligations, devolving those to quasi-autonomous entities that would be governed at a distance by means of budgets, audits, standards, benchmarks and other technologies that were both autotomizing and responsibilizing" (Rose O'Malley & Valverde, 2006, p.91)

On the one hand governing implies the shaping and controlling of behaviour while on the other hand governing works optimally when individuals have some autonomy or freedom. The professionals in this study had some choice as to how they made the RAI-MH a part of their work but ultimately they had to complete it.

In this chapter I will, 1) address the mandatory implementation of the RAI-MH, 2) compare client-centred care with computer centred care, 3) discuss the art of traditional narrative style assessments versus the science of computerized assessments, 4) explore the accuracy of inputted information and the "guestimating" or creative writing that workers engage in, and 5) examine the role of neoliberal professionals in the assembling of neoliberal patients and how language supports the reconstruction of patients as data, as

well as analyze the spaces or gaps between policy and practice that allow for professional and personal autonomy. I will conclude this chapter by providing a table summarizing the tensions or differences my analysis revealed between narrative style assessments and computerized assessments.

5.2 Mandatory Implementation

My experience of the mandatory introduction of the RAI-MH in late 2005 in Ontario resulted in personal and professional tension. Management claimed it was an assessment tool to be used by the whole team which would provide important information that could be used in research, to improve the quality of service provided to patients and decrease workload. As I began using the instrument my workload increased. Initially, I questioned my ability to do good social work and meet the requirements of my employer, wondering if this was a personal deficiency. I began to puzzle over and question the stated and unstated goals of the RAI-MH. It soon became apparent that eventually the RAI-MH was to be used as a funding formula by the Ministry to determine the allocation of resources. This starting point for my inquiry led to my pondering the role I now played as an agent of the state by fitting patients into categories to determine funding. Did other social workers and nurses view themselves as "agents" participating in "ruling practices"? Did they locate themselves as "unwitting participants" or a "critic of an authorized view" or both? (Campbell & Gregor, 2002, p.22). The official version of knowing was much different from my experience of knowing and I wondered if my colleague's experiences were similar or different to mine. This "disjuncture" (Smith, 1990b) widened as I

struggled to resolve the tension between what I thought was good social work and the hospital's definition of good social work.

I began the research interviews by asking participants to define the RAI-MH. They reported it was a mandatory, computerized, multidisciplinary assessment they were required by the hospital to complete. Many participants described it as a clerical or administrative task. Common themes throughout the interviews are summed up by the following statements,

> "I use the RAI because I am required to. I don't find it helpful at all, or useful ….I don't ever look at it again."

> "It does not influence clinical decisions … it's not adding anything, it's just something that I have to do, it's required to do .. It keeps me from doing the work I like to do."

Social workers and nurses clearly articulated and believed the RAI-MH was a hindrance by using up time that could be better spent with patients; time with patients was considered good work.

Unlike when the RAI-MH was first introduced (O'Neill, 2007), professionals now clearly identified that it was used to determine hospital funding. With further prompting they added that it was also used for research purposes, to develop care plans, and the assessment of patients. Some participants were keenly aware of the rhetoric used by the organization in promoting its use and the contradictions therein. For example, one person reported the political answer when discussing its purpose was to say it will "provide information to capture the complexity of our patients", while another reported it is used to keep track of staff time with patients and therefore likely related to benchmarking and funding. Research participants also challenged the RAI-MH developers' assertion it

would decrease workload as it would be the one assessment tool used by various team members and improve the quality of services provided to patients.

My analysis revealed social workers and nurses often have little investment in completing mandatory tasks, especially if they were not involved in the creation phase, and the research participants insisted the RAI-MH does not add to their professional practice. The separation of creativity from work processes and alienation will be discussed when labour process theory is explored in the next chapter. One social worker stated,

> "when you're doing something that you kind of feel is forced on you and it doesn't feel there's a purpose to it then you're less likely to want to do it."

Social workers and nurses continually questioned the relevance of the RAI-MH to their practice and consistently complained that the resulting work intensification meant less time spent with patients. On the one hand they reported that time spent caring for patients was their priority and yet on the other hand organizational pressures resulted in them prioritizing the RAI-MH over patient time on many occasions. The dilemma of prioritizing organizational values over personal and professional values resulted in contradictory statements during individual interviews. At times the tensions or cognitive dissonance was visible or palpable as they struggled to resolve tensions in the moment they were speaking to me about them. For example, in these moments they stared straight ahead or rolled their eyes or hesitated seemingly rethinking things over before speaking.

This tension, generally speaking, makes sense given the personal values that led them into a career in care work. Their personal values were reinforced by professional

knowledge gained during training. This will be discussed further in chapter six. All the social workers and nurses wanted to be viewed as "doing good work" which to them means providing client-centred care and yet computer-centred care often dominated their practice in ways that was difficult for some of them to acknowledge. As will be discussed in greater detail in the next section, while traditional narrative assessments construct a documentary reality or a patient's experience in particular ways, a computerized assessment draws them into the social construction of other's experiences in more troubling ways; not only are they constructing a patient's experience of illness but they are aiding in the production of patients into useable computer data.

5.3 Client-Centred Care versus Computer-Centred Care: The Neoliberal Patient

Prior to the implementation of the RAI-MH, initial assessments used open and closed ended questions to guide the interview, were handwritten in a narrative style in the patient's chart (nursing) or typed (social work) and added to the chart. These assessments relied on training by peers, with questions drawn from their respective professional knowledge bases. Given the organizational and professional emphasis on providing client-centred care along with literature suggesting care professionals are drawn to this type of work following particular life experiences and values (Hoggett, Mayo & Millar, 2006) I wanted to explore how these dynamics played out in day-to-day practice.

Participants were asked to describe the step by step approach they now engaged in to complete their initial assessments and the RAI-MH as they tried to meet organizational, professional and personal goals. Social workers and nurses usually tried various

approaches to completing initial interviews and the RAI-MH before settling on a method that worked best for them. For example: 1) completing their initial interviews with patients as per usual (narrative style) and then going to an office to complete the written/typed narrative followed by the RAI-MH; 2) meeting with patients and using the RAI-MH questions to guide the interview and then going to an office to complete a narrative note and the RAI-MH, 3) using only existing chart information to complete the RAI-MH in an office and then asking the patient a few RAI-MH questions and returning to an office to add to the RAI-MH; 4) completing the RAI-MH with the software program open in front of the patients and systematically going through the questions together. Only two participants, both nurses, completed the RAI-MH the last way.

Implementation of the RAI-MH resulted in an increased workload. All the participants complained about the need to "double document" in order to meet organizational and professional requirements. Some social workers reported completing a handwritten chart note, many stated they completed a brief handwritten assessment using a template (Brief Social Work Note) while others indicated they completed full typed psychosocial assessments consisting of between 4-15 pages. The length of the assessment seemed to be influenced by the average length of stay of patients on their wards. On wards where patients stayed longer social workers completed longer assessments. In the past, all tertiary units (patients expected to need a longer admission in a specialized unit and funded accordingly) completed longer social work assessments but as length of stays, even on tertiary funded units, have decreased so has the length and fullness of assessments. This makes sense as lengths of stays decreased, the number of admissions

and discharges increased and professionals struggled to find ways to cope with this work intensification. The brief social work assessment, currently completed by most social workers, is a way to deal with workload. However, it limits the contribution of the profession to patients and the team as it lacks the detail once provided in all patient assessments. There is a danger this may lead to deskilling by minimizing the assessment skills and role of social workers on health care teams where discharge planning has become their main role on the team.

Nurses also complained about work intensification and double documenting, indicating one strategy to decrease this burden was to print out their sections of the RAI-MH and add them to the chart. The handwritten initial assessment often includes "refer to the RAI-MH" as well pertinent information for their colleagues. Nurses indicated the RAI-MH only allowed for six lines of narrative so they had to keep this short and write more in their nursing note in the chart. They reported the handwritten initial nursing note gives them the opportunity to incorporate more in-depth details needed for their colleagues to provide good care but details which were not relevant to RAI-MH. One social worker indicated she did not complete an initial social work note on every patient as it was not read or valued by the organization or by her colleagues.

> "I'm not going to do it for it to sit in a chart …..doctors don't read the *(handwritten)* chart ….but if it's typed with a signature they're more likely to read it …I'm only doing them typed up…if there is someone who's going to read them and use the information."

She completed a typed note or a letter only when she believed it added to the patient's care and/or discharge planning and would be read by the treating psychiatrist or by community partners. This blatant resistance was risky as a note is required by the

organization and by her college. She engaged in overt resistance in other areas of her practice and considered herself different from social work colleagues or an outlier. Many participants reported overt and covert resistance during implementation of the RAI-MH but over time and with increasing surveillance and reprimanding they tended to comply with managerial requirements. Outliers and their overt resistance strategies will be discussed in relation to more covert strategies in chapter seven.

A nurse stated that having the patient present while completing the RAI-MH was more client-centred as the patient was more fully aware and involved in their own care. She asserted there are ways to do this without impacting the therapeutic relationship or as she put it without the patient feeling like "Oh, you're the nurse that asked me all those nosey questions. I don't like you." This method was considered to be more progressive as it included the patient as well as being much more efficient than completing the RAI-MH separately after meeting with the patient. The nurse indicated this approach was in place when she moved to this unit though she was aware other units did not use this method. I suspect that combined with the pressure to comply with an existing approach along with work intensification she may have been engaging in pretending. When there was tension or a clash in values some participants engaged in resistance or pretending or both, as a way to reduce the strain. For example, when this nurse appeared to be experiencing tension or cognitive dissonance during the interview she provided explanations or justifications as to why this method was the best approach. Pretending will be discussed later in chapter seven.

Some of the other social workers and nurses tried this method before quickly abandoning it and reverting back to a more traditional narrative style initial assessment and later completing the RAI-MH without the patient present. Most were concerned that having the patient present inhibited rapport building, limited eye contact and impeded the patient's opportunity to tell their story. The initial assessment is viewed as an opportunity to begin building a solid therapeutic relationship which is an essential component in mental health treatment and recovery (Dozier et al, 1999; Hostick & McClelland, 2002; Howego et al, 2003; Nolan & Badger, 2005; Rhodes et al, 2006; Ohayon, 2006).

Below is an excerpt highlighting one nurse's experience of trying to complete the RAI-MH with the patient present. It highlights the tension many reported between being a professional caregiver and a representative of the hospital organization or the state. The tension between allowing a patient to talk about what they feel is important information for the caregiver to know and interrupting them to fulfil the requirements of the employer is evident in the following passage.

> "So, I actually had a woman come in with her husband and I thought, okay we're going to do this all at once and I used a room that actually had a computer. It was very difficult because you try to establish rapport. They want to tell you a story but I need to document this piece so can you just hold on a second, keep that thought **typing noise** I type in that one and then I have to read the *next* question, okay now I need to know, how many cups of coffee do you drink in a day, but they want to finish that other story, you know, and so I can let them go on and I realize that sometimes that what they're telling me, because I know the RAIs, that's on page 6, I know that. I'm going to need to know that so I end up making notes because their order that they want to do (it) is not the same as the RAI order. But I'd rather them tell me their story than do this. So that was a disaster. I thought I'm never doing that again. I felt bad for them when I had to ask them to wait a minute and be quiet, you know, just a minute, stop, stop where you are, I need to do this. They were very understanding and luckily this was a good client, because

> it did take longer but it was very disruptive, you could not have a meaningful interview."

After this "disaster" she like most of the social workers and nurses chose to not have the patient present when completing the RAI-MH even though it is less efficient. This was articulated as an effort to remain more client-centred rather than document-centred. One social worker stated,

> "I don't like the idea of the client seeing me sit in front of a computer clicking boxes about their life. When I meet with clients I try not to take too many notes. I try not to write too much down because I feel like it's institutionalizing them quite a bit and it takes away from me being there for them and it kind of implies you're here because I need to get this work done. So you're helping me get my work done. So it's not about the client, so they're here helping me complete the requirements my manager has put forward. And I don't like that idea….I never do it with clients in my office."

This social worker was aware of her dual roles and the tension between meeting patient needs and organizational requirements. She elected not to have this tension played out in front of the patient.

These findings support studies conducted in the community that also highlight the adverse effects of Minimum Data Set assessments on client care (Campbell & Gregor, 2002). Similarly, a study conducted in UK long term care homes reported the structured format of Minimum Data Set instruments may inhibit clients from revealing important information and negatively impact the assessment. Additionally, it is argued that closed-ended questions may suggest to clients that staff "are not interested in their stories." (Lambert et al, 2009, p.432).

5.4 Narrative Story Telling and Computerized Assessments: Art and Science

There is a long history of narrative style assessments in social work and nursing that acknowledges the complexity of patient's lives and encourages context. Thus allowing the individual to position themselves both currently and historically which stimulates them to process their experience (Weick, 2000; Wilder Craig, 2007; Campbell & Gregor, 2002). For social work this process of gathering valuable in-depth contextual information permits the evaluation of patients' strengths, supports, and a collaboration to determine moving forward in recovery and ensuring a successful discharge plan. The art of interviewing in this way stands in sharp contrast to the asking of approximately twenty computer screens of close-ended questions with drop down boxes on the RAI-MH.

It was noted by many during the interviews that social work deals with "the messy grey type stuff", such as emotions, family relationships and so forth, that are not easily reduced into categories or boxes on the RAI-MH. Anne Weick (2000, p.396) stated "the problem of describing what social workers do continues to plague us" while others stress the need to prove or show the "added value" social work brings to hospitals (Nelson, 2004; Davis, 2004). This ability to deal with the messiness of patient's lives or their humanness while at the same time mediating between patients/families and physicians and the organization is part of the role of social work. Doctors viewing patients as cases to be cured and the organization seeing them in terms of risk management led Heimer and Stevens (1997) to refer to social workers as handmaidens. While many may resist the term envisaged by handmaiden the skills referred to are valuable, even essential, to the efficient running of hospitals, and are difficult to quantify or measure. This work is

usually invisible to other professionals and administrators as the messiness of patient and family lives or barriers to discharge are resolved by social workers and so rarely brought to their attention (Davis, 2004; Auerbach, Mason & LaPorte, 2007).

A common recurring theme was the importance of a narrative style initial assessment and note. The RAI-MH was viewed as "a ticky box kind of thing" or a task or clerical duty rather than something that was useful to practice. Few participants reported reading previous RAI-MH's or the sections completed by other professionals but they did consistently read the initial assessments, handwritten or typed, by colleagues in the patient chart.

Narrative interviews are generally viewed as a window into the lived experience of patients in ways that a more scientific method does not permit (Wilder Craig, 2007). The RAI-MH fits with Wilder Craig's idea of a scientific method rather than the art of interviewing. When describing initial assessments research participants indicated it was an opportunity for patients to tell their story and highlight what they see as important aspects of their experience. While for the professional it was a time to draw on their practice wisdom or professional knowledge base to interpret these stories with patients. The initial interview was viewed as a more informal, spontaneous, natural conversation. This sounds quite the opposite to the rigid predetermined structure of the RAI-MH as these two social workers assert,

> "I usually find out about what brought them in and then from there they start talking …. you know the stories kind of unfold naturally."

> "…a lot of the questions, discussions with the client organically come up throughout the conversation."

These social workers suggest that patients' stories unfold naturally, almost effortlessly, but I would argue that the ability to have initial assessments unfold in this way is related more to the art and skill of interviewing.

While acknowledging the use of some guided questions drawn from their professional knowledge base to guide the initial interview, all but a few participants insisted the RAI-MH did not shape their practice. A contradiction emerged as I explored what some participants said and how they at times described their practice. For example, while adamant the RAI-MH did not shape practice, they included some of the RAI-MH questions in their initial interviews, they engaged in surveillance both of themselves and colleagues to ensure it was completed in a timely and accurate manner, they rearranged work priorities, including spending less time with patients in order to complete the RAI-MH, used the brief rather than full social work assessment notes and acknowledged there was pressure from some managers to complete it as it was viewed as a priority to be completed at the expense of other things. For example, one participant described how her manager wanted the team to have, and be known for having, the best RAI-MH compliance in the hospital. While another commented,

> "it gets in the way of clinical practice because I'm more than tempted to say to the client look I have to get this done, my managers pressurizing me."

The pressure to be an entrepreneurial worker is inherent in neoliberal strategies such as surveillance and performance management which place workers in competitive positioning to each other and rewards meeting quantitative metrics rather than goals of patient well-being. Care professionals genuinely wanted to do good work in a client-

centred way. Denying the impact of the RAI-MH on their practice may be a way to deal with tension or cognitive dissonance but also may be viewed as a form of resistance.

Nurses who completed the RAI-MH with patients present acknowledged their practice had become shaped by the instrument. It shaped the initial interviews, questions they asked and what information they recorded in the chart. These nurses suggested their method was more open and client-centred resulting in more accurate information and increased efficiency. This method was also viewed as more progressive as the patient was openly a part of the process.

While this approach may initially appear empowering there is a real danger the patient's story or experience is reduced until the patient becomes a source of data to complete an administrative task. One nurse stated,

> "..I think you get a better understanding of who this person is, maybe a little bit of the past history without going in-depth so that you can be supportive, hopefully start directing them in the right path for their goals to become well, and what they want to achieve. So I think the RAI brings that out. I think the RAI starts us, on our unit at least, starts a way of communicating."

She goes on to say that this method is more efficient and she hopes it will lead to more direct time with patients, however, she later contradicts this idea of efficiency by stating the RAI-MH and "double documenting" is time consuming. When asked if patients expand on the RAI-MH questions this nurse states "no rarely do they expand" and when asked why this might be she reports "I think they're still feeling us out". Later she comments on collecting data and

> "once you get rolling on the RAI you don't want to stop and start, which isn't good…because… what if you forget a section."

This nurse's role in objectifying patients seems at this point clear. It is supported by Dorothy Smith's (1974) ideas on the construction of a documentary reality and by the work of Campbell and Gregor (2002, p.37 & 38) with Minimum Data Set instruments for long term care services in Canada. The authors found that "text mediated processes subordinates the client's interests to the organization's". Additionally, a version of the client's story was created by removing them as the subject "allowing for easier differentiation among people" in order to "manage scarce resources more effectively".

This leads to questions about the awareness of the nurse. Is she an unwitting participant or is something else going on? Once again I wonder if pretending is at play given the tensions observed during her description and explanation of her practice or perhaps she genuinely favours a more rigid but predictable job role. It has been suggested that some nurses prefer to use more structured, medical and diagnosis focused instruments (Read & Bond, 1991 in Lambert et al, 2009) even though computerized checklists have been found to compromise patient-centred practice (Rhodes, et al 2006; Kontos, et al 2009).

The push for efficiency reported by the nurse quoted above and the way in which she completed the RAI-MH with patients stands in stark contrast to another nurse who emphasized the importance of embodied caring. This caring or therapeutic relationship begins at the initial assessment. She went on to say that in the caring relationship, oftentimes, it is while providing physical care that more information or a fuller, more detailed story is given by the patient which includes information important to the team and treatment planning. This view is more in line with the art and skill of interviewing

rather than the science and efficiency based approach of the RAI-MH indicated by the first nurse.

The goal of assessments, such as the RAI-MH, may be to facilitate an in-depth conversation that allows the patient to disclose information more efficiently, however, in my study I found most social workers and nurses were concerned that it would lead to a negative impact on the therapeutic relationship. Lambert et al's, (2009) research highlighted the importance of the invisible skills of nurses, including clinical judgement, led them to delve deeper or ask questions not on the RAI when needed. They also indicated that these same invisible skills were used to overcome the lack of rapport building inherent in Minimum Data Set assessments suggesting some nurses find ways to overcome barriers or impediments to caring relationships. Below I will highlight concerns social workers and nurses had regarding the accuracy of the RAI-MH when I review some of the ways they resisted its impact on their relationships with patients.

5.5 Accuracy, Guestimating and Creative Writing

All of the social workers and nurses emphasized their belief in the importance of the therapeutic relationship which is substantiated in the research literature (Hostick & McClelland, 2002; Howego et al, 2003; Nolan & Badger, 2005; Rhodes et al, 2006; Ohayon, 2006). In this section I will show some of the ways they resisted the importance attributed to the RAI-MH by managers by engaging in "guestimating" and "creative writing". My findings call into question the reliability and validity of RAI-MH data.

The researchers and developers of the RAI-MH assert it is a reliable and valid instrument that is the answer to the lack of good quality, clinically relevant data (Hirdes et al, 2002, Martin et al, 2009). A moderate level of training for health professionals using the RAI-MH was considered to be two to three days. This short term training was claimed to lead to high levels of reliability and validity (Hirdes et al, 2009). However, it is argued that most inter-rater reliability tests for Minimum Data Set instruments are made under optimal conditions that may not reflect real life conditions and variation in reliability will undermine the validity of the aggregated quality measures used for comparison with other facilities (Mor et al, 2003c; Rahman & Applebaum, 2009). The reliability and validity of Minimum Data Set tools remains contested in the literature where it has been argued that research studies that found the instruments to be reliable and valid are those conducted by the researchers and developers of the MDS tools (Lum et al, 2005; Teresi & Holmes, 1992; Ouslander, 1997; Crooks et al, 1994; Casten et al, 1998).

While participants indicated they wanted to enter accurate information into the RAI-MH all of them complained about the inaccuracy of the information inputted either by themselves or by colleagues. How this contradiction between complying and resisting played out in practice will be shown below. At this study site staff training varied from a two hour workshop, to one hour alone with the RAI-MH Coordinator, to an hour with a peer in a busy team office with frequent interruptions by patients and phone calls, to staff training themselves. While some participants indicated the RAI Coordinator was available to train or answer questions only a few of them actively sought out this resource. The acknowledgement of widespread inaccuracy leads me to question the

reliability and validity of the RAI-MH's being completed and is summed up by the following social worker.

> "I don't see it as being very valid because when I anecdotally talk to my colleagues, people are still very unclear about how to answer the questions and also the questions are not really reflective of how we actually work with people. So we're often guessing, guestimating answers or making creative writing attempts and I mean how valid is that information, so, there's a lot of cynicism about the tool."

The participants also had some very specific critiques of the RAI-MH instrument. Firstly, they commented on the variation in interpretation on specific questions among social workers. As one participant commented, "the thing I found most difficult about it is everybody had a different interpretation of what certain things meant." A Canadian study (Kontos, et al, 2009) examining the use of the RAI in nursing homes also argued the lack of standardized definitions of terms in RAI's results in problems with reliability (Dellefield, 2007), as well as poor inter-professional and intra-professional communication and collaboration (Rantz et al, 1999), with some staff such as Personal Support Worker's being excluded from the process of assessment.

Secondly, social workers and nurses critiqued the questions in various ways. There was concern the closed ended nature of questions that compelled them to fit a patient into a category with no opportunity for them to explain why the patient didn't quite fit into any of the categories for that particular question as "the choices you have don't capture the client's situation." The lack of opportunity to add qualitative information to explain an individual's particular situation was a recurring theme throughout the interviews. This resulted in many of the social workers and nurses reporting sentiments such as, "even when we did care we knew that the process was not

allowing us to be accurate" and "it was done incorrectly because it's whatever you feel like plugging in."

The first statement suggests that even when participants tried to input accurate information the limitations of the instrument itself prevented this. The latter quotation speaks to the idea that when something is not a priority for workers inaccurate information may be "plugged in" as the goal is not accuracy but completing the RAI to meet employer expectations. For example, some participants commented on inaccurate information inputted by peers from a person's height, to their source of income, to their use of walking aids, which they stated further highlighted for them the inaccuracy and uselessness of the material collected. On the one hand they wanted accuracy but on the other hand they did not view the RAI-MH as an important factor in providing good patient care. It seems it is a priority to complete the RAI-MH, due to surveillance by management, but not necessarily in an accurate manner. Professionals did not want "flags" on the RAI-MH which indicated it was not complete to management. Plugging in any answer or participating in "guestimating" is a resistance strategy against mandatory implementation of a computerized assessment which takes away precious time from doing what they consider good work – direct patient care.

Thirdly, social workers expressed concern regarding the requirement to complete RAI's for patients they had never met. This occurred when, for example, a patient was admitted and discharged over one weekend when the social work does not work, or was admitted and discharged while the social worker was on vacation. Some social workers refused to complete these RAI-MH's while others complied and worried about

repercussions by their professional college. This was not raised as a concern by nurses perhaps because there are always nurses on duty and therefore coverage always provided by peers. Almost all of the social workers and nurses reported reluctance in having colleagues from the other profession complete their sections. There was concern the other profession would move into their domain or territory potentially leading to a diminishing role and future job losses. This is supported by labour process theory which argues that standardization may lead to competitiveness within the workplace as workers try to retain jobs (Baines, 2004) and will be explored in the next chapter.

Fourthly, the requirement to complete the RAI-MH within seventy-two hours after admission also leads to the input of inaccurate information. The examples that many participants relayed were cases where the patient was experiencing psychosis or a state of delirium and interviewing them proved difficult to impossible. This led to social workers and nurses using chart information and also "guestimating" answers so that they could complete the assessment in a timely manner. Some social workers responses where contradictory in that they on the one hand reported they inputted inaccurate information and yet on the other hand they resisted nursing colleagues completing their sections by informing managers that only they could complete it accurately. This resistance or claiming of professional territory will be discussed later when labour process theory and performativity are discussed in subsequent chapters.

Fifthly, on an even more troubling note social workers and nurses described situations where newly admitted patients exhibiting psychotic behaviour were given an initial diagnosis of a mental illness, such as bipolar disorder with mania, or schizophrenia,

and were later found to have a drug induced psychosis. While the diagnosis may be changed at discharge to reflect a drug reaction they were deeply concerned that these patients now had a permanent record of a severe mental illness on a computer at the hospital and Ministry and "the RAI-MH is now tagged to your name forever," stated a senior nurse.

Sixthly, some participants in this study expressed concern that particular diagnoses and particular questions may directly influence funding, future resources and therefore eventually frontline jobs. They indicated they are careful to overestimate, rather than underestimate, when answering particular questions they suspect or know are SCIPP (System for Classification for In-Patient Psychiatry algorithm) questions as this will directly impact funding. This strategy may be considered a form of resistance as professionals strive to maintain resources and ultimately jobs. A consequence of this creative writing may be patient's appearing more ill or needing more care on the RAI-MH than they actually do.

The developers of the RAI-MH continue to argue the goal is to "inform the clinical assessment and care planning process" and its administrative uses (planning, data case mix funding and quality indicators) are "by-products" (Hirdes et al, 2009, p. 4; Martin et al, 2009). This is misleading and deceptive. Rahman and Applebaum (2009, p.727) argue RAI assessments in nursing homes may led to "unintended consequences" as it has multiple purposes (describe the population, assessment, informs care plans, determines funding, generates quality indicators) for multiple audiences (government funders, facilities/staff, researchers, the public–including current or future residents and

their families). This results in an incentive for facilities/staff to classify residents as more impaired in certain areas to receive higher payments and/or to show residents as less impaired in other areas to avoid looking poorly in public reports. For example, overestimating residents' functional dependency/needs and underestimating depression or pain, which would call in to question the quality of care or the quality of life of the residents (Rahman & Applebaum, 2009, p.728 & 729).

The incentives to input inaccurate data diverges from the goal or basic principle of Continuous Quality Improvement which stresses that data used to improve care should not be used to punish the service providers (Deming, 1986 In Rahman & Applebaum, 2009). Further "unintended consequences" results in what Rahman and Applebaum refer to as paper compliance and diminished attention to residents' quality of life. With paper compliance staff complete the tool in a way that will support maximizing funding and underreport problems so the nursing home looks good in public reports rather on what is actually occurring at the frontline so that genuine problems can be addressed to improve care. Interestingly, although not surprisingly, the private market has responded to this particular sector and its dilemma by creating software products that assist facilities in maximizing their funding or reimbursements while also helping them avoid looking negative or deficient when compared to other facilities (Unger, 2007 In Rahman & Applebaum).

Clearly the output of information is only as good as what is inputted. One social worker wisely summed up the concern over the accuracy of information inputted,

including whether the questions capture the reality of the patient's situation, when she stated,

> "if the tool is not really measuring what you want it to measure then you have an issue when you are looking at funding in the long term because you are not sure what you are actually funding then."

The training of student nurses and social workers to use the RAI-MH varied amongst participants. Some asserted the importance of students learning to do all aspects of the job when in training while for others there was a tension between teaching them a task/competency that may be misinterpreted by them as a priority of the job. For example, a social worker was worried teaching the student how to perform this task would be at the detriment of learning about rapport building and completing a full narrative style psychosocial assessment. Part of the concern with the RAI-MH was also that,

> "someone else has determined what are the important aspects of social work. And I think there is a lot missing from that and I don't even know if the things they are asking are important."

She further stated that she did not want her students to become "a ticky box social worker". While this social worker insisted that the RAI-MH did not shape her practice she was concerned it would shape students'/future social workers' practice. This participant, like many of the social workers in this study, no longer supervised student placements, citing increased work intensification as the primary reason. However, nurses working on wards seemed to have little choice and continued to supervise students and show them how to complete the RAI-MH.

I have argued above that this social worker's and others' practice was indeed shaped by the RAI-MH as its completion became a priority of the organization and for

them. Referring to the priority given to the RAI-MH by her manager this same social worker stated, "But number one is those RAI's have to be done." Surveillance strategies used by management ensured its completion was a priority although for participants the surveillance of the accuracy of inputted data is not of the same importance, as of yet.

5.6 Neoliberal Patients: The Assembling of Neoliberal Patients

I have noted above how the RAI-MH is used in governing workers, leading to them subsequently reconstructing patient's stories or lives to ensure the success of "governing at a distance" (Rose & Millar, 1992). I will illustrate further how social workers and nurses are coerced into using neoliberal strategies, or becoming neoliberal workers, leading to the assembling of neoliberal patients.

One of the side effects of accountability and fiscal restraint in Canadian health care is that citizens, who are marginalized through illness, are being defined as data in order to determine the allocation of resources. Social workers and nurses are at the forefront of converting patients into data for their organizations and the Ministry. In this study professionals exhibited different levels of awareness of their role in governing or being part of the "gray sciences".

Technologies such as the RAI-MH or Alternative Level of Care (ALC) policies and practices results in social workers and nurses regularly fitting patients into predetermined categories. They reconstruct patient's stories in order to make "governing at a distance" easier while at the same time engaging in the rhetoric of consumer choice and client-centred care. ALC documents are completed when patients have concluded

treatment and are ready to be discharged but unable to leave the hospital for various reasons. The use of texts and the language use will be shown to dominate social workers' and nurses' practice and result in the taking up of managerial language. This in turn influences their relationships with patients and the care they provide.

As participants described their work, I recognized the tension between being a neoliberal worker shaping neoliberal patients and their deep-seated desire to provide care in a more client-centred way. The worker and patient are strongly shaped, manipulated or managed through IT's in order to allow "governing from a distance". I will highlight ways in which patients resist becoming neoliberal patients. The ways in which social workers and nurses resist becoming neoliberal workers will be discussed in detail in the next chapter.

Dorothy Smith (1990b) asserts ruling takes place when the interests of those who rule dominate the actions of those in local settings. Additionally, it is through technologies of ruling, such as the RAI,-MH, which becomes a routine or mundane part of daily practice, that clients become objectified. Research participants expressed their frustration that the RAI-MH forced them to fit patients into categories, however, only some of them expressed an awareness of their role as agents in ruling practices and in the objectification of patients.

The nurses who completed the RAI-MH with the patient present seemed unaware they referred to patients as sources of data. One of them expressed her concern regarding inefficiency when nurses on other wards kept the initial interview and the completion of the RAI-MH separate when she stated.

> "They don't usually sit with the patient on the admission; no, they usually do it on their own, they often have to start and stop because they have to go collect data, come back, put it in, go back, put it in, go collect data, come back, put it in, go back, put it in….."

When asked where they went to collect data she replied from the patient. This nurse also stated that when the patient is present during completion of the RAI-MH it ensures the RAI-MH has the most accurate information on how the patient sees themselves. It is unlikely the patient sees themselves as being made up of numerous closed ended questions with no context or depth unless the transformation into a perfect neoliberal patient is already complete. Perhaps some patients admitted on a regular basis, revolving door patients, do more readily accept and comply with the mundane tasks completed by staff upon admission. The nurse above reported some patients respond by saying "oh yes, yes, government forms" and accepted the process while for others their body language becomes closed and they give shorter answers when she begins asking structured RAI-MH questions compared to the more "conversational type responses they were giving me earlier". Even though at times this nurse seemed to acknowledge the ways in which the RAI-MH may interfere with the assessment process it seems it does not outweigh the benefits of efficiency. This is an example of how even the most caring professionals can be drawn "into the dominant practices of hospital management as agents" when "they begin to think of their work in the terms given" (Campbell & Gregor, 2002, p. 20). The nurse's views and behaviour noted above were clearly influenced by the RAI-MH text which uses specific language and closed ended questions to ensure the task of admission is completed in a particular way.

The above example also illustrates how patients can become viewed as data or dehumanized as their human qualities and experiences are peeled or stripped away leaving only the bare essentials required for a computerized assessment and a funding algorithm. This is in glaring contrast to the embodied caring described by another nurse who defined good nursing as more than task based work when she stated,

> "when you are a nurse it's not about pushing the bedpan but when you do have a bed bath you're actually talking to the person and you learn most about them when you do those kinds of things. When you are rubbing their back…..they tell you their life story and you start finding out tidbits of information that isn't in the chart ..but it's relevant to their care…. a real nurse doesn't look at that as a task."

The RAI-MH may be helpful in noting physical conditions such as hearing, vision problems but it does less well with psychosocial wellbeing and personal preferences (Kontos et al, 2009; Holkamp et al, 2001; Carpenter & Challis, 2003). It is in the act of caring for a patient's body that nurses come to really know their patients and it is in this relationship that empathy flourishes and recovery is supported.

Social workers and nurses described a "subset of clients who refuse to participate" or resist, intentionally or unintentionally, this assessment process either because they are "uninterviewable" or they do not fit nicely into the predetermined categories. Research participants described patients who due to the severity of their illness, including psychosis, paranoia, drug induced psychosis, dementia, delirium and an inability to sit for any length of time could not be interviewed in order to answer the questions on the RAI-MH. A nurse who completes the RAI-MH with the patient present stated,

> "..you get as much data as you can from them.. because some of them just can't sit for that period of time, so you may not be able to get them to sit and do all of that. So, you kind of gather data from them, fill it in,

get some more…"

Language barriers were also cited as an obstacle to completing the RAI-MH. Individuals admitted on an involuntary status sometimes refused to participate in assessment and treatment making it difficult to complete the RAI-MH accurately. In these instances workers experienced tensions when pushed by the organization to be neoliberal workers by completing the RAI-MH within the predetermined time frame, while they struggled to shape some individuals into neoliberal patients who could be easily questioned and categorized. As mentioned earlier, concern was expressed regarding patients' assigned labels or diagnosis that would eventually be changed as assessment continued over their admission, but the initial diagnosis on the RAI-MH would not be changed accordingly. For example, several participants gave examples of young people admitted after consumption of illegal drugs that resulted in drug induced psychosis which led to the RAI-MH "being attached to them forever".

Many participants discussed their role in discharge planning and recent changes to the Alternative Level of Care process whereby patients, ready for discharge but with no suitable place to go, could no longer be placed into a "to be determined category" as this category was eliminated from the form. Those patients whose illness and subsequent behaviours resulted in them being viewed as "difficult to serve" lead to tensions between professionals, the hospital and CCAC (Community Care Access Centre) as staff were compelled to and yet resisted fitting patients into the remaining categories. This social worker is keenly aware of the game played in order to manipulate statistics,

> "they're usually the guys that are Huntington's and ABI's and
> dementias with behaviours …the very difficult to serve people

> ….we're eliminating the "to be determined" *(category).* ……So it's like a game; they're hiding them. They're hiding them in supportive living *(a category on the ALC document).* That's never going to show up…..so now the Ministry can report to the public….we have nobody waiting in any of our hospitals without a disposition. Because they've eliminated that category and artificially put them somewhere else. So they get hidden; nobody sees them."

This social worker expressed her concern that the standardizing of patients has resulted in a game between agencies/institutions were the most ill and marginalized, those that have been refused places in long term care institutions, are made invisible so that they are not counted as being without a disposition (somewhere to go upon discharge).

A nurse described the dilemma faced by staff when the hospital and family exert pressure to have a patient discharged to long term care even if the patient does not fit neatly into categories that would ensure suitability for long term care,

> " the whole idea that someone who is sick needs to conform to certain criteria to get them where they need to be. How do we make him fit back into long term care without knocking him off his feet *(over sedation via medications*)."

This nurse describes the "game playing" engaged in when wards and long term care facilities trade patients as follows; the ward has a patient who long term care facilities have repeatedly declined and then when a long term care facility needs to admit a patient they negotiate an exchange. This may be viewed as creative resistance or exploiting the gaps/spaces in policies to move patients around the system. As nurses and social workers are at the centre of patient care and discharge they are required to simultaneously care for the patient/family and the hospital. To be considered good neoliberal professionals they must perform their role as carers and handmaidens to the organization carefully so that risk and or/complaints are minimized (Heimer & Stevens, 1997) and this requires

knowledge and creativity on the part of professionals. This resistance or manipulation of the system is likely not the creativity of knowledge workers in Ontario envisioned by Florida and Martin (2009).

The standardizing and categorizing of patients may lead to professionals seeing patients in an increasingly objectified way and as sources of data. This is especially true when their practice includes making messy, unruly, non-compliant, inflexible individuals into ruled, compliant, flexible neoliberal patients that can be counted or made invisible for government statistics. It is only then will they be viewed as good neoliberal professionals by their organization. While their goal may be to provide client-centred rather than document or computer-centred care they are caught up as agents in the governing of those citizens marginalized by society; those diagnosed with a mental illness.

Earlier I discussed "fractal organizational logics" whereby each part of an organization is made up of smaller parts embedded in it (Connell, Fawcett & Meagher, 2009). This leads to the individual worker being treated similar to and expected to produce results like a business and is held accountable to the manager and organization through performance management strategies. This sheds light on how surveillance by the organization compels some workers to adhere to the business of the organization and produce the results desired by the organization even when it clashes with client-centred care. I will describe how professionals engage in peer surveillance and ultimately self-surveillance in order to be viewed by others and themselves as good employees in an environment that encourages entrepreneurism at the individual and team level. This will

be discussed further in the next chapter when I highlight the impact of standardization and in chapter seven when I discuss performativity. In later chapters I will discuss in some detail the ways in which some workers resist the standardizing of their work but with regards to the RAI-MH ultimately workers have to ensure its completion, whether it is accurate or not, otherwise they may be performance managed and disciplinary action taken.

Paul Garrett (2008) argues that Gramsci's description of Henry Ford intervening into the private lives of his workers and their activities outside of work is similar to the way social workers intervene into clients' or patients' lives aided by technologies of intervention. The literature on governmentality further supports the role the 'gray sciences" and the technologies they take up play in governing marginalized citizens. I have shown how social workers and nurses intervene or intrude in patient's lives when using the RAI-MH, as they compel patients to restructure or rewrite their experiences or lives to fit into predetermined categories, and when patients are non-compliant or resist this process they reconstruct their private lives for them. Often this reconstruction is inaccurate due to guestimating or creative writing in order to complete the RAI-MH and thus the requirements of their employer. The creation of neoliberal patients serves to support or further neoliberal strategies as patients are viewed as pliable data to be shaped to suit the needs of auditors or funders and so make governing or managing citizens a matter of statistics. Language plays a key role in governing as it is used to emphasize what is important on an organizational and Ministerial level. Some of the ways language is taken up by workers is described below.

5.7 Language: Patients as Data

The importance of language is stressed by Rose, O'Malley and Valverde (2006, p.89) who state that "language was an intellectual technology…and one element among many for rendering reality governable". The importance of language in governing at a distance is seen in this study as social workers and nurses used the language of audit and accountability frequently when describing their day to day practice. They use terms such as efficiency, accountability, benchmarking, patient flow, face to face contacts and so forth.

I have previously mentioned the danger inherent in patients being viewed as data to be gathered and entered into the RAI-MH software program. Language plays an important role in texts and that can influence the language used in practice as well as actions taken. When individuals' experiences are converted into text this "translates them into official and bureaucratic accounts" that then become the basis for professional and managerial action (Campbell & Gregor, 2002, p.25). It becomes even more critical in texts, such as the RAI-MH, that forces patients into different categories and in the extreme leads patients to be viewed as data by workers to be inputted into the computer to determine funding.

One social worker offers a critique of the language used in the RAI-MH and why she avoided asking questions the way they are worded in the RAI-MH as it uses "heavily medicalized language and heavily psychiatrized language" and she describes a "bilingualism going on." Unlike some of the other participants this social worker is extremely aware of how language can be used to label and objectify patients. Despite this

awareness and critique, contradictions surfaced whereby this worker and others continued to describe their work and interactions with patients in neoliberal terms influenced by audits and accountability technologies. It seems this language, even when at times it was used with disdain, had become embedded in their practice.

Perhaps it is useful in communicating with colleagues and management in terms each understands and therefore requires no explanation. For example, social workers and nurses frequently used the term "face to face" during the research interviews when referring to interactions or meetings with patients. A "face to face" contact is a term derived from the software program that professionals complete to account for each minute of their day. All are aware that "face to face" contacts are more highly valued or worth more in determining funding and the allocation of resources than other types of contact, such as telephone conversations or advocating with community partners. Also, only one face to face contact per patient per profession is counted per day. In terms of statistics and funding it is better to see more people for a short period of time than spend a half or full day accompanying a patient to see potential rental properties or going to the ODSP office with them. This leads to social workers trying to optimize "face to face" contact opportunities by facilitating group therapy rather than individual therapy and sending patients alone by cab to view housing or meetings at the ODSP office. Some social workers describe having short daily interactions with all the patients they provide services to on a ward so they can maximize "face to face" contacts. While social workers and nurses may be well intentioned, the language of ruling, governing, objectifying and subordinating shapes their work day and the care provided to patients.

Language is powerful and may be used to oppress, subordinate and control (Garrett, 2008; Gramsci, 1979). Ives (2004, p. 5) reports that Gramsci viewed "language as a political issue" and Garret (2008, p. 246) cautions professions such as social work to consider the language or keywords they take up and use as it may reinforce "neoliberal hegemonic order". For example, when patients and their families are described in terms of compliant or noncompliant, flexible or inflexible, and their experiences are reduced to data that fits into categories or "face to face" contacts they can all too easily become objectified allowing the neoliberal dominant discourse to further shape work and patient/professional relationships.

5.8 Variation and Autonomy: Exploiting the Gaps

By asking the details of how social workers and nurses completed the initial assessment and the RAI-MH I discovered many variations that were noted at the beginning of this chapter. It was a common theme throughout the interviews that traditional narrative assessments were more flexible and allowed not only for more autonomy for professionals but gave patients the opportunity to tell their story in the way that made sense to them. In this study social workers and nurses had the autonomy or discretion to make adjustments and alter the RAI-MH to fit with their particular preferences or way of doing things. Even those who were trained and complied with completing the RAI-MH with the software open and the patient present, found ways to shape or adjust how questions were asked and also "tweak" the questions that were required to be answered. Lambert et al (2009) compared two standardized tools, including the RAI for nursing

homes in the UK, and found staff changed the order of questions and adjusted the language to be more sensitive to the needs of the individual being assessed. Additionally, the worker's skills and clinical judgement permitted them to respond to nonverbal indicators by asking questions not included in the RAI. Many social workers and nurses described opportunities to use their professional judgement, experiential knowledge and intelligence during initial assessments and completion of the RAI-MH in this study. This allowed them to walk the tight rope of providing client-centred care while meeting the needs of their employer to ensure hospital care continues to run as smoothly as possible.

However, I am left wondering about the contradiction between exploiting the gaps or spaces in policy and practice and the freedom to act as an entrepreneur; as long as it is still within the parameters of governing. Earlier I mentioned an important aspect or strategy of governing in advanced liberal societies was to allow some autonomy or freedom and the "obligation to maximize one's life as a kind of enterprise" (Rose, O'Malley & Valverde, 2006, p.91). So while most social workers and nurses described the ways in which they completed their work and looked for the gaps and spaces in policies to provide more client-centred care, they ultimately had to complete the RAI-MH to prevent disciplinary action but they were also motivated to be seen as good workers. This will be discussed further in the next chapter.

5.9 Conclusion

The ways in which participants have taken up the RAI-MH and are both governed and are implicated in the governing of patients was discussed in this chapter. By comparing

traditional narrative assessments with computerized assessments the tensions experienced by social workers and nurses, as well as the push to restructure clients as data in order to determine future resources, makes visible some of the neoliberal strategies used in hospitals.

Below is Table 1 which highlights the differences or tensions between narrative style initial assessments and computerized initial assessments, such as the RAI-MH, that were highlighted by the research participants and discussed in this chapter.

Narrative Assessments	**Computer Assessments**
Client centred care Guided story Patient focused Patient as unique individual –embodied caring Client reports on what they see as important Autonomy to adjust assessment Flexible Facilitates client care Focus on strengths Guided by professional values Meets college and professions guidelines Open to "messy, hot potatoes, grey social work"	Computer centred care Drop down boxes – yes or no Patients as data Patients dehumanized/disembodied Patient voice silenced/muted/minimized Mandatory predetermined closed questions Inflexible Funding formula – determines funding needs Focus on limitations/diagnosis Practice shaped far from frontline Increases workload Patient must fit into predetermined categories

Social workers and nurses may have good intentions but they are still agents implicated in the oppressive relations of ruling whether they are fully aware of this or not. Campbell and Gregor (2002, p.40) suggest,

> "the power of an officially mandated organization overrules personal or professional intentions and experiences ……The official

objectified version dominates."

One of the aims of this study was to create awareness of the role we play in caring and as agents of governing. Are we located as "unwitting participants" or a "critic of an unauthorized view"? (Campbell & Gregor, 2002). By asking how social workers and nurses completed the RAI-MH they were given the space and time to reflect on their daily practice and how it is shaped by forces outside of their professions. Asking questions about subversion, resistance or bending rules may lead them to think more about what they can push and to what limit while still remaining employees. This will be discussed in further in chapter seven when resistance strategies are analysed.

It seems a full narrative style social work assessment is becoming a luxury for selected patients rather than the backbone of good practice. Many of the social workers and nurses described completing a brief social work assessment or an initial chart note and the RAI-MH to meet the needs of their professional college and their employer. All of them reported that work intensification and double documenting was leading to less time spent with patients. There is a danger that standardization, through computerized psychosocial assessments, may lead to deskilling, alienation, the blurring of roles and inter-professional conflict. This will be discussed in the next chapter when labour process theory is used to further examine the work of social workers and nurses.

Chapter 6
The Standardization of Hospital Social Work and Nursing Work

6.1 Introduction

This chapter will explore the ideological forces outside of the health care professions that influence work processed and lead to tensions for social workers and nurses. An analysis of professionals' experiences of standardization will show the promises of increased efficiency and improved quality of care, through the implementation of the RAI-MH, are deeply contested by them. In the previous chapter, I commented on social workers' and nurses' concerns with work intensification, including increased administrative tasks, resulting in less time for direct interaction and relationship building with patients. I suggested that the RAI-MH leads to the standardizing of mental health patients or the assembling of neoliberal patients at a time when health care organizations state their focus is on providing client-centred care. I will now make explicit how the adoption of private sector strategies leads to the standardization of clinical practice and attempts to assemble neoliberal health care professionals.

I will use labour process theory (Braverman, 1974; Burawoy, 1979; Thompson & Smith, 2009; Thompson & McHugh, 2009; Thompson, 2010) to highlight the shortcomings inherent in the standardization of care work. Labour process theory will be supplemented with Michel Foucault's (1979, 1991) work on governmentality and surveillance. IT's are used to monitor and shape psychiatric patients and I will now illustrate how computers are used to regulate, monitor and shape professionals' behaviour or clinical practice. Some theorists argue that technological change and standardization may lead to upskilling, especially with the adoption of strategies used in high

performance workplaces, such as the Toyota Production System (Adler, 2007; Ohno, 1988; Womack & Jones, 2003; Fine et al, 2009). However these can also be an exercise in increased management control (Shalla, 2007; Lewchuk, 2002). In contrast to studies in the manufacturing sector, the use of IT's in regulating, reshaping or redesigning clinical hospital practice remains underdeveloped and less theorized and it is to this gap that this chapter speaks.

This chapter will discuss 1) the promises and reality of information technology (IT) and how they are used to standardize health care work, 2) how standardization may result in conflict among and between professionals as they seek to maintain or expand professional territory, 3) how standardization has the potential to impact the critical thinking of professionals, 4) the surveillance of professionals through the computer panopticon, and 5) introduce the complexity of the labour-employer relationship in high performance workplaces.

I will conclude this chapter by providing a table summarizing the idealized portrait of workers in the knowledge economy and the actual experiences or the daily realities of workers in a 21st century standardized workplace.

6.2 The Promises and Reality of Information Technologies

The RAI-MH requires social workers and nurses to input, specified, close ended data about patients. The RAI-MH breaks down into parts (specific sections and questions) the traditional psychiatric assessments carried out separately by frontline mental health professionals. It is divided into sections which are completed by a nurse, social worker,

psychiatrist and sometimes an occupational therapist. Participants' reported the hospital's RAI Coordinator determines which team members are to complete the RAI-MH and which sections they complete.

The developers of the RAI-MH (Hirdes et al, 2002) claimed it would reduce administrative burdens as well as improve communication between care settings. Hirdes et al (2009, p.8) acknowledges that the existing division of labour between health care professionals, is such that each professional group uses their own assessment instruments drawn from their respective professional knowledge basis. Further, Hirdes et al, report the RAI-MH may be seen by professionals as compromising these assessments and threatening professional autonomy. However, Hirdes et al go on to argue that using the RAI will "improve productivity through the reduction in duplication of data collection …" and "offers an opportunity to pass on information efficiently to the subsequent care setting".

It seems the promises of improvements in productivity and efficiency is more important than the professional knowledge of nursing and social work and professional autonomy. Research participants stated the promises of the RAI-MH developers has not been fulfilled, instead their workload has expanded, intensified and become more alienating. Firstly, the research participants complained they had to "double document" as they are required to complete the RAI-MH and other assessment/documentation to fulfil the requirements of their professional colleges or the hospital organization.

Secondly, the RAI-MH has not improved communication and efficiency between care settings as the following in-house example illustrates. One social worker described a

patient admitted to the hospital for treatment of her mental illness but whose medical issues complicated treatment. During one continuous admission the patient was moved to four wards within the same hospital. This meant an admission and discharge RAI-MH was completed three times each (not completed when admitted to a medical ward); resulting in three professionals on each of the three psychiatric wards, completing a total of six RAI-MH assessments during her stay. The only real difference clinically between the first initial RAI-MH and the final discharge RAI-MH would be that the patient's health would have improved post-treatment, but the system did not allow the one RAI-MH to remain open throughout her admission. Instead, it had to be completed six times.

Another example of broken promises and IT's is the use of the Tough Book. This is a portable device (similar to an IPad) that has patient information stored in it, such as how often nurses are required to check on the patients, the level of privileges they have to leave the ward or not, as well as note where the patients are located during these rounds. This means some of the same patient information is recorded and stored in several places; in the patients chart (handwritten), on a cardex (handwritten), on a SMART Board (another new and expensive IT) located in the team office, and in the portable Tough Book. Nurses complained about duplication and the inability of the SMART Board and Tough Book to sync or communicate with each other. The nurses continued to use two types of hard copies in case the IT failed, which had happened on occasion. One nurse describes her frustration as follows,

> "..they're hoping eventually all the technology will talk to itself but it's not there yet. So it takes time and it takes time to problem solve if it's not working right to fix it or to get somebody to fix it so that you can get going as soon as possible … it takes time to learn it, problem solve

….we have to print off everything in case the technology goes down…
so we have a piece of paper to work off."

Computers are used to complete the RAI-MH, to record workload measures and generally to gather all kinds of statistics required by the organization and the Ministry of Health and Long Term Care. Some research participants expressed their frustration that everybody is gathering statistics, from their wards, to the mental health program, to the hospital organization, to the LHINS, to the provincial government. This results in staff completing numerous computer software programs. Research participants complained of the IT's unreliability and the need therefore to keep hard copies of information. This supports the work of Hutchinson (2008, p.291) who argues workers and management are frustrated with IT's; workers are frustrated by the use of IT's to standardize and control work, and managers by the poor returns on investment dollars. If the goal is to encourage knowledge building and creativity in 21st century professionals, these IT strategies fail. Instead, computers are being used as just another scientific management strategy to control and monitor work. The biggest productivity paradox is the investment some organizations have put into IT without a significant successful return (Hutchinson, 2008). In Canada a significant portion of new healthcare costs are attributed to new IT and new medications, rather than wages as has been the case in the past. This is in spite of the fact, as Armstrong and Armstrong (2008) note, seventy-five per cent of all new IT projects in healthcare fail and there is no evidence they lead to improved patient care or efficiency.

Other ways in which standardization impacted social work autonomy and had the potential to deskill or constrain communication skills was revealed when a senior social worker described the implementation of the Home First script by managers. Home First is

a policy that requires patients who have completed treatment, but who are unable to live independently, to be discharged home to await a long term care bed. This option is less expensive than a hospital stay and prevents beds from being blocked thus allowing the admission of new patients. Unfortunately, this often means that the family will have to provide the bulk of care while CCAC will step in to provide very specific services in a culture where resources are scarce. Social workers were given a script to memorize and relay to the patients and their families about Home First. The social worker reflected,

> "I felt devalued, I felt I can't even speak for myself now…...we were all offended by it because they didn't trust us to say the right thing and it was like Big Brother watching over us and you make sure you say the right thing because you're rogue social workers."

This management strategy seems to suggest that social workers are untrustworthy in delivering the corporate message. Or could it in fact be the opposite where they were considered compliant, trustworthy and reliable messengers capable of delivering this important message to patients and their families? Ironically, I would speculate the importance of skillful communication or interpersonal skills came into play after the script was relayed to patients and their families when social workers sought to defuse the situation with families and reduce the risk of complaints to the organization.

When clinical health care work is viewed as a set of tasks to be defined, assigned and completed it may appear that things run smoothly on their own leading management to see this as an opportunity to reduce staffing levels. When the completion of texts is seen as a competency that can be easily learned and measured, in terms of a value added activity, the discretionary activities of staff that keep the ward or unit running safe and sound may be ignored or become invisible. Campbell and Gregor (2002) suggest these

discretionary activities may include judgement or the interpersonal skills used to reduce conflict and prevent complaints; it is this work that is essential to the smooth operation of hospitals. In the previous chapter I highlighted Lambert et al's (2009) study that reported nurses' professional skills and judgement were invaluable and were specifically used to address the limitations inherently built into standardized assessment instruments, such as the RAI or I might add to this the Home First Script noted above.

There has been a push to describe the work of care professionals in terms of competencies with professional organizations striving to define, delineate and measure parameters regarding minimum expectations of workers. Hirdes et al (2009) states that a nurse trained to do the RAI in one sector could quickly learn the RAI for another sector. It may be that in the future within nursing and social work a competency may be the ability to complete this computerized assessment and yet the ability to tick boxes is not a good measure of the critical thinking skills or the ability of a professional to provide quality care. Earlier I discussed the problematic position that social work sometimes finds itself in due to the difficulties inherent in adequately measuring and defining what is quality care. Complicating this is the "messiness" of most people's lives that are not easily explained or quantified and the therapeutic relationships which are at the core of social work. If what can be easily measured continues to become the priority in health care, unfortunately a narrowing of what is seen as value-added may result in the creation of social work competencies around for example, completing the RAI-MH.

6.3 The Assembling of Neoliberal Healthcare Professionals

Labour process theory asserts that standardization results in a tendency towards deskilling and the potential to replace workers with cheaper lower skilled workers (Thompson & Smith, 2009; Thompson & McHugh, 2009; Thompson, 2010). Labour process theory, as depicted by Braverman (1974), refers to the Babbage principle of economical production where, via the division of labour, purchasing labour to complete individual elements is cheaper than purchasing a skilled worker who would complete all the elements of the work. Thus Braverman argues that dividing the craft cheapens its individual parts, or as Greenbaum (1999) notes control over skill is one of the main ways to decrease wages and increase control over the worker.

The deskilling of professions has the potential to lead to lower wages perhaps through hiring less skilled workers to complete routinized tasks for reduced wages. This was a fear expressed by some of the research participants. Perhaps in the future one worker will complete the whole tool and this would then eliminate the skillful assessment role of the other professions based on their respective knowledge bases. Or alternatively the next logical step is to assign the completion of the sections in the RAI-MH to a new classification of worker, creating an assistant position, or hiring a social service worker, who could be paid less than a social worker to complete this and other mundane tasks, so social workers could focus on more clinical work. One social worker was quite concerned when a union representative suggested one of the advantages of social work assistants (SWA's) was that,

> "the social workers can focus on more clinical work and leave all the paper work and mundane tasks to social service workers but that's

> concerning….it's just like the RN's feeling threatened by the RPN's, I think the social workers should then feel threatened by the social service workers."

This trend of hiring lower skilled workers represents a polarization of skills, typical of neoliberalism where some groups of workers are increasingly deskilled and others are upskilled to more interesting and higher level tasks (Baines, 2004).

In mental health RN's and RPN's perform a very similar role when it comes to providing patient care. RN's are expected to take on a more leadership role but essentially perform the same duties as RPN's when working with patients. One RN commented,

> "I find they are hiring more RPN's at the moment. We are training more RPN's then we are RN's…..it's a money saver for the hospital, RPN's are much cheaper than an RN …on nights before it would be three RN's and now it's one RN and maybe two RPN's…they're watching their budget"

This sometimes creates tension between RN's and RPN's. Some RN's in this study reported their RPN's colleagues expressed resentment and frustration that they were performing the same role as RN's for half the pay. RN's also expressed concern that the hospitals are "hiring more Health Care Aides and Personal Support Workers" to provide care previously provided by nurses. Introducing an additional dimension of insecurity, this work is sometimes contracted out to private, temporary agencies, expanding reliance on a highly insecure and precarious workforce.

Several social workers expressed concerns regarding deskilling and one social worker sums it up when she describes her angst over the RAI-MH as well as the social work role more generally,

> "..it really deskills us. I think we struggle as social workers and sometimes we are our own worst enemies, because we deskill ourselves by engaging

> in it and I don't think it's purposeful us not being critical. We deskill ourselves when we defer to the paternalism that exists in the organization and not value the skills and the scope of practice and training that we have had…. it takes a pretty strong voice and a very strong sort of person to be able to do that with confidence."

In chapter seven I will discuss how this social worker and some others are outliers and seem to have the skills and strength to resist more overtly, as well as highlight the factors that support them in doing this.

As Braverman (1974) argued in his classic analysis of the tendency to deskilling, the labour contract outlines an agreed upon number of paid work hours and the capitalist finds ways to exploit labour by maximizing surplus labour and so, profit. Capitalists buy labour time but organize work through scientific management principles to maximize the rate of converting labour time into effort (Braverman, 1974; Yates, 2005). More contemporary labour process analysts have described the ways in which employers extract surplus labour from community workers and other public service workers in Canada and the UK within and outside of paid work hours using many of the same basic techniques outlined by Braverman (Baines, 2004; Lewchuk 2002; Carey, 2009).

Research participants in this study are unionized with a long-standing labour contract specifying an agreed upon number of work hours and hourly wage rate. Despite this, all participants reported that their work had been significantly intensified which led most of them to undertake unpaid labour in the form of unreported, undocumented overtime. For example, some nurses reported starting their shift a half hour early and staying a half hour later so they could better prepare for the daily reports to their manager and ensure a smooth transfer of care to the next shift. This represents a subsidy to the

workplace in the form of their unpaid labour, so even if their wages can be said to be fair, in this situation the professionals experienced increased exploitation. The blurring of work-personal time boundaries or paid work and unpaid work and its relationship to personal values will be explored further in chapter seven.

Secondly, according to classic Braverman (1974) theory, standardization leads to the division of labour which results in separating conception from execution. This may lead to more dehumanizing work or work degradation and so, alienation (Braverman, 1974). My findings in the previous chapter revealed that workers have little investment in completing some mandatory tasks, especially if they were not involved in the creation phase. This in turn may influence their opinion that the RAI-MH does not add to their clinical practice. I wonder if the RAI-MH was a local hospital initiative, initiated from the ground up, rather than developed by academics, would it have been more readily accepted. The move from the traditional narrative style assessment completed by professionals to the narrowed and tightly scripted RAI-MH may be considered a step towards separating the conception and execution of work, resulting in increased alienation. For example, dividing the previously open-ended, narrative style social work assessment into specific elements in ticky boxes or short questions on the RAI-MH, likely leads social workers to routinely ask only the questions on the RAI-MH. This is likely to negatively impact therapeutic/relational work with patients given that the social worker probably knows much less about the patient than in previous eras. This may result in the loss or reduction of therapeutic skills among social workers as their need for robust assessments are displaced by rapid-pace, thin, standardized assessments. As will be

discussed more in a later section in this chapter, inflexible, computer-based assessment tools also contribute to a reduction in the use of critical thinking skills associated with their profession. According to scientific management principles the next logical step would be for the employer to assign the RAI-MH to a new classification of worker (SWA's) who may have the practical training or competency to complete the tool but lack the critical thinking that would link a person's individual situation to wider social and political forces. With the opening of the new Public Private Partnership hospital in 2014 a new job classification has been posted (Addiction Attendants) seeking individuals with college diplomas in Social Service Work. Will they be completing the RAI-MH or are there other aspects of the social work or nursing roles they will be expected to complete for half the salary of social workers and registered nurses?

Currently hospitals are emphasizing the importance of shorter stays and therefore discharge planning is not only important but a hospital priority. One of the social work roles is discharge planning. While in the past assessment and therapy work was an important aspect of social work this seems to have taken a back seat with the recent emphasis on discharge planning to ensure patients move quickly through the hospital system. Social work is based on a caring therapeutic relationship and when discharge becomes the priority, in an environment of scarce resources, it may begin to address what Fraser (1989) refers to as "thin needs" rather than the "thick needs" of mental health patients. For example, discharge to a shelter is vastly different to discharge to your own apartment but either would meet the requirements of a current hospital discharge plan. Most social workers and nurses are drawn to this area by a desire to work in close contact

with people in caring relationships and thus asking them to adopt an assembly line approach to care is likely to dehumanize work and increase alienation. The leaning out of hospitals through the adoption of lean strategies from the Toyota Production System, stresses the importance of "pulling" patients through the system at faster rates, from admission to discharge, in order to contain health care costs. Increased pace of work and the regulating and narrowing of practice may result in significant job losses for social work given that this function (discharge planning) is not a skill set unique to social work and can fairly easily be completed by other groups of less specialized, lower waged workers.

As noted earlier and confirmed in my data, professionals' exploitation and alienation are closely linked with work intensification. Research participants reported the "staff to patient ratio" is increasing as are delays in replacing social workers who resign. On some wards this led to social workers frequently covering for two social work positions. One social worker described her experience thusly,

> "..just feeling like I couldn't catch up, just the workload…it was creating workload havoc for me…a lot of time went by before they finally filled the position."

She and other social workers experienced fears about performance and potential risk management issues which led her to submit a "workload alert" form (recording daily workload) rather than a grievance, and soon after the empty position was filled.

According to a union representative convincing social workers to complete "workload alert" forms is difficult due to the complexity of their work which is not easily measured in the terms valued by the organization and hence, hard to prove that they are

doing too much. As one social worker stated "work is measured in a way that is not reflective of quality of work it's only the quantity of work" that seems to be of importance. The person from the union noted that if all social workers are experiencing increased workload but only one complains it may be personalized and argued that the other social workers are able to manage their workload and so why not you.

Interestingly, another social worker reported that when covering for an empty position she kept a record of the additional work hours as she was fearful that the second social work position would eventually be eliminated if she quietly covered all the extra work. She worried that if all the work was getting done, managers may assume only one social worker was needed for that ward. Some social workers reported being told by managers that their wards or programs had more social workers than others and this led to the continual fear that positions would be cut. Professionals also described trying to find the balance between minimum expectations and being a "super social worker and go above and beyond" just in case this meant managers would conclude less social workers were needed and more positions would be eliminated. This type of fear-mongering also led to participants being concerned about maintaining their role or professional territory resulting in inter-professional tensions at times.

One social worker described her reluctance to complain about work intensification for fear that she would be told to withdraw from committee work. This committee work not only provides satisfaction in an otherwise alienating environment, but enabled her to have input into current and future programs/projects. So she says "it's a catch 22 when it comes to complaining about workload." As work becomes more standardized, resulting in

decreased autonomy, committee work seems to provide an avenue for workers to increase autonomy or regain some sense of control over current or future changes to their workplace. However, undertaking committee work also leads to further exploitation as workers take on extra responsibilities, often partially fulfilled in unpaid time. For example, Continuous Quality Improvement committees may be interesting venues in which professionals can develop new skills by taking on roles and responsibilities formerly undertaken by managers. However, undertaking committee work is still a site of exploitation as the hospital extracts surplus labour from staff with no increase in pay or decrease in other responsibilities.

Most social workers and nurses resisted the standardization of their work while a few others appeared to comply with little resistance. The exploration of this is a complex endeavor which I will introduce here but it will be discussed further in chapter seven when I examine the relationship between values and resistance. Many participants insisted the RAI-MH did not impact their initial assessments while others reported they no longer completed traditional initial assessments as the completion of the RAI-MH was the organizational priority. A social worker stated she rarely writes a narrative social work assessment, as her manager's priority was the completion of the RAI-MH, which then became her priority given her increased workload,

> "But number one is those RAI's have to be done. And they take time. And so, if that's their *(management)* priority then I'll make sure those are done and I can't do everything else…..So I'll lose about two days because I'm not going to do anything until those RAI's are caught up ….two weeks of vacation means…eight discharges and admissions per week ….that's thirty two RAI's. "

Once again when workload is a concern often what is monitored and measured takes priority. This social worker stated her primary role is the RAI-MH and discharge planning. The "everything else" she is referring to is not only the traditional social work assessment but group and individual therapy which was a primary role of the previous social worker rather than something to complete after all the documentation is completed. Many social workers resisted this new documentation regime by limiting the time taken to complete the RAI-MH and "guestimating" rather than spending time finding accurate data, as they saw their major role as providing direct patient care and pushed back other tasks in order to have the time to do it.

Nurses described their work as less autonomous than that of social workers. Nurses reported following work practices that were more prescriptive and laid out in organizational policies, Best Practices or ward based routines. While some nurses indicated they wished they had more autonomy it was not a concern for others. It may be as, Heponiemi et al, (2008, p 2929) suggests, that some individuals have a personal need for structure, clarity and certainty and do not like the ambiguity that may come with a more autonomous workplace. Additionally, they are more likely to organize information in less complex ways and more likely to process or think about work (and patients) in terms of either/or categories rather than shades of grey than other workers. Minimum Data Set instruments such as the RAI-MH emphasize categories and so may satisfy a personal need for structure. It may be that ticking boxes about symptoms or functioning offers support or reassurance when determining complex individual medical situations for nurses who are pressed for time.

If those preferring high structure are placed in workplaces with low structure they may experience role ambiguity and less satisfaction with work (Elovainio & Kivimaki, 2001). For example, a social worker who has a high personal need for structure may more easily accept the standardization of their work, including the RAI-MH, as it decreases the ambiguity of their role, making it easier for them to know what is required to be a good social worker or neo-liberal professional. Alternatively, a social worker who has a low need for structure may resist standardization and seek out areas where she can be more autonomous, such as committee work. Lambert et al (2009, p.43) found that some nurses in UK long term care settings prefer using tools, such as the RAI, as they focus on medical assessment and diagnosis. It may be that ticking boxes about symptoms or functioning offers support or reassurance when determining complex individual medical situations for the nurses in Lambert et al's study. This supports the work of Rhodes et al (2006) with nurses using computerized checklists when assessing outpatients with Diabetes Mellitus. Rhodes et al indicated computerized checklists supported nurse's attempts to manage workload by maximizing efficiency but limited client-centred care and consequently treatment outcomes. The authors refer to the industrialization of Diabetes care where a biomedical audit is achieved at the expense of client-centred care. In my study some nurses completed the RAI-MH with the patient present and this may have reduced ambiguity even further as they inputted patient responses to individual questions right there and then. They also believed this process improved efficiency which was probably welcomed with increasing workloads.

A UK study with community social workers found regulation and standardization led them to adhere more closely to administrative procedures and protocols which subsequently led to intense deskilling and the virtual removal of therapeutic interventions (Carey, 2008). My findings in hospital work supports some of what Carey found in community social work. Whether social workers and nurses accept or resist standardization they all had to find ways to complete the RAI-MH as part of their work. Ultimately, my data shows that what is regarded by these care professionals as an administrative task did not lead to increased efficiency but to duplication and work intensification, resulting in less time spent providing direct therapeutic patient care and increased alienation.

6.4 Professional Collaborations and Tensions

Labour process theory suggests the potential for job insecurity gives rise to inter-professional tensions or "turf wars" between workers (Braverman, 1974; Baines, 2004; Carey, 2009). This has parallels to what is occurring in the hospital sector.

There has been an increase in the hiring of professionals into roles with more generic titles. For example, Mental Health Worker, Transitional Case Manager, and also the emerging classification of System Navigator who will follow patients through community to hospital to community. A Mental Health Worker's job role is similar to the work traditionally provided by social workers and yet they may be paid less than social workers. I would speculate the same will be found with the emergence of System

Navigators. The creation of System Navigators may lead to a decrease in the number of social work or RN positions at the hospital.

Professional conflict was illustrated when some social workers expressed concern that if they permitted nurses to complete social work's RAI-MH sections, this could lead to a diminished role for social workers within the health care team and they feared future job cuts. Professionals were well aware of the priority that is attributed to the RAI-MH within the organization, in a context of cutting costs, and this led to some professionals fearing the loss of professional territory.

As health care bodies strive to reduce costs, new ways of regulating the provision of care are adopted. Earlier I discussed how standardization permits the hiring of cheaper labour, such as RPN's, PSW's, and Health Care Aides to complete some of the tasks previously performed by RN's. We will have to wait and see what the role of the new Addiction Attendants will be but I suspect they will be completing aspects of the current social work role.

Some participants raised concerns that their managers were exploring another strategy referred to as the "transdisciplinary care model". Opie (2000, p.39) describes three types of teams as follows. Multidisciplinary teams include various disciplines who work in parallel with each other but independently. Interdisciplinary teams work closer together with shared responsibilities and language. They work interactively through consensus to determine actions or tasks to be completed. Transdisciplinary teams have the highest level of knowledge intersections and thus professional boundaries are more blurred with individuals involved in "role release rather than role retention. One social

worker illustrated why managers would be attracted to this model while she was adamantly opposed to it. She observed sarcastically,

> "everybody can do everything… why would we spend money on professional social workers to do this job at $40 dollars per hour when we can have someone who makes $25 do it"

This social worker went on to argue that transdisciplinary care will not work because the different healthcare professions have specialized education and training resulting in them being good at doing particular things and their job descriptions currently reflect this.

Some of the participants in outpatients had already moved from a multidisciplinary model to a transdisciplinary model they called the Most Responsible Clinician (MRC) model. Prior to the introduction of this model, a patient was assigned a psychiatrist, nurse and social worker as well as the services of an occupational therapist and therapeutic recreationist, as needed. With the introduction of the MRC model each patient was assigned a psychiatrist and a clinician who was from one of the above professions. Research participants noted that the MRC model resulted in increased frustration and inter-professional tensions rather than the seamless care promised. A senior nurse expressed her frustration given that while she is the MRC for a specified number of patients, she has to provide backup for allied health professionals (social workers, occupational therapists, recreation therapists) whose scope of practice does not include injections or monitoring blood work, and hence, when they are the MRC for a patient, a nurse has to do a portion of the work. She stated,

> "So you're the MRC *(social work)* but I'm the one who is looking at the blood work, I'm the one who is watching the clozapine which is what I was doing before but then I could say to you, to even off the workload, this person needs ODSP papers filled out, can you do that? Now I do it

> all…..So what are you doing for me, nothing. But I'm doing for you …so the nurses find this very frustrating…..now the expectation is that I do everything…I'm actually getting good at it *(social work role-ODSP & housing)* and can do it much faster now....so now I don't need you. I can do everything and you can't…..I think professionals should do what they are trained to do."

This nurse went on to illustrate the importance of involving different professional perspectives when it comes to patient care. She argued that when a patient comes in limping she will view this in a particular way (wound care) whereas a social worker will focus on a different aspects (finances, supportive resources). She asserted,

> "You think one way, I think another way…I think we are doing a disservice to our patients where before they had access to everything *(other professions' expertise)*, now they're really just getting me…. So let me do my job, you do your job and we will work much better."

The nurse goes on to express her sadness at moving from a multidisciplinary approach to the MRC model and her frustration at the chaos created by the new model. She also indicated the previous team based model was more efficient than the MRC model. With the MRC model the RAI-MH is completed by the MRC. This means that if a social worker is the MRC, she will complete all the sections including those completed by psychiatrists and nurses in inpatient settings. The blurring of traditional professional roles leads to frustrations and tensions as well inter-professional conflict. This model of care also permits the organization to pay, for example, therapeutic recreationists a lesser rate of pay than social workers and nurses for performing essentially the same role or job description. Perhaps in the future this program will hire more therapeutic recreationists and less social workers and nurses to reduce costs even though clinicians are reporting this way of providing care leads to patients "not getting the best care".

Another area that highlighted inter-professional tensions was perceived differences in extra training and research opportunities. It was reported by a social worker that nurses had easier access to money for training as well as the time and money to pursue research projects compared to social workers. A lack of transparency on how decisions were made also caused concern and tensions between nursing colleagues and herself.

On wards where workload was particularly excessive staff reported experiencing extreme pressure and feeling overwhelmed, which led to “some toxicity” in the workplace. One social worker reported difficulty trusting colleagues and found it hard to find allies when “everyone was in survival mode; you’re just trying to get through the day and survive.” This work environment led to her considering leaving social work altogether but fortunately she found another position which was less stressful and much less toxic.

Professionals also described times of collaboration. Social workers and nurses described working well with other team members and respected each other’s expertise. Social workers described occasions when patients were clinically ready for discharge but social workers needed more time to set up supports in the community and they negotiated and were supported by the psychiatrists and other team members in delaying discharge. One social worker summed this up succinctly when she said, “we’re all individual practitioners and then we collaborate”. She also described utilizing a team or collaborative approach especially when there was the potential for risk management

issues or a complaint. In this situation she would get the whole team involved in the case, including the manager.

Professional collaboration was also illustrated when, for example, nurses completed the social work sections of the RAI-MH for a colleague who was covering two social work positions or was behind in her RAI-MH's due to increased workload. This collaboration was occasionally overt but generally more covert or even an unspoken agreement between the two parties. This covert collaboration makes sense when research participants described instances of nurses being chastised by the RAI-MH coordinator or managers for completing the social work sections.

The RAI-MH is an IT surveillance mechanism as it can determine which employee completed which section (each individual has their own login password). This may compel those who want to collaborate to share passwords, which is forbidden, or risk disciplinary action by logging in under their own name but completing work for colleagues.

Social workers and nurses described receiving support from colleagues when they vented or complained to each other about the RAI-MH. In some ways it created a common ground or a stance of "we are in this together". This view somewhat challenged individual beliefs about responsibility for falling behind in the RAI-MH's and helped assign blame or responsibility externally. One social worker reassigned responsibility during the interview when she stated,

> "it's me that has a sour attitude about it or I'm not able to pull my own weight on it. A lot of people felt like that. So it must be the nature of the RAI that's the cause of concern, not necessarily me."

6.5 Critical Thinking: Running Out of Brain Space

During the interviews I observed times when the social workers and nurses engaged in critical thinking either when I asked questions or as they were describing a story or situation in their clinical practice. Critical thinking is the ability to link individual circumstances or situations to wider hospital system issues and the larger political economy. Research participants described critical thinking as the ability to take a step back and look at the "big picture". Topics they critically examined during the interviews included not only the RAI-MH's impact on patients and professionals but also the current neoliberal and gendered view of patients, families, caregivers, community services and the impact this has on accessing resources.

The research interview provided a time and a space to reflect and critique their practice which some research participants reported is very difficult to do when workloads are high. One social worker commenting on the pace of her work said cynically, "we are trained to get through the day." Another social worker described being overwhelmed by workload which results in her "running out of brain space". This level of workload intensification is not conducive to the reflection and critical thinking we expect from knowledge workers but perhaps this must be an expected outcome of standardization; workers who complete tasks but do not have the time or brain space to challenge standardization and the subsequent fallout experienced by patients and professionals. Completing the RAI-MH impacted critical thinking as this social worker indicates,

> "..it's a ticky box kind of thing….focused on efficiency and it takes away from the critical thinking that a social worker might use."

Managing increased workloads has resulted in many research participants no longer completing the traditional narrative style social work and nursing assessments which allowed time for reflection on a patient's particular situation, past and current, as well as past and current responses to it. It takes time to reflect on systemic issues rather than focus on individual patient problems and how they can be solved quickly to permit a discharge. When the organizational emphasis is on discharge planning, and lengths of stays are decreasing, the time to reflect on practice during the work day is greatly reduced. This perhaps explains the contradictory statements made by some research participants during interviews when their ideological stance was not always aligned with their practice experiences. For example, a social worker described herself as a feminist and critical thinker and then later stated, "when I'm in survival mode I don't think I'm doing a lot of critical thinking." Once again just trying to get through the work day becomes the priority. Some research participants described having no time to reflect during the work day and so reflected on their practice after paid work hours, such as on the drive home or when at home. They reported processing, analysing, critically thinking, problem solving about patients, policies and work practices after work. Others, specifically the younger professionals, consciously tried not to think about work outside of paid work hours by compartmentalizing work and home life. This will be explored further in chapter seven when boundary crossings and refusals are explored.

Some of the research participant's engagement in critical thinking led them to overtly challenge policies and work practices. Social workers and nurses who were outliers used critical thinking to not only assess a policy or practice but they often went to

the literature to look for evidence to support their position. One senior nurse describes using her critical thinking skills and knowledge of navigating the research literature to overtly challenge practice changes, including the new Most Responsible Clinician (MRC) model. However, despite presenting evidence critiquing this model her managers "did not want to listen". This nurse also confidently outlined how she overtly challenged existing medication practices which led to her being very involved in writing a policy that went hospital wide impacting nursing practice positively. She stated her critical thinking skills led to her gaining the respect of her physician colleagues over the years because they knew "I won't say it unless I can prove it … and point them in the direction of the literature." The skill to use evidence based research in challenging a practice concern provided this nurse with increased status among team members.

One social worker referred to herself as an outlier in comparison to other social workers in the hospital indicating she had the confidence to inform her healthcare team that,

> "I bring my own sort of critical thinking, my own analysis, my own skill to this. This is my opinion. This is what I think……I mean ultimately they *(psychiatrists)* make the final decision but I had the platform to be able to do this."

This is in contrast to the social worker who lamented when referring to social work that,

> "we have that minions kind of mindset….we should be focusing on the patient…..so bigger picture thinking is not really encouraged…"

I will explore differences in covert and overt resistance as well as the characteristics of outliers and rogues in chapter six when values and resistance are discussed in more detail.

Some nurses had difficulty understanding my questions about critical thinking, despite giving further explanations, and consequently they had difficulty recalling stories to support their comments and/or their practice examples where limited. These interviews tended to lack the richness and depth of the other interviews. Perhaps this difficulty relates to the prescriptive nature of nursing work. Nurses have more policies or written standards of practices to adhere to than social workers whose practice is more autonomous. Likely there is also a link to standardization and work intensification which leaves little time for reflection and critical thinking. It may also be related to their training and knowledge base; some of the RN's had college diplomas while others had university degrees and it may be that critical thinking is taught more at the degree level than college level. Or then again perhaps critical thinking is more emphasized in social work training overall than it is in nursing. Unlike nursing, social work's Code of Ethics (OCSWSSW, Code of Ethics and Standards of Practice, 2005) refers to social justice and the importance of reflection and critical thinking. This is an area that might be pursued in more depth in future research.

Is it that work intensification, a focus on completing tasks, as well as competition for resource allocation, leads some professionals to treat patients as objects rather than as individuals in a system that can be critiqued for not meeting patient needs? Roxana Ng's (1996, p.46) study of community counsellors' providing services to immigrant women, found that accountability by government resulted in success being measured in numerical terms rather than relational. This led to a shift in perspective by agency workers from focusing on the "lived experience of the clients" to "the perspective of an impersonal

institutional order" where producing good statistics became the priority. Something similar may be happening here where an emphasis on statistics and funding puts patients at risk of being seen as sources of data and funding. This objectified view is in contrast to seeing patients as individuals with complex life histories and stories whose hospital experience is impacted by larger system and ideological forces. The RAI-MH is symbolic of the strategies used to transform the welfare state into a culture of audit that potentially reshapes the relationship between health care workers and patients while at the same time discounting or making invisible larger systemic and political issues.

6.6 Surveillance: Caring Through the Computer Panopticon

This section will discuss the surveillance of health care professionals through the Information Technology (IT) panopticon drawing on the work of Michel Foucault. IT has the potential to be used creatively in the workplace. However, this study shows it is often used to regulate, control and monitor work and workers. Michel Foucault's thoughts on governmentality and surveillance are useful in illuminating how technology shapes the labour process in hospitals. Foucault (1982, p.221) states, "To govern ….is to structure the possible field of action of others" and computer technology and specifically the RAI-MH, is used to govern patients and the practice of healthcare professionals. As mentioned earlier the architecture of psychiatric hospitals enables the monitoring and controlling of patients. Today IT is used to monitor and shape patients *and* professionals.

Foucault's description of Bentham's panopticon is useful here. Bentham's concept of the panopticon is used to describe the ability of the tower in prisons to keep prisoners

under constant surveillance. The panopticon ensures the efficient expression of power as individuals are keenly aware they are constantly monitored. Ultimately, this results in them monitoring themselves (Foucault, 1979; Chambon, 1999; Moffatt, 1999). In the manufacturing sector a panoptic gaze is described that penetrates walls that resulting in the manager's physical presence no longer being required (Sewell & Wilkinson, 1992). Zuboff (1988) takes this a step further by referring to the information panopticon where the computer functions as a disembodied eye that overcomes architecture to bring the disciplinary gaze right to the labour process. The RAI-MH and other computerized workload measures in hospitals give managers and the government the ability to quickly assess work performance and make funding and workforce decisions.

Research participants are cognizant of monitoring by the ministry/government, the organization/managers, peers and themselves. All of them described various surveillance and coercion strategies used by managers to ensure the RAI-MH's timely completion.

Organizational surveillance through managers leads to the RAI-MH being viewed as a priority for some workers and that failure to complete it in a timely manner will be considered a performance or disciplinary issue. Coercion strategies included being "hounded", "harassed" or "nagged" by managers, "name and shame" or "wall of shame" lists being posted in team offices, of receiving phone calls, sent emails or being given lists of their outstanding RAI-MH's. One social worker commented,

> "There is a real shame component to it. You have got to get it done
> so your name isn't on the front of the binder."

Peer surveillance through the appointing of RAI champions (usually nurses) is another strategy used. RAI-MH champions were initially to act as resources for staff

should they have questions about how to complete the RAI-MH, but eventually their work shifted to monitoring and ensuring the RAI-MH is completed within the prescribed timelines. This puts the RAI champions in a difficult position as they are monitoring peers, from their own and other professions, and yet they do not have the title or receive payment to act in the role of supervisor or manager. One professional described receiving an email from a RAI champion informing her she was behind in her RAI-MH's. The RAI champion later approached her and apologized for the email reporting that the manager made her send it.

This downloading of responsibilities will be discussed at the end of the chapter under high performance workplaces and it is a strategy used in lean healthcare management. Another nurse highlighted the current trend to download a manager's tasks onto frontline staff when she commented,

> "..and the "champions" are monitoring… so it's a manager's job that's been passed down …they (*frontline nurses*) are getting things that the administration use to do, I think everything's trickling down."

Peer surveillance is built into the RAI-MH software program. Each professional needs to complete their section individually so that the RAI-MH is considered complete. If, for example, the nurse and the physician have completed their sections of the admission RAI-MH and the social worker has not, then the nurse and physician cannot create and open a discharge RAI-MH. So not only is the RAI-MH listed as incomplete by social work but social work delays the nurse or physician from completing their work on the discharge RAI-MH. This reliance on each other is reflected in the following examples. One nurse expressed frustration that, "I can't complete my part because

somebody hasn't done their part." Another professional expressed the guilt and shame she experiences when she falls behind,

> "..the message that I get is that I'm bringing them down. They use to be so good *(at completing RAI-MH's on time)* and I'm bringing them down…. And I've even gone in to say, as soon as I get the email, I say to x *(the manager)* and y *(the nurse champion),* I know I'm bringing you down."

The RAI-MH software also has the capability to visually display a message on the opening screen, after an individual has logged in, stating the person has outstanding RAI-MH's to be completed. The monitoring of peers and of self is built into the RAI-MH allowing workers to print lists of incomplete RAI-MH's and so quickly ascertain which staff have not completed their sections.

This social worker describes the process of moving from organizational to peer to self- surveillance when she comments,

> "You get a list. It is pointed out to us that we are falling behind. Then *we (her and her social work colleague)* have to clean house on the RAI-MH list…. Yes, but now we print our own lists. Every morning we print an incomplete list and go through and see which ones need JLOPS *(social work section)*. I circle mine and cross hers *(social work colleague*) off with a little star and then give her a copy… Yes, we are pretty on top of it." (O'Neill, 2007)

Another social worker described the process of organizational and peer surveillance resulting in what the literature refers to as self-surveillance (Foucault, 1979; Moffatt, 1999) and what she calls "self-policing".

Labour process theory suggests self-surveillance and even self-exploitation may be due to attempts by workers to ensure job security. This makes sense in a climate were funding and resources are becoming scarcer. My findings showed most of the

professionals' engagement in caring work is closely linked with their identity, personal values and the desire to be viewed and feel like a "good social worker" or a "good nurse". The performativity literature would suggest workers striving to be seen as "good employees" or to ensure job security may change their behaviour or work practices to meet performance indicators that are valued by managers or the organization (Ball, 2003; Powell & Gilbert, 2007). My findings suggest that managers and organizations are keenly aware of this and use it to their advantage to engage in the exploitation of nurses and social workers. One social worker summed this up when she stated,

> "My opinion in healthcare is that they know that we're caring health professionals and they just add more and they don't take anything away. Maybe because they know that we won't let, that we will try not to let patient care suffer."

When subsequently asked if she felt exploited she quickly replied, "Absolutely, they take advantage of us in that way." The connections between care work, values and gender will be elaborated further in chapter seven.

6.7 High Performance Workplaces

The standardization of work may lead to work intensification, alienation, deskilling and decreased autonomy but this is more complex than was initially suggested by Braverman's (1974) labour process theory (Burawoy, 1979; Thompson & Smith, 2009; Thompson & McHugh, 2009; Thompson, 2010). As noted earlier in this chapter as autonomy is reduced in one area of work some professionals, especially the social workers in this study, sought out ways to increase autonomy in other areas of their work. This leads to extra responsibilities and the perceived ability to engage in more

discretionary work that permits increased decision making. I use the word perceived as I noted in the literature review when discussing lean healthcare management's use of Continuous Quality Improvement committees, they remain at risk of continuing to be top down decision making ventures. Managers may skillfully introduce improvements or changes in ways that appear participatory but are often predetermined and professionals may have a more muted voice at the decision making table.

Interestingly, some professionals in this study indicated being either encouraged or coerced by managers to take on committee work while others appeared to welcome or even seek out the opportunity to more fully participate in committee work or special projects. There are limitations to my analysis given the small sample numbers of nurses but the trend tended to be social works seeking out opportunities for committee work while nurse often reported being "voluntold" and reluctantly participating in this extra work.

The literature on high performance work systems adds to the discussion on the complexities of standardization in hospital organizations. On the one hand I have argued that the standardization of some aspects of hospital work is similar to the standardization in manufacturing while on the other hand I acknowledge that the work of professional nurses and social workers is less Taylorized than other work sectors. Professional training for work in health care often results in permanent, full time, secure employment in a unionized environment for many, despite the increase in part time precarious work for others.

There is no clear definition of a high performance work system. A broad definition adapted from Applebaum (2002) "refers to approaches to labour management characterized by participative forms of work, skills enhancement and mechanisms to motivate employees" to improve the bottom line in organizations (Harley, Sargent & Allen, 2010, p.741). Hospitals may be considered high performance work systems under this broad definition.

The outcome of high performance workplaces continues to be contested in the literature. There are those who argue the outcome is positive for the organization and employees describing increases in employee autonomy, commitment and satisfaction (Mackey & Boxall, 2007, 2008; Harley, Allen & Sargent, 2007). While others argue the outcome benefits the organization in terms of performance gains but for employees it leads to work intensification, increased responsibilities and workload as well as heightened stress (Ramsey et al, 2000; Danford et al, 2004, 2008). The former is a more managerial perspective while the latter would be from the critical labour process theory view, according to Harley, Allen and Sargent (2007).

The degree to which an organization is considered a high performance work system also complicates the debate, especially when what is in the 'black box" has yet to be clarified. On the one hand Heffernan and Dundon (2012) suggest organizations with a high degree of high performance work systems in place, have employees with lower job satisfaction and affective commitment with a higher perception of job pressure, than those organizations with a medium or lower level of high performance work systems in place. On the other hand Macky and Boxall (2008) suggest the more an organization is

considered a high performance workplace the greater the job satisfaction. They do acknowledge it is possible that work-life balance may be tipped to the extent that employees feel pressure to work longer hours, feel overloaded and managers make demands on personal time. Work-life balance will be discussed further in chapter seven and in particular why some nurses and social workers have more spillover into personal time than others.

Currently there is limited research on high performance workplaces in the social service sector. However, Harley et al's (2007, 2010) study of RN's and Personal Care Workers working with seniors in Australia, in a high performance work system, found positive outcomes for these employees as it led to orderly and predictable work environments which were desired by the employees. Additionally, it is argued these findings support the "disciplined worker thesis" postulated by Edwards et al (1998). This work resonates with some of the findings of this study especially for those research participants who appeared to be more comfortable with routines and so the expectations of them from managers making it easier to know what is a "good" social worker or nurse. The dance between managers and workers, and thus between control and autonomy, is evident in high performance work systems, including my study with nurses and social workers. On the one hand "managers need to exert direct control over employees in pursuit of standardized service, while simultaneously using less direct techniques to encourage labour effort and flexibility" (Harley et al, 2010, p.746).

High performance work systems include reward systems for employees connected to their performance. In the private sector these rewards may be monetary and/or include

promotion. In the hospital sector with the flattening of hierarchies, including the elimination of supervisory or lower management jobs for social work, promotion is an unlikely reward. Hospitals are prohibited from giving the majority of employee's financial rewards and incentives. The only financial incentive I am aware of is the recent introduction of a $5 Tim Horton's card for a perfect attendance record. Therefore, the motivation to take on extra responsibilities differs from the private sector to the public sector.

The push for example, to be a 'RAI-MH champion", is driven by managers as this study shows some nurses reluctantly accepted this extra responsibility and the additional workload required with no financial compensation. Clearly, for many professionals a desire to increase autonomy and be involved in decision making motivated them to take on the added responsibility of committee or project work. I highlighted earlier social workers who were reluctant to complain to managers about overwhelming workloads for fear they would be instructed to step down from the various committee work they were involved in and received much job satisfaction from. Interestingly, the perceived carrot dangled by managers to these employees is that if you can keep up with your workload then you can participate in "extracurricular activities" or committee work. Committee work itself becomes the reward for good work performance. Interestingly, often this committee work leads to further work intensification as extra responsibilities are unburdened from managers onto frontline staff.

6.8 Conclusion

The previous chapter highlighted the assembling of neoliberal patients while this chapter expanded on the manufacturing or assembling of neoliberal professionals. Social workers and nurses attributed work intensification to organizational changes, such as the introduction of the RAI-MH, shorter lengths of stay and lower patient-staff ratios. Interestingly, some research participants did suggest the inability to keep up with these changes and dissatisfaction at work were personal or individual issues and they attempted to justify or reconcile working outside of paid work hours. In chapter seven I will explore if working in a care profession, predominately staffed by women, leads some workers to become coerced into continuing to provide excellent care to their patients despite work intensification and increasing job dissatisfaction.

The implementation of the RAI-MH has followed the expected trajectory described by Foucault's ideas on the panopticon and Rose and Millar's thoughts on "governing at a distance". The Ministry/government mandated the RAI-MH and eventually threatened hospitals with monetary fines if they did not complete it. Consequently, managers began enforcing its use through various strategies, including the use of RAI champions to monitor staff. Eventually staff became acutely aware of the surveillance they were under and began to monitor each other and themselves. This illustrates how IT enables governing at a distance leading to professional practice being shaped by outside influences rather than just from within the different health care professions. Standardization leads some workers to seek opportunities that will increase autonomy, such as committee work. Often these are "extra" responsibilities on top of

their patient workload resulting in work spilling over into personal and unpaid time. Ironically, professionals' desire to seek opportunities to use their creative talents, critical knowledge and other skills in an increasingly standardized workplace, provides an opportunity for greater exploitation by management.

Below is Table 2 highlighting the idealized attributes of knowledge workers along with the realities faced by many standardized or leaned-out health care professionals. While acknowledging the nuances are more complex than the table below, they do serve as a stark reminder of the gap between the promises of 21st century work and the realities for many.

Knowledge Worker	**Lean/standardized Health Care Worker**
Highly Skilled/Upskilling Flexible Creative Self-actualized Perpetual learner Efficient Globally competitive	Deskilled Decreased autonomy Exploited Alienated Stretched thin Work intensification Efficiency driven not client driven Increased responsibility
IT - promises	IT – promises unfulfilled – duplication & surveillance

Work organizations are complex and hospitals seem to engage in many different strategies to increase the performance or exert more effort from employees. In the next chapter I will examine how personal, professional and organizational values influence how social workers and nurses respond to organizational changes. I will explore why some professionals appear to be engaging in self-exploitation and other strategies as they strive to be good neoliberal professionals, or good social workers and nurses, as ways to cope with standardization and work intensification.

Chapter 7
Personal, Professional and Organizational Values: Moments of Alignment and Collision

7.1 Introduction

The previous chapter used Braverman's (1974) classic labour process theory as well as concepts such as governing at a distance and surveillance through the panopticon (Rose & Millar, 1992; Foucault, 1977, 1982, 1997) to explain how social work and nursing practice is controlled and monitored through technologies such as the RAI-MH. My findings on organizational, peer and self-surveillance and exploitation were presented. In this chapter I will add to the discussion by exploring the impact of personal values and investigate why some individuals appear to have a tendency to engage in self-exploitation.

This chapter will examine the ways in which personal values, developed through life experiences, and professional values, cultivated via education, guide how social workers and nurses respond to the regulating and restructuring of their practice. I will focus on how organizational, professional and personal values align or bump up against each other in increasingly prescripted or controlled workplaces. Examples from frontline practice are analysed to illustrate the strategies professionals engage in to decrease the cognitive dissonance or tensions arising from conflicting values. The concept of pretending is put forward as one of the key strategies professionals may use, either consciously or unconsciously, to work in progressively more neoliberal workplaces.

As the research interviews and analysis progressed findings emerged that highlighted a connection between work-home boundary crossings that were supported by

information technologies (IT's) and subtly or unofficially encouraged by managers. I will present findings on the flexible and rigid boundaries between home-work life or paid-unpaid labour as well as the organizational expectations that encourages professionals to cross these boundaries as hospitals becomes leaned-out and thus time and resources more limited. The concept of time is explored as participants often discussed not having enough time and work spilling over into home life due to their inability to manage work time in an efficient manner. Interestingly, I found differences in the way work is viewed by younger social workers and nurses compared to their older colleagues and subsequently I highlight the contrasts between clear, rigid, inflexible boundaries and porous, flexible boundaries.

I will use a critical approach in my analysis drawing on concepts from the feminist literature on organizations and community social services (Aronson & Neysmith, 1997; Acker, 2009; Baines, 2004, 2006) to highlight the exploitation of care workers, who are mostly women, and the tensions and contradictions experienced by them. Organizations are gendered as they value and implement strategies and technologies considered masculine (Acker, 2009; Benshop & Doorewaard, 1985; Lindsay, 2008). Hospitals are hierarchical and complex organizations with large gaps between the highest (CEO's, Drs.) and lowest (housekeeping) paid workers (Lindsay, 2008; Armstrong, 2008). Similar to other organizations those in the highest positions (CEO's) tend to be male. Dorothy Smith (1990) argues that although objectified forms and rational procedures may on the surface appear neutral there is an underlying class, racial and gender subtext. The RAI-MH may seem like a neutral computerized document but it

further marginalizes those already most vulnerable by forcing them into rigid categories, reducing them to sources of data for funding purposes.

The literature on performativity (Ball, 2003; Powell & Gilbert, 2007; Powell, 2012) is helpful in understanding why some professionals adapt to the outcomes of restructuring with little resistance, seemly moving smoothly from organizational to peer to self-surveillance and even self-exploitation at times. Some community care workers have become “self-regulating” deep managed” to the extent that management could have a more hands off managerial approach. (Brown and Crawford, 2003, p.67). It seems this “deep management” or “governing of the soul (Rose, 1990) is made easier when caring for others is highly valued by workers. The shaping of employees’ behaviours through performance measures often leads to tensions for professionals who are trying to balance being a good social worker or nurse with being a good neoliberal employee. These tensions and ways of resolving or coping with them will be explored in this chapter.

This chapter will discuss 1) the impact of organizational, professional and personal values on caring work, 2) the tensions or cognitive dissonance often experienced by social workers and nurses when these values collide, 3) how professionals respond through adapting, negotiating, transparency as subversiveness and pretending, 4) organizational changes that encourage boundary crossing and the differences between older and younger professionals, 6) similarities and differences between covert and overt resisters or what the research participants have referred to as rogues and outliers.

7.2 Values: Why Caring Work?

While classic labour process theory offers valuable insights into work organization and how workers respond to standardization there is also a literature that suggests engaging in caring work is often closely linked to personal values and life experiences (Aronson & Neysmith, 1997; Aronson & Sammon, 2000; Baines, 2004, 2006; Hogget, Mayo & Millar, 2006). Tensions arise when values around care work clash with organizational values (Ball, 2003; Powell & Gilbert, 2007).

As the interviews progressed the importance of values emerged from the data and I began asking several questions that approached this topic from various vantage points. For example, why and how they came to choose this career path, what their parents' occupation was and whether they believed this influenced their path into the care professions. I also asked them directly if their personal, professional and the organization's values where in alignment and were there any times of tension between these values. I asked if, and why, they left worked feeling troubled. Research participants were also asked to give examples from their practice as this was an opportunity to examine when, how and what values became prioritized as well as an opportunity to discover if values play a role in professionals engaging in unpaid work or self-exploitation. Additionally, is there any contradictions between stated beliefs or values and practice choices or behaviours?

Research participants varied by age, experience, gender (one man) and whether this was their first or second career and these differences proved to be helpful with the analysis. The social workers and nurses described coming from families where caring for

others was an important role. For some this may have been informal (unpaid caring for a grandparent) while for others it was more formal (family member working as a paid caregiver). Many of the research participants came from working class families and a few described the impact of poverty, and inequality on their early life. Overall the research participants described being "drawn" to a career in care work or that it "came naturally" as caring work aligned with their personal values. They also believed care work would lead to more job satisfaction as it connected with their views on social change compared to other occupations. This supports the work of Hogget, Mayo and Millar (2006) who reported public sector employees in the UK are drawn to this employment sector due to their life histories, values and identity.

For three of the six nurses and two of the eleven social workers this was a second career purposefully chosen, around age 40, after careers in the public sector (one social worker only) and the private sector; administration, business/accounting, and factory work (one social worker & three nurses). One social worker succinctly revealed,

> "It came naturally although (*it was*) not the original plan. Identifying issues of oppression, prejudice, inequality… came naturally, it's what I live by and I was very immersed in that sort of thinking already (*family life and religion*)."

While personal and professional values were reported to be in close alignment the research participants reported that these values came into conflict with the hospital organization's values regularly. One social worker reported, her personal values dominated her practice as she is more concerned with how she treats the,

> "person and the experience they had rather than the greater good of the healthcare system…..I understand that their (*organizations*)

> agenda is getting our healthcare dollars secure and alleviating blockages in the system. But that's not my agenda. My agenda is seeing what is the best outcome for *this* person."

Another social worker critiqued the organization because they, "really don't seem to care about what happens after discharge" to patients. Professionals were keenly aware of the importance of optimizing funding and not wasting healthcare dollars. One participant commented on the strong organizational push to discharge patients faster when she asserted, "I care about length of stay but I don't put it ahead of what's best for the patient."

Many individuals described the organization's values, as per the mission statement, as similar to their personal values, but then reported what was written and "looked good on paper" was not the same as the day to day experience of working in a large organization. A senior nurse sums up sarcastically the mission statement of the organization, "It's an honour to serve the sick….only if we can face to face it, it's sad". The three main arenas that research participants consistently described as leading to value conflicts or tensions where around discharges, long term care discharges and completing the RAI-MH, examples of which will be illustrated further in the next section. A distinction was made by one research participant between the organization's values and the managers' values. She indicated the organization's values were similar to hers but that managers' values were different as they valued efficiency and accountability.

Only two participants, both nurses, indicated that the organizational priority trumps personal and professional values. They indicated this was due to their concerns about risk management as they wanted to ensure they will be fully supported by the

organization should a problem arise. Unfortunately, this was even if they "know in their gut" and their advocating for the patient "falls on deaf ears" and they have to "pick up the pieces at the end again if the patient falls through the cracks." One of the nurses also sadly stated, "It really makes you feel bad." One senior nurse commented risk management is more of a concern now than in past years, and the result is a pressure to document well, which she says now takes priority over time spent with patients. Other nurses reported their personal values trumped organizational values and their stories included many instances where the prevailing values of the organization led to internal tensions. Later I outline the strategies professionals used to cope with this friction or tension so that they can continue to work with patients and not be fired by their employer.

One social worker suggests that managing the tension between organizational and personal/professional values is an important skill, however, there are times that she optimistically describes as opportunities to practice grounded in her personal and professional values as,

> "…here's the pure practice where you get to really experience
> the purity of how you interact with people and you get to really
> live out your values."

Likely it is these moments that help sustain and support care professionals in leaned- out health care systems.

Social workers and nurses all commented on seeking out and remaining in their professions due their desire to work in meaningful relationships with clients as opposed to spending their time completing documents. The importance of relationships in caring work is supported in the literature. Lindsay (2008) found, that even in the technologically

heavy intensive care units of hospitals, women still identified strongly with care work, while men in the same roles, tended to emphasize the technical aspects of their work. As might be expected in gendered organizations Lyndsay reported "technological caring" was more highly valued than traditional caring skills.

Several research participants' comments illustrated the gendered assumptions of the organization in terms of their employees and of patient families. Some social workers and nurses indicated their caring nature and concern for patients led them to engage in unpaid work, such as searching for patient resources at home or working longer hours. It was also suggested by many of the social workers and nurses that the organization took advantage of them as caring professionals who would try and prevent patients feeling the impact of work intensification and consequently work would spill over into unpaid time. This is supported by the work of Baines (2004, 2006) in community social service work and Lewchuk (2002) in the public sector who both suggest that a strong identification with caring or marginalized clients led to exploitation and self-exploitation at work. Many of the social workers and nurses referred to the gendered expectations placed on families in terms of care giving as one social worker states,

> "There's coercion of the patient, of the family, there's a lot of assumptions made that are very sexist around who's going to be caring for this person."

Overall social workers' and nurses' personal values were consistent with their professional values while tensions arose when these collided with organizational values. One social worker summed up this ongoing dilemma when she indicated that every social worker has to deal with this conflict; how you should practice social work according to

your social work education and the actual lived experience of being employed by a large hospital means you "have to let go of some of your ideals or you will go crazy" if you want to continue to work in health care. The older or more traditional principles of professional judgement and co-operation have been replaced by the values of competition and performance in the public sector (Ball, 2003).

7.3 When Values Collide: Cognitive Dissonance

Research participants were asked to describe moments of tension or times when conflicts between personal, professional and organizational values occurred. Their examples most often centred on discharge, including discharge to long term care, and the RAI-MH. One social worker described this tension as "cognitive dissonance". Cognitive dissonance is a psychological term used to describe the internal or mental distress experienced when trying to hold two conflicting beliefs or when there is a conflict between an individual's belief system/value system and a behaviour they engage in (Cherry, 2013). Festinger's (1957) cognitive dissonance theory suggests individuals do not like being in this state of distress and so seek to find consistency between their beliefs and/or behaviours. All of the nurses and social workers described instances of tension or cognitive dissonance between their beliefs or values and coerced compliance by the organization so that organizational goals could be achieved. One social worker illustrates this tension,

> "I experienced that clash more on the in-patient unit, and in particular, around discharge planning where it was very obvious and clear that my client was not the patient. My client was the hospital and I was serving the hospitals needs and not the patients. So, that was very apparent and that there was a lot of cognitive dissonance…"

This social worker seriously considered leaving the profession but fortunately she was able to find another position where the tension was at a lower level that she could cope with.

Stories from practice suggested a lot of worrying and guilt was occurring when for example social workers "shuffled people out and it went terribly" and this worry spilled outside of work time and was viewed as a personal failure rather than a systems breakdown,

> "I'm just worried somebody is going to fall through the cracks or I may have been less effective than I wanted to be. I will often leave work thinking, oh I should have done that or I should have done this or why didn't I think of that. I'm self-critical".

As mentioned in an earlier chapter, during the interviews some of the research participants while reflecting on their practice actively worked out or reduced cognitive dissonance. They reassigned more responsibility for some practice decisions to the system rather than taking on all the blame as they had done initially. While this strategy may somewhat decrease the distress experienced when organizational and personal values clash other strategies such as adapting, negotiating, transparency as subversiveness, pretending and various forms of resistance proved more useful as will be shown in the remaining sections of this chapter.

7.4 Dealing with Tensions: Adapting, Negotiating, Transparency as Subversiveness

Social workers and nurses engaged in various strategies to deal with cognitive dissonance or the colliding or clashing of personal and organizational values. My analysis revealed

depending on the situation, and how far they felt they could push back, determined which strategies social workers and nurses engaged in. Several also indicated that experience and confidence plays a major role in when and how they challenge organizational priorities or values. This makes sense given that most new employees would desire to fit into a new workplace to ensure job security and the knowledge of when and where to push back would come with experience.

7.41 Adapting

Research participants often described reluctantly adapting their practice in order to meet the demands of work intensification and/or the requirements or priorities of their employer. One social worker stated she changed her practice in order to complete the RAI-MH's along with the organizations push for shorter admissions and so faster discharges,

> "Sometimes because of the pace, you feel like you can't be the kind of social worker you want to be. But over time I think I adapted. I adapted my practice to be able to feel competent in this setting."

When asked what a competent social worker in the past would be doing she replied they would complete a more thorough assessment which *was* more important but in her current setting acting quickly and efficiently to ensure a faster discharge is *now* the priority for the organization.

Another social worker explained why she adapted her work practices such that the managers' priority (RAI-MH's and discharges) became her priority as she searched for ways to cope with increased workload. She described adapting her practice for

"mercenary reasons" in other words to make things easier for herself rather than for altruistic reasons. For this social worker she resisted doing the "everything" or all the other aspects of her role previously completed. In this instance adapting may still be considered a resistance strategy. Carey and Foster (2011) suggest deviant practice is taken up for various reasons and not necessarily altruistically motivated. Additionally, they found that deviant social work was not automatically linked to a commitment to epistemological or professional based ideologies such as radical social work, anti-oppressive practice, service user participation and so forth. Whereas other social workers and nurses resisted by finding ways to continue to do the "everything" so that the impact of restructuring did not impact patients even if this meant work spilling over into unpaid time.

In an earlier chapter I illustrated how social workers and nurses made the RAI-MH a part of their practice by engaging in "guestimating" answers, as a way to limit the time they spent searching for accurate answers which would be more time-consuming, this is another example of adapting. There is a distinction between accepting without question and adapting to enforced changes or work intensification. One nurse described nurses responding to potential restructuring with optimism hoping it would improve practice but following implementation they quickly had a change of attitude and found ways to adapt or resist if promises or hopes where unfulfilled. Professionals wanted to believe they were doing good work and adapting their practice to meet organizational demands was one way to reduce the tension between personal and organizational values.

7.42 Negotiating

Negotiation was another strategy used in order to reduce the conflict between beliefs about good care and organizational goals. One social worker describes how she manages this tension,

> "Sometimes the organization wants us to do things we don't want to do but I always somehow figure there's always a middle ground. There's always a process of negotiation."

Social workers gave examples of negotiating with other team members, in particular psychiatrists, to delay discharge dates so that they had more time to set up more comprehensive discharge plans such as stable housing or community follow-up.

Interestingly, another social worker described a process that sounded like she initially negotiated with herself and then subsequently with the manager as she attempted to do what she believed would be best for the patient without getting fired. She talked about reflecting on what she could and could not do. Sometimes this steered her to consult with her Professional Practice Leader in order to determine just how far to push during negotiations with her manager

When negotiating fails and organizational priorities dominate a nurse indicated she feels frustrated and angry and these emotions often spill over into her home life. At that point she reflects on how she can learn from the experience, how she can use the system better in the future so clients are better cared for and she then "puts it in a little box" mentally. This compartmentalizing and setting aside mentally the tension between personal and organizational values and the direct impact on patients is another strategy

used to reduce cognitive dissonance when negotiating does not result in a successful outcome.

7.43 Transparency as Subversiveness

Many research participants described the importance of transparency and honesty in their work with patients especially when organizational policies and subsequent pressures impacted client-centred care. One social worker explained she wanted "to be real with herself" and "pragmatic" in how she coped with the changes or leaning out of health care. She believes that transparency is an act of subversiveness,

> "I try to be transparent. I realized early on that was maybe a way of practicing some subversiveness as a social worker in a big corporation, by always making sure that the patient and family are aware of the larger pressures that are being brought to bear and so therefore trying to empower the patient and the family to complain to their MPP about the health policies in the Ministry of Health, to be aware of where these decisions were originating, that these are policies (*that*) are out of our hands but we have to operate within them and if they (*patient and families*) don't like them here's how they can complain."

The long term care process, and in particular the push to have families accept the first available bed or return home to await a long term care bed, was an area that social workers reported they found a very difficult part of their practice. Their employer expected them to deliver this message and often in a very specific way (Home First Script, suggest they may have to pay for the hospital bed). Through their transparency and knowledge of the policies and processes they could highlight gaps in the system that allowed families to push back. For example, some social workers stated while medical wards could charge for beds there was a different policy for mental health beds. So while

some managers in mental health wards suggested patients be told they could be charged for their bed social workers knew this was an idle threat. This is supported by the work of Clarke (2004) who argues the opportunity for subversion occurs in the gaps between policy and practice. Additionally, employees are not merely robots but will find ways of "surviving, negotiating, accommodating, refusing and resisting" (Clarke, 2004, p.159).

7.5 Performativity and Pretending

Compliance with procedures to regulate work processes, such as standardization, makes sense when workers are fearful of job losses or wish to maintain jobs that pay fair wages and have good benefit plans. The professionals in this study acknowledged they had good jobs with a fair wage. One social worker describes these good jobs leading to conflicting values and thus they come with significant costs,

> "When you work for a large corporation, like (*name of the hospital*), it's very disconnected from the roots of social work really, it's so corporate and I think we exchange some of our roots and radicalism for the high pay check...I think there is a certain trade-off that people make, if we are really honest with each other, I think you sell your soul a little bit and there's a complacency… your radicalism has kind of gone to sleep to some extent."

Professionals need to find ways to cope with the tensions inherent in being a good social worker or nurse and being a good neoliberal employee in large healthcare organizations. The literature on performativity illustrates the ways that workers deal with organizational values centred on efficiency, accountability and excellence which is often in tension with personal values focused on caring relationships.

Ball (2003, p.224 & 226) claims "performance has no room for caring" and leaves little space for "an autonomous, or collective ethical self". Earlier I highlighted that what is measured tends to be prioritized and management develop strategies to ensure employees are aware of this through surveillance and disciplinary measures. In this study research participants were well aware of the importance of completing the RAI-MH and one social worker described delaying direct contact with patients after returning from vacation until she had completed outstanding RAI-MH's. It was also her perception that the manager believed,

> "If my team is compliant and our RAI's are always done here timely then we're doing well' and I think they see it as a management issue. Can I get my staff to do what they need to do in the time that their supposed to do it?"

At times being viewed as a good employee was a priority. Research participants are well aware that "we don't get dollars if we don't hit benchmarks" and so the priority given to "face to face contacts" and "increasing the flow" of patients through the hospital system makes sense in such a culture. The language of audit and performativity often leads to professionals learning to talk about themselves, relationships, purposes and motivations in new ways and we become good at "presenting and representing ourselves with this new vocabulary, suggests Ball (2003, p.218). Ball (2003, p.215) suggests that for some workers the focus on performance through measuring productivity or output leads to "inner conflicts, inauthenticity and resistance" while others accept the restructuring of their work and become "an enterprising self, with a passion for excellence".

One social worker comparing herself to her social work colleague stated, "She's very efficient. She's more efficient than I am…I'm pretty efficient but she's newer." However, this social worker goes on to say that her colleague is a newer social worker who is more concerned about her performance whereas she is less concerned as she has already established herself and is trusted to "get the work done". This makes sense given new employees desire to fit in and be viewed as good workers. The path from organizational/managerial surveillance to peer and then to self-surveillance described in the chapter on standardization also fits with the literature on performativity. Ball's (2003) views on performativity illuminate the pressure to be viewed as a good neoliberal social worker or nurse captures the complexity of moving from surveillance by management to peer surveillance to surveillance of the self.

In this study research participants were aware their performance was being measured by managers in various ways, specifically in terms of how many "face-to-face" contacts they had daily or weekly with patients and the timely completion of the RAI-MH was part of some social workers performance reviews. Many of them stated that when they have been unable to get all their work done managers have suggested they need to improve their time management skills highlighting the pushback by managers that often results in worker seeing this as a personal issue rather than an organizational concern and so they complete work in unpaid time. This supports the performativity literature which asserts that workers as they struggle to meet organizational and personal values/goals begin to engage in individualized self-doubt and blame rather than seeing this as a matter for public debate.

One social worker claims the result of restructuring is work intensification leading to "less good work" and "more work on the run, in the hallway, as there is less time to sit down with patients and families". Time is an important concept and commodity to consider in increasingly neoliberal, performance driven workplace, leaving workers struggling to align competing values or priorities. It is suggested that time today is made up of quick time and slow time. Quick time is short, intense and used to complete tasks while slow time is time for immersion, building relationships and future planning. The spaces in-between quick and slow time or the natural breaks allow time for reflection and creativity. However, increasingly these natural breaks are now filled up with quick time tasks. For example, checking emails, texting and so forth (Erikson, 2007, Urry, 2000 & Notwotny, 1994 in Kamp, Lund & Hvid, 2010). A study exploring nurse-patient relationships found nurses literally running to complete tasks such as phone calls (*quick time*) so they could spend uninterrupted time listening to their patient's needs and experiences (*slow time*) (Waterworth, 2003). When work intensification and a lack of time leads to seeing patients and families "on the run" therapeutic relationships are compromised and workers have little time for reflection and engaging in collective resistance strategies. In such situations it makes sense that work and reflecting on practice spills over into unpaid time. This will be discussed further in the next section.

There is a difference between performativity and pretending. On the one hand Ball (2007, p.220) suggests that for some workers performativity or the implementation of performative "measures, comparisons and targets" in more regulated workplaces may lead to professionals who prefer structured workplaces flourishing. While on the other

hand many professionals may experience conflict, a decrease in autonomy and "alienation of the self". I argue that those who experience the latter seek to find ways to cope with the tensions between being a good social worker or nurse and a good neoliberal employee. In this study research participants resisted the impact of restructuring by adapting, negotiating and engaging in transparency.

Another key strategy that emerged from the data was pretending. As hospitals become leaner professionals, experiencing work intensification and subsequent clashing of personal and organizational values, must find new ways of coping if they are to remain in their current work environment. During the interviews contradictions arose whereby participants stated values contradicted with their behaviours or actions. For example, stating the RAI-MH did not shape their work practices and then later their stories highlighted the ways in which they had changed their practice to accommodate this new information technology. Or when social workers and nurses who stated they were very active in their unions and encouraged their colleagues to complete union work monitoring forms to support potential grievances themselves engaged in unpaid work. Or when they reported they put patient needs ahead of organizational priorities when it comes to discharge and then later gave examples to the contrary. Finding ways to reduce tensions and cognitive dissonance in order to feel like a good social worker or nurse and a good employee is important. A couple of social workers used the term pretending to describe how they did this while others clearly engaged in pretending without using this terminology. One social worker when asked how she copes with increased workloads

reported, "I just do it." However, as I paused and watched her mull over or reflect on this comment she then went on to say resignedly,

> "You don't really. You just *pretend* to, and you try really hard to, and you work more time than you are supposed to, to get it all done."

Work intensification in a leaned-out health care organization leaves frontline professionals with reduced options and this social worker chose to work longer hours (unpaid) in order to provide good care rather than let patient care suffer. Working extra hours not only conflicted with her beliefs as a strong union supporter but likely led to the questioning of her ability on an individual level to get her work completed within paid time frames. Many of the social workers and nurses engaged in individualizing or engaging in self-blame rather than seeing this as a systems issue.

This concept of pretending was used by another social worker who when reflecting on the "clashing" of organizational and personal values and the "cognitive dissonance" she experienced reported that in order for her to continue to do her job she needed to rethink situations,

> ".. so that I could *pretend* that I was working for the patients' needs but in fact at all times I was conscious that I was actually working for the corporation….that's one of the many reasons why I left working on the in-patient unit ….it's not a very good feeling, yeah, it's like, you know, being a fake, I mean we fake things all the time, you know."

It seems there are limits to pretending. This strategy may help professionals deal with value clashes but when those tensions are to the point of burnout or compassion fatigue a radical change is needed. This social worker seriously considered leaving the profession altogether but found another position within the organization.

This social worker went on to describe the conflict between personal/professional ideals and the "actual lived experience of being employed by a hospital and having to let go off some of your ideals" to protect your own wellbeing. Pretending was one of several strategies that helped her get through the work day.

She went on to elaborate why pretending is a significant dilemma in social work or caring work in comparison to other professions when she stated,

> "I guess people do this in all kinds of settings so it isn't maybe particular to social work but perhaps what's most poignant here is that social workers have usually selected into this field because of, deeply felt personal values, about human beings and human rights and all of that and I don't think it's equivalent to what an accountant feels, I'm not sure that an accountant feels that deeply…it's a more rational approach as opposed to a feeling approach, so yeah, so when you have to *pretend* it just doesn't feel very good."

This same social worker describes how "we pretend all day long…..we couldn't do our jobs, we couldn't function…that's how you get the job done, so there's a lot of acting going on" as she describes working alongside her colleagues and with patients.

While other research participants did not use the word pretending to describe resolving or reducing value collisions the ways in which their stated values and beliefs where at times contradictory to the stories they told about their practice suggested they too sometimes engaged in pretending.

Charmaz (2003) encourages researchers to not only emphasize the overt statements made by research participants but to also look for the unstated, implicit or unspoken. In this study the social workers and nurses all reported their primary goal was to provide excellent patient care, however, upon closer examination there were times

when other processes took priority, such as when expediting discharges to alleviate hospital system pressures or the need for beds to admit new patients to. Or when participants reported their practice and more specifically their initial assessment was not shaped by the RAI-MH and then described incidences when this proved contradictory. These examples illustrate the underlying and often unspoken tensions or dilemmas faced by social workers and nurses and how what is spoken may differ from actions (Goffman, 1989; Charmaz, 2004). In this study my digging deeper into stories illustrating tensions and dilemmas or looking beneath the surface was an attempt to get at these contradictions and unspoken processes and from this the concept of pretending emerged.

Within managerialism and a culture of performativity it is possible to comply with an institution's procedures and also be resistant to those procedures at the same time (Thomas & Davies, 2005; Powell & Gilbert, 2007; Clarke, 2004). The social workers and nurses in this study responded with various strategies in order to deal with the restructuring of their practice. Strategies included adapting, negotiating, transparency as subversiveness and pretending. It may be argued that the refusal to cross work-home boundaries as well as the crossing of work-home boundaries are strategies used to survive or carry on working in the caring professions. This will be further developed in the next section.

7.6 Boundary Crossings and Refusals

Work intensification encourages the crossing of work-home life boundaries in health care. My analysis revealed IT's supports this boundary crossing and therefore assists in the

extraction of surplus labour or the exploitation of some of the social workers and nurses in this study. Many of the research participants indicated they regularly check emails, voicemails and conduct internet searches for example to find resources for patients, outside of paid work time. Some research participants reported the exchanging of emails between themselves and managers on evenings, weekends or during vacation time. While this was not overtly directed by managers there appeared to be a culture where managers themselves had porous boundaries between work and home and thus it was some research participants' perception that this flexibility was expected of them as well by managers and the organization.

The culture of an organization, especially when promoting private sector value-based forms of management, such as team spirit and shared program/ward goals, is often at the expense of overall worker solidarity. Additionally, this may lead to blurred work-home boundaries along with paid work time becoming more intense (Casey, 1999; Aronson & Neysmith, 1997; Garsten & Jacobsson, 2004; Kamp, Lund & Hvid, 2010). There is an expectation by organizations in the caring work sector that employees are flexible, even elastic, in order to continue to meet the needs of clients when resources are limited, leading to the exploitation of workers (Baines, 2004).

One of the promises of IT is to save workers time. However, Sabelis et al (2008) suggest that while the internet has resulted in flexibility for some it also leads to the blurring of work-home boundaries for many others. Additionally, the flexibility of, for example, the Blackberry, is really flexibility for the employer as workers are now instantly accessible inside and outside of paid work hours. In many ways to control time

is to control the worker and information technology supports this, inside and outside of the work site.

Many of the social workers and nurses reported working extra unpaid hours at the work site and had a tendency to blame themselves for this as they believed it was a personal time management issue rather than a problem with workload. One social worker revealed that on an acute ward she,

> "worked probably an average of about 5 or 6 hours of overtime every week at least and that was just to barely keep up, it was pretty hectic, but in order to survive you had to put in those hours or I did anyway. I wasn't maybe as skilled at time management as some of the other social workers but I have a feeling that there's a lot of unspoken overtime."

Some of the nurses indicated they worked between one and two extra hours per day in order to complete their work to the satisfaction of their managers and/or themselves. One nurse describes working at home on reports or projects because, "you've run out of time, you need that space where you are not going to be interrupted (by patient care/needs). She also completes written work tasks at home as it is quieter, without interruptions as she has "no time to think at work".

My study supports the work of Kamp, Lund and Hvid (2010) who describe the ways in which Danish teachers make use of time and in particular how a lack of time to complete work tasks leads to crossing boundaries into unpaid or home time. Additionally, there has been a change from the industrial era when work was confined to a predetermined paid work day and workers were paid for number of hours worked to now when work is more task orientated; management are focused on output (completed tasks

or projects) rather than hours worked. On the one hand it seems as if professionals have more autonomy in terms of how, and when tasks are completed but on the other hand this leads to an emphasis being placed on the time management or self-management skills of professionals leading to the "rhythms of work…becoming increasingly boundaryless" (Kamp, Lund and Hvid, 2010, p.229). When tasks cannot be completed within the paid work day many professionals, such as the social workers and nurses in this study, see this as an individual issue they alone are struggling with rather than a collective problem and so the spilling over into home time is more likely.

Taking on personal responsibility and blame through the questioning of your time management skills and engaging in unpaid work is supported by the literature. Wilder Craig (2007, p.434) a Canadian social worker in her narrative research study reported "the pace of the work left no time for emotional processing" and she moved from self-blame in terms of "not *(being)* efficient enough" or requiring more "time management" skills to recognizing the impact of restructuring, downsizing and shorter lengths of stay which all resulted in work intensification. Also Antle et al (2006) who conducted a quality of life study for the Ontario Association of Social Workers found that 71.6% of respondents engaged in between 1 and 6 hours of unpaid work weekly. This meant an average donation to their respective organizations of $5,824 or $6.5 million in 2005.

In this study social workers and nurses engaged in self-exploitation or the giving of surplus labour was clearly connected to work intensification, managerial expectations and a tendency to take on personal responsibility. Others viewed the "extra" projects and/or committee work as outside of their usual work role. They described enjoyment or a

sense of fulfillment gained from this "extra" work and yet the hospital organization clearly benefited from this creative, unpaid work.

Some research participants' acknowledged their unpaid work was in conflict with their trade union principles. One social worker commented on this unpaid work,

> "it's a real conflict for me because I mean I'm quite a strong Union member and I certainly believe in the (*union*) contract and all of that. Again, sometimes there's a conflict between what's expected (*by managers/organization*) and what you actually do. …I think collectively social workers are quite poor at doing that; we're not terribly good Union members; it's hard for us because we're people pleasers, it's hard for us to, kind of, stick our necks out and say, "Hey we're not doing this" or "we need/ demand overtime". …. even though we have historical roots in Unionism."

The conflict between personal and organizational values means that for many social workers and nurses their personal values, which are strongly linked to their socialization as women and therefore the social construction of caring, leads to their personal values dominating work-practice decisions. They repeatedly commented on managers and the organization being aware of their "caring nature" and taking advantage of this as they attempted to prevent patients from "falling through the cracks in the system". Gender differences have been found in community social service work; women were more likely to engage in unpaid work and use their own money or resources when caring for clients than men (Baines, 2004).

Recognizing the difficulty switching off when the work day is over one nurse stated,

> "I think I'm missing a gene….they *(some of her peers)* can turn it off and work lives in this little box and when they go home they can put work in this little box and never think of it again … I don't have that

> gene in the past they *(management)* didn't like that gene now I see them working from home and on vacation and everything …everything is like water falling down."

The nurse is describing the difficulty she has compartmentalizing her work life from her home life and she clearly sees the spillage into her personal unpaid time resulting from the downloading of work responsibilities from managers onto nurse leaders and nurses. There is an expectation that workers should be as flexible as managers and accept not only the downloading of what was previously managers' responsibilities but also the inevitable spillage into personal unpaid time. This nurse reported she wanted less porous boundaries but the organizational culture is such that a good worker is a flexible worker who completed tasks in a timely manner even if that means completing them at home.

Likely the "missing gene" she is referring to is in actuality the different ways women and men have been traditionally socialized. My findings revealed the colleagues she is referring to that can compartmentalize were men (one man) and younger women. This will be discussed further below. It may be that with advent of third wave feminism the socialization of the younger women social workers and nurses has been somewhat less gendered than previously and also as society moved from single to dual income families the expectations placed on women has changed so that clearer boundaries between work and home are necessary to survive as the following nurse illustrates.

One nurse initially indicated she did not work extra hours, paid or unpaid, due to family commitments which forced her to leave work on time. The juggling and pressure inherent in being a two income family with young children was evident. This nurse stated there was only 45 minutes between the time she arrived home and her husband left for his

job. She did not engage in work tasks at home and claimed to successfully compartmentalize work issues. However, she did go on to report that she regularly missed her lunch and breaks so that she could complete work tasks hence being able to leave work on time or at the end of her paid shift. Workload was such that she did in fact engage in unpaid work; instead of it being before or after her work it was during the work day at the work site.

When I analysed social worker's and nurse's work and personal boundaries there were some interesting age and gender differences. Research participants who had more porous, flexible boundaries tended to be women over the age of forty while those with more impermeable, inflexible boundaries where younger women and the one man (over forty). While unfortunately my sample only included one man he did describe rigid, impermeable boundaries between work and home. This is consistent with the literature which found gender differences between men and women working in the social service sector (Baines, 2004).

Adding to the work of Baines (2004) my findings also indicated the younger women (under forty) tended to have clear, rigid boundaries as they did not work late, did not check emails or voicemails outside of work and also took regular breaks. Interestingly, they were able to compartmentalize and so not think about work/patients outside of work. This seems to be a conscious decision by them as they have come to accept that there will always be work to complete. One younger social worker matter-of-factly states,

> "Basically, the way it is on this unit, the work never ends so you need to be able to accept that."

Another younger social worker captures the stressful complexity of her work suggesting that the only way she pragmatically copes with this is to have impermeable, inflexible boundaries as she skillfully compartmentalizes work issues to prevent spillage into home time,

> "I think what made me do it is the nature of this job. So I know that if I worked say in advertising or web design or something I would be more tempted to spill over my work hours. But it's the issues that we deal with, so the topics of poverty and abuse and marginalization; I don't have the energy or the strength to be thinking about or introducing those topics outside of work hours. So, that's why I would never do it. It's just the nature of the work is too emotionally demanding. Yeah and like I'm here in this hour, I'm here in this day (*to work*)"

Interestingly, this younger social worker seems amenable to crossing the work–home boundary if engaged in a private sector employment but refuses boundary crossing in public sector care work. This distinction is puzzling given that one might expect care workers to be more willing to cross work-home boundaries in order to help meet human needs, even if it's emotionally demanding. Or I would have expected her to say she refuses to cross boundaries no matter what the type of work is. Whereas older workers may be resisting the impact of neoliberalism on patients and so crossing boundaries may in fact be an act of resistance.

As health care becomes more standardized and lean the demands made on workers has increased significantly from twenty or more years ago. Additionally, those who have entered the field more recently seem to view work differently than those who entered the caring professions prior to this work intensification. Senior workers may be striving to

provide the same care (fatter/thicker) they had the time to provide when they embarked on their careers twenty or more years ago. However, with work intensification and likely with recent economic downturns the patients hospitalized have more complicated social factors, while at the same time the competition to access community resources has increased due to the leaning out of services and other austerity measures, than previously.

The social workers and nurses with porous, flexible boundaries also tended to take more personal responsibility for their inability to complete work tasks during paid work time compared to the man and younger women workers. Some of the senior professionals were active in their respective unions and yet engaged in unpaid work and attribute this to poor time management skills rather than work intensification and exploitation. Earlier I described a senior social worker who almost left the profession due to work intensification and overwhelming value clashes and during the interview she asked if the other research participants had also considered leaving the profession. She then insightfully acknowledged that the newer/younger social workers where different from her as they seemed able to leave work at the office and not take it home as she did. She viewed this as a more healthy way of working in today's economic and health care culture.

Personal values, including a desire to meet patient needs despite work intensification along with difficulty separating or compartmentalizing work and personal life seemed to play a role in the porous, flexible boundaries of senior social workers and nurses. However, strategies used by managers to exploit professionals and control their time deserve some consideration as well. Many of the senior professionals described

involvement in activities within the hospital and the academic institution the hospital is linked to that were above and beyond their job description. These activities included various committee memberships (often in lead roles, including Continuous Quality Improvement committees), designing and implementing programs or new therapeutic options (groups, medication protocols), supervising and teaching of learners (presentations/tutorials at the university), research opportunities and so forth. Professionals described the sense of enjoyment and fulfillment these activities provided as well as a belief their involvement would result in improved services to patients. Managers encouraged and supported their involvement in these activities while at the same time using them as a point of manipulation and exploitation, when needed. Social workers and nurses indicated that despite work intensification they are reluctant to complain to managers as, even when managers hand selected them for leadership positions on committees and so forth, this led to managers suggesting they step down from their "extra" responsibilities. This makes sense given the dilemma illustrated below by one social worker,

> "One of the issues with workload is that I am a member of several committees, which is actually an enjoyable thing that takes me away from some of the other stressful things I do and I have no doubt that if I say my workload is really high and I can't handle it that's what they are going to say for me to give up. Ok what can we take off your workload, what about that committee and that committee. So then it (*work*) wouldn't be as enjoyable for me. So it's a catch 22 when it comes to complaining about workload."

The concept of time and worker exploitation is closely linked particularly when work is seen increasingly as a series of projects or tasks to be completed rather than a defined set

of work hours as it was during industrialization (Kamp, Lund & Hvid, 2010). These authors also suggest work time and tasks fall into 5 spheres; scheduled time, learning time, relational time, quick time and slow time. Additionally, professional norms for teachers, and I would argue for social workers and nurses, requires relational time (in patient relationships) and slow time (reflection and creativity) while quick time tasks (RAI-MH, reporting statistics) often need more immediate action and results in the fragmentation of time; more slow time spaces are now filled with quick time tasks. With work intensification the conflict between quick time and slow time increases. In order to deal with this conflict boundary crossings occur and the spilling over into private/home/unpaid time can all too easily become the norm for many social workers and nurses.

7.7 Responses: Covert Rogues and Overt Outliers

A major focus of this thesis was to look more closely at how social workers and nurses respond to changes such as the standardization of their work; with acceptance, compliance or resistance (Casey, 1995). There has been an ongoing debate in the literature regarding the different types of resistance and which may be more effective in which situations. On the one hand it is suggested that collective forms of resistance, through unions or social movements, are more effective (Acker, 2009; Collinson, 2005; Carey, 2008) while on the other hand the importance of individual acts of resistance or small victories are put forward as central (Aronson & Sammon, 2000; Thomas & Davis, 2005). My analysis revealed research participants responded in multiple and varied ways

that appeared to be closely connected to their personal values and how much pushback they believe the organization will tolerate from them.

All of the research participants engaged in covert or overt resistance strategies while describing themselves using terms such as negotiators, subversive, rogue social workers and outliers. Even though some of the participants reported strong links to their unions they did not give examples of collective forms of resistance that would result in larger scale transformations. The majority of the social workers and nurses engaged in what might be regarded as individual acts of resistance. Interestingly a few of them seemed to inhabit the space between individual acts and collective acts of resistance. They covertly resisted individually and yet at the same time found ways to overtly seek changes that would benefit other workers and all patients without jeopardizing their jobs or reputation. I explored these participants in some detail in this chapter in order to learn how they successfully navigated this intermediate space.

On the surface it appeared as if some of the participants where accepting of the RAI-MH as a part of their practice. Earlier I commented on one nurse who reported that when the RAI-MH was first introduced she and her colleagues were accepting, even optimistic that it would add to or improve their practice.

> When it first came out we were all keen, it's like the Stepford Wives, right. Initially it sounds like such a great idea and now I'm digging myself.

However this nurse goes on to comment that as they began using the RAI-MH this attitude of acceptance changed to one of compliance and resistance.

All of the social workers and nurses exhibited an attitude of resistance and in most cases engaged in resistant behaviours. Resistant attitudes include not only negative comments about the RAI-MH but also insisting the RAI-MH did not shape their practice when their practice examples at times indicated otherwise. Resistant behaviours have been noted throughout the thesis; from guestimating, creative writing to acts of subversion. Even those health care professionals who were appointed RAI Champions engaged in attitudes or acts of resistance while on the surface or in dealings with managers appearing to comply. Compliance at best was superficial in that outwardly it looked as if they were accepting but under the surface was resistant attitudes and behaviours.

Casey (1995) stated gender, race and age play a role in the kinds of resistance strategies taken up by employees. Women were more likely to practice covert resistance strategies, such as avoidance of team meetings, in contrast to men who were more likely to engage overtly by vocalizing their critique of the organization. In this study due to the difficulty recruiting men and only having two women of a different race, my comments on gender and race differences are limited. I did find some differences in patterns of resistance. All of the professionals engaged in covert resistance strategies while three of them also used overt resistance strategies (no differences by race, class, gender or profession). I will use the terms covert rogues and overt outliers to describe social workers and nurses who tended to engage in particular acts of resistance. The terms rogues and outliers emerged from the data; they were terms used during the interviews by some of the participants and seemed to sum up differences in patterns of resistance. There

are disadvantages to categorizing participants into either or groups as there is the risk that one pattern may be viewed as superior to the other. Overt outliers described many instances of openly challenging changes at work but they also gave examples of more covert resistance as well. I would speculate that overt outliers may have had more social capital that enabled them to more directly challenge work processes they disagreed with. Covert rogues described more furtive or secret resistance strategies and they did not give any examples of overt resistance during the interviews. However, they may well have engaged in this type of resistance unbeknownst to me.

Below is Table 3 outlining the similarities and differences noted when exploring the characteristics of covert rogues and overt outliers. I would caution that this may oversimplify covert rogues and overt outliers but the hope is that in doing so the value, and the why's and how's, of both modes of resistance will become clearer for professionals who wish to successfully engage in various kinds of resistance strategies.

Rogues – idealistic transformers	**Outliers – pragmatic transformers**
Covert resistance	Overt resistance
Want change - transformation	Want change – transformation
Doubt larger system can change	Expect larger system will change
significantly	Change for all – colleagues/team/patients
Small individual changes through their	Use research literature – evidence based
practice	practice to change policies
Look for gaps in policies	Challenge rules
Bend rules	Feel respected/vital part of team
Don't feel respected/role recognition	Hierarchy–equal to doctors/other
Hierarchy – feel marginalized	professions
Interdependent – prefer peer support	Independent yet team player
Modest/Unassuming	Confident/Self-assured
Feeling orientated	Analytical/rational
Creative writing, guestimating, fiddling	Challenging policies/practice
statistics, ignore/avoid changes	rewriting policies

7.71 Covert Rogues

Participants gave many examples of times they "flew under the radar" or were "rogue social workers". One social worker confidently stated "I think most social workers fly under the radar in some way" while another social worker described the Home First script as a way managers attempted to control their interactions with families fearing they were "rogue social workers". Managements' concern and attempts to constrain resistance or rogue social work did not prevent social workers from finding ways to "push the envelope a little bit…to try to advocate for our patients", by "bending the rules" in various creative ways with much success.

Participants resisted the RAI-MH by delaying RAI-MH training and obtaining RAI-MH passwords. They reported they used delay as a tactic as they believed the RAI-MH would not add to their practice but rather it would keep them from doing the work they considered good practice. Some social workers quietly refused to complete RAI-MH's on patients they had not met, or when workload was particularly high. This led to an unspoken agreement with nursing colleagues who often quietly completed the social work sections of RAI-MH's for social workers. Possible reasons for this type of covert resistance include concerns about performativity and disciplinary measures by management. For some social workers there was a fear positions would eventually be decreased if they didn't do the RAI-MH or were not viewed as essential by team members or managers. Unfortunately in the long run covert resistance strategies may backfire as the organization remains unaware of excessive workloads placed on social

workers and may view the issue as specific to particular social workers who lack good time management skills.

Covert resistance was not limited to the RAI-MH and was described in other areas of social work and nursing practice particularly around long term care and discharge issues. Many participants described exploiting the gaps in policies or procedures, cheating, game playing and ignoring policies so that patients could receive services and items they believed they needed from access to Community Care Access Centre services, to free bus tickets, to free condoms. Participants described their frustration when told by managers that, "it's legislated" and one social workers response was "just because it's legislated doesn't mean it's right". She went on to describe the creative ways she used the gaps in policies to access services needed by patients.

Covert rogues described feeling marginalized in an organization that placed doctors at the top of the hierarchy rather than being equal partners in a health care team. Additionally, they often described feeling their profession was not as respected as other professions. One social worker reported that as "a feminist and a critical thinker it was hard to deal with the inequality on a ward" where nurses acted as "handmaidens to doctors" to the extent that "doctors where a step higher than God in the nurses eyes". It was her hope that through attrition and as new nurses entered the profession this attitude would change.

Some of the social workers in *program managed,* as opposed to social work *department managed*, wards complained about the elimination of social work supervisors or managers and suggested, "The strong voices for social work have left. They left

because they had been overlooked for other things *(leadership positions*)." Prior to program management all social workers were managed by a social work manager and social work supervisors giving the profession a higher degree of autonomy and collectivity despite being dispersed throughout various wards in the hospital. In the early 2000's the psychiatric hospital implemented a business model whereby the social work department was eliminated and was replaced by a program management model. This meant that all the professionals working on the same ward or for the same service within the hospital were now managed by a local manager who was not necessarily a social worker. This same restructuring occurred for nursing, occupational therapy and so forth. Doctors were exempted from this restructuring and they retained their medical department. The ability to keep their medical department was due to the higher status of physicians allowing them to retain more professional autonomy than other professional groups (Grinspun, 2000).

Many of the social workers, reported their profession did not receive the recognition it deserved within a medical organization and they considered social work a marginalized discipline within the hospital. However, Charmaz, (2008) suggests this view from the margins may also open up possibilities for change as workers find gaps that can lead to transformation.

7.72 Overt Outliers

One social worker referred to herself as being somewhat different from her colleagues and described herself as an "outlier". As participants described their experiences at work

and the ways they resisted I found another social worker and a nurse who also appeared to be outliers. While only three of the seventeen participants described using both covert and overt resistance strategies I still wanted to look more closely at characteristics and contexts in an attempt to understand overt response to practice changes. Gladwell (2008) defines an outlier as "a scientific term to describe things or phenomena that lie outside normal experience." In quantitative research outliers may not receive the same attention, even be ignored, as those that fall within the traditional normal distribution. While it is important to find out where for example, the majority of people fall in a range, much can also be learned from those who fall outside of this range.

Overt outliers viewed themselves as an important and equally contributing health care team member. They reported they were respected by peers and management. Outliers felt confident and safe in overtly challenging the system, management and team members. One social worker reported,

> I'm not rude, adversarial, like I'm pretty calm but I will stand my ground calmly….if we as individuals take the initiative and sort of stand firm with those value systems it can help us sort of connect the organizational values with our values in social work".

She also stated that for her negotiating with others while standing by her personal and professional values helped her come to solutions acceptable to all involved.

Another social worker described meeting with the RAI manager at the hospital to challenge some of the questions on the RAI-MH. This resulted in the RAI-MH manager changing or adjusting some of the questions that were inserted by local hospital stakeholders and taking the social worker's other concerns up the RAI-MH chain to the

provincial level. This social worker seemed to have a very pragmatic, transparent approach when engaging in resistance as the following example illustrates,

> I told them (*RAI manager*) that the question about having a birth certificate was ridiculous because we have people that are not born here in Ontario or Canada and they have immigration documents and passports and all of those are valid pieces of ID…They've changed it. Now they were able to change that because it's not part of the big provincial RAI, but there were a few other pieces that I suggested they make changes and they've taken that further.

This same social worker has also challenged the statistical system (GRASP/STAR) that records face to face contacts and specific times spent with each patient. She is not easily deterred when her suggestions are not accepted as the following example highlights,

> I've already put a push in and I went as high as I could to get in-patient social workers not have to GRASP their 7.5 hours. At this point I've got stymied but I'm going back with another approach because I've heard that there are two social workers on community teams who are not having to GRASP their 7.5 hours. So I'm going to track those two people down and get the statistics. …. I took it right to up to the top, to the GRASP people. They took it all the way up to the finance.

She clearly states that she will complain about things that don't work but does it in a way whereby she "can back-up" her concerns and suggest potential solutions. This social worker comments that many of her colleagues do not complain as they believe "this is just the way it is, it doesn't do us any good and nothings ever going to change."

While the covert rogues engaged in individual acts of resistance the overt outliers also acted in ways that sought to invoke change for themselves and others. One nurse described making a "ruckus" when nurses were asked to complete the diagnosis section of the RAI-MH as she states diagnosing is outside her scope of practice. This nurse

commented that "anything that we say that does not go with the flow is being perceived as being negative… Don't come to us (*managers*) unless it's positive". She goes on to give examples of using the research literature to provide evidence when formulating her argument to challenge new or existing policies and practice. She comments on the grey areas of policies, what the social workers refer to as the gaps in policies, and how she works these to the advantage of patients. This nurse recognized extensive practice experience helps her know when it is safe or not safe to bend the rules. It seems that her preferred response or method is to overtly challenge policies and lead the rewriting of policies that are ineffective or unsafe in her experience.

Overt resistance requires research, a strong voice, patience, tenacity, and perseverance, as many changes took 1-2 years to see to fruition. Overt outliers are not easily dissuaded or "stymied" when their ideas are not initially accepted by a manager, they are prepared to take the lead on projects and also seem prepared for it to be a lengthy process. The nurse above stated it took over one year for the new policy she considered her "baby" come to fruition. While a social worker stated it took two years to resolve the power struggle between herself and a physician in order to achieve a less hierarchical approach to team meetings. She reported that other team members seemed surprised that she was willing to take this "project" on and she connected this to her strong value system.

> "I stand by my values. I'm pretty confident in them….I strongly believe having your value system that is about collaboration, cohesiveness, about equity, accessibility, care and passion. When you practice those values usually you have a decent outcome. This is not the only place I have worked. I have worked in some remote difficult places. As long as I can stand firm on those values I've done alright. I've

been able to accomplish."

Her value system enabled her to not only seek equity, collaboration and so forth with regards to patient care but also for herself and her team members. On the one hand outliers came across as independent individuals, in terms of taking on and running with an idea, project, or challenge, while on the other hand they viewed themselves as team players, in fact as an integral part of their health care team. One outlier stated she is not a sheep or follower and was confident in expressing her opinions whether it was agreeing with or disagreeing with others in her team. In many ways the health care team was the outliers collective rather than other social workers or nursing colleagues. The role and expectations of the individual within a team fits with Connell et al's (2009, P. 334) ideas on "fractal organizational logics, such that each part of an organization is a microcosm of the larger unit in which it is embedded". The authors argue this works down from the organization as a whole to the individual worker. Additionally, the individual and the team are to follow a 'profit-making logic" and are held accountable through performance management. Given this neoliberal approach to public organizations it makes sense this social worker identifies more with her team than her social work colleagues scattered throughout the organization.

The nurse outlier also indicated her personal values guided her practice. She described being twelve years old and the impact of a conversation with her brother who was completing his Masters in Engineering. She connected the conversation to a critical thinking class in university. Her brother told her not to trust everything adults say and to always question and,

> "don't speak up unless you know what you're talking about …so that when you formulate your argument you have your backing then you can open your mouth, and I gained the respect of surgeons and people because I won't say it unless I can prove it. And if I can prove it then I can point you in the direction of literature to say, this is what I'm saying."

This nurse was aware of the importance of using the research literature to support her arguments in a workplace that places high value on evidence based practice and thus increased the likelihood of accomplishing the change she wants. Outliers seemed to understand what the organization values and so realize the importance of using the language and resources that would be more likely to lead to change. This picking up or using the master's tools (Lorde, 1984) to make organizational changes may be viewed as both resistance and also the behaviour or performance of the enterprising or ultimate neoliberal worker. Although outliers may initially be viewed as resistant, complainers or bringing negativity to the workplace, the ways in which they operationalize their opposition or dissent is within the acceptable parameters of the organization.

Outliers commented on their colleagues' fears of overt resistance despite being given reassurance by the outliers that they are union members and so dismissal is unlikely if you use the right means.

> "A lot of people will worry about the consequences of being the trouble maker, being the one that challenges and I don't see it as that. I see it as constructive and it will help everyone in the end and that's different."

This outlier indicated she does not take her colleagues and managers opinions or criticisms of her dissent personally, seeing her opposition as separate from who she is as an individual, also noting that she is more than just a social worker as she has a rich life

outside of work. She goes on to comment that her overt resistance is at times "mercenary" as she is always seeking ways to make her life at work easier. This is supported by Carey and Foster (2011) who report that not all resistance is altruistically motivated or linked to anti-oppressive practice or other professional ideologies. For this social worker she was quite open about trying to improve her conditions at work for herself, her colleagues and patients.

The participants who were overt outliers were around 40 years and older, they had long work histories in various areas of hospitals, they exuded an inner confidence, articulated strong personal values, were pragmatic and not deterred when some of their challenging did not come to fruition. They described themselves as independent and not requiring the support of allies as they challenged the system and believed changes would benefit patients and/or their colleagues. Outliers all commented on their extensive experience as an asset in their overt resistance strategies and clearly recognized that "…younger people … (*the*) less experienced perhaps would feel more intimidated by the rules or by the employer". As noted earlier they may have had or believed they had more social capital than their colleagues allowing them to challenge more directly.

One of the outliers recently contacted the hospital's president to challenge an existing policy that she claimed stigmatized mental health patients. She is optimistic her concerns have been heard and the policy will be changed. She displayed confidence and optimism that the policy would be changed and she will be invited to be a part of the committee looking at revisiting the policy.

It appears that overt outliers expect the larger hospital system will change while the covert rogues have doubts the system will change significantly and so the latter focus their efforts on smaller individual acts of resistance. Both forms of resistance have an important place and are supported by the literature in manufacturing and public service work. Resistance is conceptualized and articulated differently in different bodies of literature and is in a continuous process of development. In manufacturing it is characterized as soldiering (Taylor, 1947) and misbehaviour (Ackroyd & Thompson, 1999), while in the public sector it is articulated variously as resistance (Thomas & Davies, 2005; Aronson & Summon, 2000), subversion (Clarke, 2004) and deviance (Carey & Foster, 2011). Resistance encompasses acts or practices, recalcitrant attitudes and emotional responses that challenge organizational policies or required practices (Carey & Foster, 2011).

Ackroyd and Thompson (1999) map out a variety of strategies used by workers that are considered counter-productive or non-compliant behaviours; from small individual resistances to collective action. The authors argue all resistance strategies have a place in the today's workplaces. As management try to increase worker commitment and engagement using the "appropriation of identity" this leads to "clashes with worker identities and interests potentially leading to employee cynicism and so further resistance (Ackroyd & Thompson, 1999; Thompson & McHugh, 2009, p.119; Fleming & Spicer, 2002; Fleming, 2005). Recognizing the importance of all acts and types of resistance I wonder is it possible to encourage and support more overt resistance which seems to

occupy the space between covert and collective resistance strategies? Could the outliers be mentors to other less experienced workers?

7.8 Conclusion

The previous chapter highlighted the assembling of neoliberal professionals through standardization and surveillance strategies. This chapter's focus was on the ways in which social workers and nurses respond to practice changes. I explored how personal, professional and organizational values align and collide. The social workers' and nurses' stories revealed practice moments when values collided leading to tensions or cognitive dissonance and so permitted a detailed analysis of the role values play in resistance. Social workers and nurses on the surface may appear to be accepting or complying with the RAI-MH and other practice changes but are clearly engaged in resistance or dissent on a regular basis.

Strategies such as adapting, negotiating and transparency as subversiveness were used to decrease the tension between personal/professional values and the organizational values. The concept of pretending was put forward as a strategy participants engaged in when values clashed as it allowed them to continue working in a caring profession when at times the organization pushed them to be not so caring. There does seem to be a limit to this pretending and subsequently a risk of burnout or compassion fatigue.

The tension between being a good neoliberal employee and a good social worker or nurse led many professionals to have leaky work-home boundaries. This spillage into personal time was assisted by technology and the expectations of the employer who relied on caring professionals blurring boundaries in order to meet the needs of patients despite

work intensification. Senior professionals, who were women, seemed more susceptible to the exploitation of their time while the younger social workers and nurses and the one man described being more resistant to this form of exploitation due to their more rigid, impermeable boundaries.

The responses or resistance strategies used by social workers and nurses tended to be more covert than overt. The terms rogues and outliers emerged from the data. I used the terms covert rogues and overt outliers to describe the general characteristics or different patterns of resistance described by professionals. While both have an important place and function in terms of resistance in neoliberal health care organizations I sought to reveal how a small number of professionals had found a safe way to challenge the organization without putting their jobs or character on the firing line.

Chapter 8

Discussion

1.1 Introduction

This thesis study is rooted in my social work practice at a hospital in a large urban centre in Ontario, Canada. With the mandatory implementation of the RAI-MH, computer-centred care seemed to be interfering with the ability to provide more client-centred care. This practice tension prompted me to consider what is good social work? In what ways does being a good social worker conflict with being a good employee? The RAI-MH became the gateway into exploring the restructuring and regulation of social work and nursing practice in hospitals with a particular focus on standardization, autonomy and professional responses.

The situation I found myself in was not unusual, especially given hospital organizations' ongoing discourse of quality improvement, along with an emphasis on cost containment. In chapter two my model or map of the competing tensions that impact social work and nursing situated and illustrated the linkages between neoliberalism, work organization (managerialism and lean healthcare), and professional and individual values. Throughout the thesis I moved from the everyday lives of social workers and nurses, or the research data, to the empirical and theoretical literature. This process illustrated how neoliberal ideologies influence work organization strategies, such as lean healthcare management and the impact on professionals and patients. This study's analysis of the complexity of these competing tensions supports the work of Hoggett, Mayo and Millar (2006) who acknowledge the ethical conflicts and dilemmas inherent in public sector

work in the era of neoliberalism. Public sector workers are caught between competing claims including private and public goods, their own interests, their organization's interests, their profession, individual service users, the community and the general public.

The literature from labour process theory, governmentality and performativity positioned my research theoretically as I explored control/power and autonomy/discretion. Synthesizing these theoretical perspectives was, at times, a struggle requiring flexibility and a level of uncertainty as I looked and relooked at the research data that was emerging. At times I reflected and negotiated with myself as to what theoretical approach seemed to fit best where, in my attempt to tell a more complete story. The four point model adapted from Paul Stepney (2006) facilitated the blending of theories from structuralism, poststructuralism and postmodernism. At the outset I acknowledged the potential for deliberate slippages between theories in order to provide a fuller analysis of social work and nursing work in neoliberal hospital organizations. At all times, when I was submerged in the data, theories and the empirical literature I asked myself what is the story I am telling here? Clarke's (2004) suggestion that we be open to contradictions or a "thinking in tension" gave me the permission or freedom to resist the temptation to compel or fit the emerging data definitely into one theoretical approach or another. This discussion chapter will highlight my findings, their contribution to the literature as well as implications for future research and professional education and training. In doing so I will also bring to the fore some of my struggles, "thinking in tension" and slippages that occurred during the research process.

8.2 Client-Centred Care and Computer-Centred Care

While there are some studies discussing the validity and reliability of the RAI-MH, as well as studies using the data from these instruments to pursue various arguments (Hirdes et al, 2002, 2009; Martin et al, 2009; Martin, 2005; Seto et al, 2004), there is a scarcity of literature on the experiences and opinions of professionals completing the RAI-MH. It is to this underdeveloped and under –theorized space that this thesis speaks. The shaping or assembling of neoliberal patients and neoliberal professionals were major themes emerging from the data. Social workers' and nurses' stories about the ways in which they completed the RAI-MH illustrated how computer-centred assessments and computer-centred care have the potential to render patients' stories or life experiences into bits and bytes of data used in funding formulas. This type of assessment is not helpful when attempting to build therapeutic relationships and collaborate with patients around care planning. My findings support the work of other Canadian (Campbell & Gregor, 2002; Kontos et al, 2009) and British (Lambert et al, 2009) researchers who have critiqued the use of MDS instruments in long term care.

Seeing patients as commodities aligns with neoliberalism and specifically with lean healthcare management strategies that emphasize "pulling" patients through the hospital system in much the same way as cars on an assembly line supporting a view of patients as commodities. Professionals are implicated in this commodification of patients and play a significant role in governing or shaping individuals into neoliberal patients. While I appreciated the candour of the research participants who were aware of their role in governing and who might be said to be "a critic of an authorized view" it was more of

a struggle for me personally when listening to those who appeared to be "unwitting participants" (Campbell & Gregor, 2002). I worried if my asking questions or probing too much might disrupt people's sense of themselves and their work and create tensions where previously none existed. I did not want the interviews to feel like a cross examination or feel like I was judging their practice choices or knowledge about the broader health care system and the politics that influence its delivery.

Social workers and nurses gave examples of times they used their clinical judgement, experience and the spaces or gaps in policies in order to provide more client-centred care. They all clearly wanted to be good social workers and nurses and found their work with patients rewarding. Linking daily practice to work organization strategies and government regulation provided an opportunity to illustrate how ideology and policies developed far from the local site are used to govern patients and professionals.

The RAI-MH is representative of the strategies used to transform the welfare state into a culture of audit that regulates and reshapes the relationship between health care workers and patients while at the same time discounting or making invisible larger systemic and political issues. The professionals in my study questioned how budgets can be cut or contained while management continues to insist that health care practitioners can and must provide excellent care. One of the ways the organization is trying to make this possible is through lean management strategies and, subsequently, through work intensification. Some of the professionals who feared the RAI-MH statistics may potentially lead to future job cuts, attempted to minimize this by learning which of the RAI-MH questions, on the form, had the most impact on funding. Practitioners ensured

that they filled out these questions accurately, or even a little "creatively", in the hopes that this might increase job security in their profession and other health care professions. This response or resistance strategy raises tensions or contradictions as it is only possible for them to undertake this kind of practice because of the freedom or discretion to be an enterprising professional that still exists in the hospital. This will be discussed further in the next section on control and autonomy.

Hospitals use multiple strategies to improve efficiency and quality through regulation and this has implications for social work and nursing practice, education and training. In response to this critical theorists, academics and practitioners must address and make transparent that the claims to improve efficiency and quality in actuality means work intensification at the expense of the therapeutic relationship in mental health. The organizational agenda to further regulate professionals in order to improve quality and cost efficiency, strengthens the current drive to define professions in terms of narrowly defined and quantifiable competencies. My concern is that, all too easily, the RAI-MH may become viewed as a required competency for new social workers and nurses and that this will displace the traditional narrative interview which actually requires far more skill and experience in order to do well.

The professionals in this study had mixed views about having students complete the RAI-MH's during their required, learning placements. On the one hand some social workers and nurses indicated that it is one of the work tasks that social workers and nurses have to undertake regularly on the job and thus students should learn how to complete it. On the other hand the majority of professionals feared that by teaching

students how to complete the RAI-MH, the students may see it as more important than the more complex interviewing skills required by traditional narrative assessments. I would contend that it is possible to include the RAI-MH as part of the student placement but it needs to be undertaken in a way that teaches students to become critical practitioners; critically examining aspects of work rather than automatically accepting new policies and procedures. This is an opportunity to open up a discussion regarding professional responses (and resistance) to restructuring and regulation as well as the perils of a competency-based profession.

One of the ways this can be accomplished is through Stepney's (2006) four point guide when a problem, dilemma or incident arises in practice. Stepney's guide is not only useful for students but also for practicing social workers and nurses, who may have a tendency to self-blame when system issues inhibit their ability to keep up with their work, or when new practices further intensify and alienate work, such as the introduction of the RAI-MH.

8.3 The Dance between Control and Autonomy

My findings suggested that as social workers and nurses experience increasing standardization and control over their work processes, some sought other avenues in which to increase autonomy or discretion. In other words, as areas of their work became routinized and deskilled, some professionals found venues that encouraged upskilling. I challenged Carey's (2007) observation that in standardized and deskilled workplaces, the upskilling of professionals leads to learning new skills that are mundane and detached

from a social worker's professional role. This may be true to some extent, especially when learning to use new IT's. However, I illustrated that in high performance or lean workplaces, through Continuous Quality Improvement committees and involvement in other special projects, professionals have the opportunity to learn skills formerly associated almost exclusively with a manager's role. Some social workers in this study referred to their roles as "informal leaders" on various quality committees and enjoyed the opportunity to increase skills and autonomy. However, I argued that these opportunities create "extra work" with no extra time, financial compensation or definite promotion. While some upskilling may occur and autonomy is increased, it is often at the expense of further exploitation by the employer and self-exploitation.

Lean healthcare management strategies include value mapping and Continuous Quality Improvement committees whose goals are to harness employees' creativity in order to perfect the work process. Individuals drawn to care work tend to value relationship building and social justice (Lindsay, 2009; Baines et al, 2012). My findings support the work of Baines and her colleagues that these very values may lead to further exploitation by the employer. For instance, with lean health care professionals' values and creativity is extracted resulting in "extra work" and work intensification which in turn may lead to spillage into unpaid time or boundary crossings. This appears to be an attempt by professionals to limit the impact of lean on patients and to increase their autonomy. Boundary crossings and refusals will be discussed in more depth in a later section of this discussion.

These findings and analysis add to the discussion in the labour process theory, governmentality and performativity literatures regarding the complex relationships between control/power and autonomy/discretion. By examining moments of alignment and collision in personal, professional and organizational values I was able to highlight many of the factors that came into play in care work in the context of lean and the use of tools such as the RAI-MH. At times social workers and nurses relayed values and practice stories were contradictory thereby illuminating the complexity of power and discretion and thus the occupying of multiple subjectivities (Foucault, 1997; Butler, 1998; Gilbert & Powell, 2010; Powell, 2012; Gibson, 2013). Given this it makes sense how good social workers and nurses and/or enterprising professionals may be implicated in the governing of patients and still continue to do good work at other levels of practice. The professionals involved in this study seemed to genuinely want to do good work with patients and also wanted to remain employed by the hospital and when these two came into tension or collided they engaged in various strategies to enable them to do this. At times, the professionals in my study were good social workers and nurses as well as good enterprising employees, seemingly knitting together contradictory aspects of identity, compliance and resistance. It seemed possible for them to simultaneously engage in various resistance strategies and continue to be viewed by the hospital organization as complying with restructuring and regulation. This aligns with the observations of Powell and Gilbert (2007, p.199) that one performance may comply with procedures while another performance finds a space to be resistant. The authors argue it is possible to be the "consummate professional social worker" and be a "radical political activist."

Unlike Casey (1995) I did not find any professionals who clearly accepted organizational changes. A couple of nurses seemed to be accepting, when they completed the RAI-MH with the patient present as per the ward norm, but as their research interviews progressed it became clearer they may have what Carey and Foster (2010) refer to as "recalcitrant attitudes" towards the RAI-MH, reflecting a willingness on some level to deviate from managerialised notions of acceptable practice and outcomes. All of the social workers and nurses described various resistance strategies they engaged in with the RAI-MH and in other areas of their work.

Hospital organizations engage in many different strategies to improve the performance or exert more effort from employees, and in turn employees find various ways to resist these strategies in order to increase or maintain their own autonomy, discretion and sense of themselves as ethical people and professionals. All of the professionals in this study participated in small individual acts of covert resistance. The term "covert rogues" emerged from the data, reflecting the workers' sense that their resistance was rarely detected by management and when it was, it was tolerated as the act of someone slightly out of line but requiring only minor correction. Covert rogues engaged in adapting, negotiating and transparency as subversiveness. They used the gaps or spaces in policy and practice to resist restructuring and regulation.

A few of the research participants also engaged in overt strategies and the term "overt outliers" came out of the data, reflecting the workers' sense of themselves as unique and alone in their particular resistance strategies. Overt outliers seemed to fruitfully navigate the space between small scale covert strategies and larger scale

collective resistance. Rather than exploit the gaps in policies these individuals vocally and directly challenged and strove to change policies. Overt outliers used the master's tools (Lorde, 1984), or in other words used evidenced based literature and language, suggesting they were both resistant and enterprising neoliberal professionals, as their dissent was still within the parameters acceptable to the hospital organization. In this instance, the data once again illustrates the fluidity and holding of multiple subjectivities among those participating in this research project. The subjectivity that came to the forefront seemed dependent on the particular context in which they found themselves in. Aronson and Smith (2011) refer to the process of "morphing" or the ability to know which strategic performance is required depending on the situation or context.

My comparison between covert rogues and overt outliers created tensions for me. On the one hand I hoped that clearly highlighting their differences in a table would lead to a better understanding of how covert rogues might successfully use the strategies engaged in by overt outliers. However, on the other hand my desire to categorize research participants into rogues or outliers resulted in tension as I did not want it to appear that one was more superior to the other. Rather my hope was to highlight the characteristics and factors that seemed to come into play for the covert rogues and overt outliers. I acknowledged that both modes of operation are beneficial while resisting the temptation to fit participants into rigidly defined categories. Ironically, the temptation *to fit* participants into binary categories is in tension with *my reluctance* to fit patients into discrete categories in the RAI-MH. On a more theoretical level this may be related to a moment or instance of "thinking in tension" where the differences between a more

structural or modernist approach clashes with a more post-structural or post-modern standpoint.

The concept of pretending emerged from the data as another strategy some professionals use to deal with significant value clashes, in order to continue working for the hospital. Two social workers coined this term when describing a coping strategy they used when experiencing tensions between what they considered good practice and the pragmatic practice they engaged in due to organizational pressures. It appears that other research participants were at times also engaging in pretending as a way to cope with tensions or value conflicts. Pretending is an internal process and is about believing and acting as if you are able to deal with work intensification, meeting the needs of patients, or that you are working to meet patients' needs rather than the organization's needs. There appeared to be limits to the effectiveness of pretending, as one social worker who used this strategy described a point where she considered leaving the profession altogether. Another social worker talked about pretending in the context of "the pressure from the hospital is to do more, do it better, do it with less and add some research to it" which links back to the ethos and mantras of lean management. According to this social worker the consequences of working at the accelerated pace demanded by the hospital is likely to lead to staff burning out faster, taking more extended sick leaves, retiring earlier, and leaving for other employment.

While I welcomed the forthrightness of those who describe using "pretending" as a way to cope with and resist the agenda of lean, as it enriched my data, I also recognize that this openness placed them in a psychologically or emotionally vulnerable position.

Given the value system held by most care professionals, it must be demoralizing to admit to pretending, as it seems to present a moment in which the individual faces the reality that they do not always provide client-centred care and do indeed put organizational values ahead of patient care. In some ways being an "unwitting participant" is protective while pretending is emotionally risky or dangerous if performed knowingly or consciously. Pretending may result in the questioning of the social worker's character by others and by the social worker herself. Sennett (1998) suggested that one of the consequences of new capitalism is the corrosion of character especially those qualities that connect individuals to one another and give us a sense of who we are.

The findings noted above have implications for social work and nursing practice in mental health as well as more generally in the education and training of health care professionals. Hospitals and other non-profit workplaces continue to adopt private sector strategies such as lean restructuring and regulating professional work in terms of control and autonomy in the employment relationship. Social work and nursing may benefit from a fuller understanding of various resistance strategies. In particular, the ways in which covert rogues operate mostly under the radar in organizations as well as the contexts in which overt outliers find ways to occupy the space between small individual acts of resistance and larger scale collective acts of resistance. Whether we consider overt outliers dissidents or enterprising professionals, or both, they do find ways to successfully challenge policies and practices in ways that improved patient care, and their own and their colleagues working conditions. How this becomes translated and implemented into university and college course may be challenging especially at the undergraduate level.

Its importance cannot be underestimated, given the findings of this study which illustrated the tendency of some professionals experiencing work intensification to blame themselves for not having good time management skills rather than seeing this as a structural and organizational issue potentially leading to their exploitation.

The question of how to incorporate pretending into professional development and the education and training of social worker and nurses is more complex. Social work is about relationships and in particular authentic relationships between professionals and their clients and I struggle as to how this information might be best circulated to those who engage in care work. It seemed that senior social workers engaged in pretending in order to cope with work pressures while younger professionals acknowledged their inability to do it all more matter-of-factly. On the one hand it may seem advantageous, even healthier, that younger professionals are able to set boundaries and compartmentalize work and home compared to their senior colleagues. On the other hand some might suggest that this detachment may be detrimental to the profession as a whole because when professionals accept that this is just the way it is working here this leads to de-politicization rather than viewing managerialism or lean as political. Aronson and Smith (2011, p.446) remind us "of the neoliberal threat to critical practice." Additionally, the authors remind us that Clarke (2004, p.113) argues the main goal of managerialism is to "take the 'politics" out of policy and practice choices".

Connecting the concept of pretending to the literature on ethics and integrity might be a way to disseminate this finding, especially in educational settings. Banks (2008, 2010) has expanded the social work discussion on traditional professional ethics to

include more than professional conduct and decision making models by linking it to the literature from moral philosophy and politics. Banks (2010, p.2168) argues that professional integrity should include "morally right conduct; commitment to a set of deeply held values; and a capacity for reflexive sense-making and reliable accountability." Situating pretending within the context of neoliberalism, which undermines personal and professional values, will perhaps highlight the threat under which the health care professions find themselves. This aligns somewhat with Sennett's (1998) ideas on the potential corrosion of character under new capitalism. Banks (2010, p. 2182) suggests one of the ways to defend against this threat is to ensure the qualities or characteristics of good practice or integrity are "located within a set of political commitments to resist neoliberal policies and practices".

Social Workers and Nurses Responses; Boundary Crossings and Refusals

Boundary crossings and refusals are resistance strategies that professionals in this study used to deal with work intensification and competing value tensions. It is suggested that women are more likely than men to blur the boundary between work and home by participating in unpaid labour (Aronson & Neysmith, 1996; Baines et al, 2012). Baines et al. (2012) suggest that women working in direct contact with clients resist performativity through self-sacrificing. The findings in my study add to this discussion as I suggest something different may be going on between more senior social workers and nurses and their younger colleagues. Senior social workers and nurses involved in this study did

indeed blur, cross and re-cross the boundary between paid and unpaid care, while the younger women and the man in this study had clearer, almost rigid boundaries.

Senior professionals may be crossing these boundaries to continue to provide care to patients in the ways that are similar to the kind of care that was possible in the past. These workers provide the older model of care despite current work intensification and constrained resources. Many senior professionals reported that managers and the hospital organisation were aware of their 'caring nature" and took advantage of this. In other words, managers knew that professionals would ensure patients continued to receive good care despite work intensification and limited resources, and actually depended on their willingness to undertake unpaid care in order to stretch constrained resources. Senior social workers and nurses assigned blame to themselves when work tasks were incomplete by seeing this as a personal failure rather than an organizational issue. Boundary crossings may be a form of exploitation by the employer, as well as forms of self-exploitation and resistance to neoliberal restructuring. Boundary crossings where supported by IT such as voice mail and computers, meaning that work could be completed outside the hospital and covertly encouraged by some managers.

On the other hand, refusing to cross boundaries between paid and unpaid work may also be considered resistance. Younger professionals and the one man reported that work in leaned-out hospitals was never ending and they had learned to accept this and deal with it. My findings indicated that the younger professionals reported that they had to deal with difficult social issues, such as poverty, abuse and marginalization, that they felt were too emotionally demanding to bring home or into unpaid time. Hence, they had

to compartmentalize or leave the work at work rather than risk becoming overwhelmed by it.

The differences between the senior and younger women may also be due to differences in the socialization of women. It was clear that the younger women and man viewed work differently than their senior colleagues. They were able to clearly separate work and home. Older social workers were aware of this, as one senior social worker insightfully commented that the younger social workers were different than her as they were able to leave work at the hospital and not take it home as she did. The older social worker saw this is a more healthy way of working in today's hospital cultures. As I discussed earlier in some ways it may be healthier for the individual practitioner but leads to all kinds of questions related to the de-politicizing of lean or managerialism and the impact on policy and practice and on the health care professions as a whole.

My findings suggest implications for both education and training of professionals and future research. Firstly, a potentially fruitful research avenue to be pursued is boundary crossings and refusals. Previous studies have suggested there are differences in resistance by gender, race and class (Casey, 1995; Lumby, 2009). My study revealed differences by age and gender (one man) but no key differences by race and class was found. While my study provided very rich and detailed data, it was limited in terms of the number of males and individuals from various races. As noted in the methods chapter, in order to ensure confidentiality, some of these differences needed to be omitted or minimized in certain quotes or circumstances due to the possibility that such small numbers may mean that it is possible to discern the identity of participants. Future

research might include a larger more varied sample to see if my findings will be substantiated or disputed.

Secondly, differences in critical thinking between social workers and nurses arose in the study. I wondered if this was due to the different knowledge and ethics basis of these professions. Unlike nursing, social work's code of ethics in Canada and Ontario contain specific references to social justice (OCSWSSW, Code of Ethics and Standards of Practice, 2008). The data suggests that the social workers understood and engaged in more critical thinking, which is often seen as an opportunity to link practice, policy and social justice issues. However, it may also be that the difference was in the training of nurses; some of the RN's were college trained while others had university degrees. Critical thinking was an interesting area that emerged from this study and would benefit from further research given that work intensification leaves little time for reflection and critical thinking during paid work time. This might also incorporate the work of Banks (2008, 2010, p.2168) on professional integrity and in particular "reflexive sense making and reliable accountability". Professionals need time to do this reflection and this becomes more difficult in lean workplaces where slow time (relationship building) is not as valued as it was in the past.

Time was another interesting aspect that emerged during the interviews. I began to situate this in the current literature and it seems this is an area that is under developed with regards to social work and nursing work. Given that professionals complained of never having enough time, and took personal responsibility for not having good time management skills, it would be useful to explore how they spend their time during the day

and evaluate the changing parameters of time in care work under managerialism. Kamp, Lund and Hvid (2010), in their study of teachers and time, discussed different types of time as well as how time has changed as we have moved from industrial (pre-set number of work hours/labour) to post-industrial time (tasks to be completed by professionals) and "boundaryless work" or spillage into home time in order to complete work tasks.

Lean management's goal of eliminating variability and waste in the pursuit of continuous quality improvement or perfecting work processes directly links to professionals' use of their time in the workplace. As I discussed in the literature chapter, there is research exploring the implementation of lean into health care but a scarcity of studies examining the experiences of professionals and patients as hospitals continue to adopt lean management strategies. The focus of this study was the RAI-MH but during the interviews lean management strategies were mentioned by the participants. Research focused on the leaning-out of different departments or services, including professionals' experiences and opinions, would be beneficial given that the current research generally focuses on efficiency and monetary savings. Of particular interest are the Continuous Quality Improvement committees as this was where the professionals in this study indicated being able to increase their autonomy and discretion. Are hospital Continuous Quality Improvement opportunities for bottom up ideas and decision making or do they continue to use top down management to select change processes? While this study through the qualitative interviews presented rich information allowing the exploration of social work and nursing work it also opened up many questions and avenues that may be pursued in future projects.

8.5 Methodological Tensions

In an earlier chapter of the thesis I explored my role as an insider and the potential advantages and disadvantages of this position. Throughout this discussion I have addressed some of the complexities of my insider status and the resulting tensions for me as a researcher and social worker practicing at this hospital site and will take the opportunity to develop these tensions a bit further. My insider position assisted me in collecting such rich information or data from the research participants. My familiarity and understanding of their daily work helped to build rapport during the interview and this in turn facilitated open communication. At times some participant's openness surprised me especially around the value collisions, resistance strategies and particularly the concept of pretending. Immediately following the interviews I wondered if it would be difficult for them to meet me in the future given their candour. While I do not work directly with the research participants the nature of the work site is such that we are likely to meet at some point.

More recently I have met the social workers who talked about pretending and I did not notice any awkwardness. However, as I begin to disseminate the findings I do wonder about what their response might be to my final analyses or interpretation of their comments. The rich information they provided me with illuminates important processes and yet I do not wish to put individuals at risk or have their covert resistance strategies blown. Although I would speculate, and labour process theory would support, that if their resistance strategies came to the attention of management these creative individuals would find new ways to resist managerialisms's impact on their work.

I elected to interview social workers and nurses as they complete the majority of the RAI-MH and have many commonalities when it comes to gendered care work. At the outset I stated one of my goals was to avoid slipping into a "them and us" typology were nurses were compared to social workers rather than the object of study being primarily work processes or completing the RAI-MH. I wanted to try and avoid an "analytic drift" (McCoy, 2006, p.109) leading to an analysis of individuals/professions rather than the organization and how it structures work processes. I acknowledge some slippages, even intended comparisons, such as when I discussed inter-professional tensions or critical thinking. However, my hope is that I articulated, even in these instances, that the critique and focus remains on changing labour processes and professional and individual identities or the institutional relations that give rise to these conflicts, differences or tensions.

8.6 Concluding Remarks

As noted in my introduction and explored in the findings chapters, the idealized knowledge worker is highly skilled, flexible, creative, mobile, perpetually learning, productive and efficient (Florida & Martin, 2009). However the realities faced by many standardized, increasingly regulated and leaned-out health care professionals is work intensification, including increased responsibilities (further autonomy but simultaneous exploitation), a decrease in autonomy in some areas of their work, exploitation and alienation through efficiency driven computer-centred care rather than client-centred care. While acknowledging there are nuances and thus these attributes are more complex, they

do serve as a stark reminder of the gap between the promises of 21st century work and the realities for many.

At the level of theory, this thesis drew together concepts from labour process theory, governmentality and performativity. This blending of theories, although not seamless and at times fraught with tensions, provided a fuller understanding of the relationship of control and autonomy, or power and discretion to frontline social work and nursing work. Professionals are mandated to document their work in ways that narrows care content, increases and intensifies their workloads, increases alienation and requires them to collect data or information that may be used to further speed up their work, lead to job losses and/or cut funding in other ways and value collisions. Though not the main focus of this thesis, the RAI-MH leads to the standardization of mental health patients or the construction of neoliberal patients, whose narrowly defined needs can be quickly addressed within a resource-constrained and lean health care organization. As lean management and other human resource management strategies are adopted in health care, the bulk of the negative impact is experienced by patients and health care workers. This is unlikely to lessen as austerity measures are implemented in order to become more lean and efficient in what now looks like what will be a lengthy period of constraint and cutbacks. However, neoliberalism is not a completed project, nor is it ever likely to be complete, given the responses and resistance from citizens and public sector workers individually and collectively.

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Appendix A: Womack and Jones - waste in health care

<u>Seven Wastes of Healthcare</u>

Waste	Definition	Examples
Overproduction	Redundant work	Duplicate charting Multiple forms with same information Same questions asked repeatedly
Defects	Work that contains errors or lacks something of value	Medication errors Missing information Wrong patient
Inventory	More materials on hand than are required to do the work	Overstock of linen, pharmacy, supplies
Processing	Activities that do not add value from the patient patient perspective	Redundant information gathering Missing medications
Waiting	Idle time created when people, information, equipment or supplies are not at hand	Waiting for others at meetings, surgeries, or procedures, reports, test results
Motion	Movement of people that does not add value	Searching for information Looking for supplies and people
Confusion	People doing the work are not confident about the best way to perform tasks	Unclear MD orders Unclear route for medicine administration Unclear system for indicating charges for billing

Source: Jimmerson, C. (2004) cited in Snyder & McDermot (2009).

Appendix B: RAI Core Items List

The interRAI suite of assessment instruments.
(Adapted from Table 1 in Hirdes et al, 2009, p.7)

Instrument	Target Population	Item Count
RAI LTCF Long Term Care Facility	Residents of nursing homes or chronic hospitals	257
RAI-AL Assisted Living	Assisted living facilities where residents have light care needs	262
RAI-AC Acute Care	Frail older patients in acute care hospitals	96
RAI-PAC Post-acute Care	Rehabilitation and other post-acute inpatients	214
RAI-HC Home Care	Community based care	253
RAI-CHA Community Health Assessment	Community settings with anticipated light care needs	135
RAI-PC Palliative Care	Palliative care in community and institutional settings	194
RAI-MH Mental Health	**Mental health inpatients**	**304**
RAI-MH Community Mental Health	**Community mental health services**	**320**
RAI-ID Intellectual Disability	Persons with intellectual disability in community and facility settings	287

Appendix C: Letter of Information

Title: Computerized Assessments for Mental Health Inpatients Beds
Investigators: Laura O'Neill, M.S.W.
Ian Smith, Ph.D.
Donna Baines, Ph.D.

Letter of Information

The purpose of this research is to explore the experiences of staff working in the area of mental health. In particular I am interested in the impact of computerized reporting systems, such as the Resident Assessment Instrument - Mental Health (RAI-MH) on your practice. The RAI-MH was mandated by the Ministry of Health and Long Term Care in the fall of 2005 and as yet there has been no research in the literature to elicit the experiences and opinions of frontline workers on the impact of this tool on their practice. This research is an attempt to address this gap in the literature and in so doing increase our understanding of computerized reporting systems within mental health. Therefore, I believe your knowledge and experience of this subject will be a valuable asset in exploring the recent trend to mandate computerized reporting systems in healthcare.

In participating in this study you will be asked to meet with myself for one interview that will last approximately one hour. You may choose the meeting place (on site or off site, wherever is most convenient for you). During the interview you will be asked questions about computerized reporting tools and your practice.

Your participation in this research will be kept confidential. Every care will be taken to respect your privacy; no identifying information will be kept or included in any reports generated from this research. All the information you provide will be kept in a locked filing cabinet in a locked office that only I, Laura O'Neill, or my supervisors Dr. Donna Baines and Dr. Ian Smith will have access to.

You have the right to withdraw from the study at any time and in doing so you can also request to have your data withdrawn from the study without reprisal. You have the right to withdraw your data from the study up until the first draft is written. You have the right to refuse to answer any question asked of you. The interview will be audiotaped with your permission so that the information can be accurately transcribed. At the completion of this study all transcripts and tapes will be permanently destroyed.
It is important that you feel no obligation to participate in this study. If you are interested in participating please read the consent package, ask questions and if you are agreeable sign the informed consent package that will be provided before the interview proceeds.

This research is being supervised by Dr. D. Baines, Professor in the School of Social Work at McMaster University and Dr. I. Smith. The results of this research project will be

submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements of the degree of Doctor of Philosophy.

Should you need any more information regarding this study, please contact:

Laura O'Neill, MSW RSW
Dr. Donna Baines
Dr. Ian Smith

If you have any inquiries regarding your participation in a research study, please feel free to contact

Office of the Chair of the Research Ethics Board.

Appendix D: Consent and Participant Information Package

<u>Participant Information Sheet</u>

Title: Computerized Assessments for Mental Health Inpatients Beds

Investigators: Laura O'Neill, M.S.W.
Ian Smith, Ph.D.
Donna Baines, Ph.D.

Name of Institution: McMaster University
1280 Main Street, West, Hamilton, Ontario.

You are being invited to participate in a research study conducted by Laura O'Neill, a student of the School of Social Work at McMaster University, Hamilton because you are a healthcare worker who has experience in using the RAI-MH. Results of this research project will be submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree Doctor of Philosophy.

If you have any questions or concerns about this project, please contact my research supervisors;
Dr. Donna Baines
Dr. Ian Smith

In order to decide whether or not you wish to be involved in this research project, you should understand what is involved and the potential risks and benefits. This form gives detailed information about the research study and this will be discussed with you. Once you understand the study you will be asked to sign this consent form if you wish to participate. Please take your time to make this decision.

What is the purpose of this research?
Over the past few years there has been an increase in the use of computerized reporting systems within healthcare for both assessment and accountability. These include STAR and more recently the Resident Assessment Instrument - Mental Health (RAI-MH). I am interested in exploring the impact of the RAI-MH on healthcare workers and their clinical practice.

What will my responsibilities be if I take part in the study?
If you volunteer to participate in this study you will be asked to meet with myself, Laura O'Neill, to participate in a single interview that will last one hour. It is a semi- structured interview and so I will ask broad questions and you will also have an opportunity to describe narratively your experience. You will be asked questions about the impact of computerized reporting tools on your day-to-day work. The questions will include the following, your role and if and how you have adapted your practice to accommodate

computerized reporting tools, whether this has had an impact on how service is provided to patients and so forth. The interview will be audio taped and transcribed with your permission. Your name will not be on the audiotape or on the transcripts.

Where will the interview take place?
The interview place will be arranged at a time and place that is most convenient for you. This can be arranged on site or off site.

How many people will be in this study?
This is a qualitative study and it is hoped that there will be approximately 40 participants.

What are the possible risks and discomforts?
Your name, employer or work location will not appear on any part of this project. Your confidentiality will be secured by not using names or other identifying personal information. People may be identifiable by the views they express. Every caution will be taken to avoid participants being identified. For this reason you can choose the level of your participation. You are not required to respond to any questions you do not want to.

What are the possible benefits for me and/or for society?
Your participation in this study could lead to a better understanding of the role of computerized assessments in health care. Also, this study may help in directing future research on the impact of computerized assessments and therapeutic relationships.

While you may not directly benefit from this research it is hoped that when the research is completed it will be disseminated via presentations, conferences and journal articles. Thus you will hear the views of mental health staff regarding computerized assessments and how staff has attempted to adapt their practice to meet these new demands.

What information will be kept private?
Participants will not be named in the study and personal identifiers will not be used. Any information obtained in connection with this study that can identify you will remain confidential and will only be disclosed with your permission or as required by law. The interview will be taped and the tape will be transcribed. The data will be stored in a locked filing cabinet in a locked room and will be destroyed when the study is completed. Myself, Laura O'Neill, as well as my supervisors, Dr. Baines and Dr. Ian Smith will have access to the data.

If this study is published your name, work location or employer will not be used and no information that discloses your identity will be released.

Can participation in the study end early?
You can choose whether or not to participate in this study. You are under no obligation to participate. If you do volunteer to be a participant in this study you can withdraw at any time without consequences of any kind. You may also request the removal of your data

from the study without consequences of any kind up until the first draft is written. You may also refuse to answer any questions you do not wish to answer and still remain in the study. The researcher may withdraw you from the research if circumstances arise which warrant doing so. Choosing not to participate will in no way affect your standing as an employee.

Will I be paid to participate in this study?
There is no monetary compensation for participating. A summary of the results will be available to you upon request at the end of the study.

What are my rights as a research participant?
You may withdraw your consent at any time and discontinue participation without reprisal. You may request to have your data withdrawn, returned or destroyed at any time. The study has been reviewed and received ethics clearance through the St. Joseph's Healthcare Hamilton Research Ethics Board. If you have questions regarding your rights as a research participant, please contact:

Office of the Chair of the Research Ethics Board

Where can you call if you have any questions or problems related to this study?
If you have any questions about this research study now or later, please contact:

Laura O'Neill
Dr. Ian Smith
Dr. Donna Baines

CONSENT STATEMENT

SIGNITURE OF RESEARCH PARTICIPANT:

I have read the preceding information thoroughly. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand I may review my transcript for inaccuracies. I agree to participate in this study. I understand that I will receive a signed copy of this form.

____
Name of Participant

______________________________ ______________
Signature of Participant Date

SIGNATURE OF INVESTIGATOR:

In my judgment the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in a research study.

____
Name of Investigator

__________________________________ _______________
Signature of Investigator Date

Appendix E: Initial Interview Guide

Interview Guide

This interview is being conducted to learn more about the impact of computerized reporting systems, such as the Resident Assessment Instrument - Mental Health (RAI-MH), on your day-to-day work with patients. You have received, reviewed and signed a consent form to participate in this interview. The interview will be taped and transcribed with your permission.

Broad areas for questions and probes include the following:

1. What computerized assessment and reporting instruments do you currently complete?
2. Describe the impact of these instruments on your daily work?
3. What are the benefits of these instruments?
4. What are the disadvantages of these instruments?
5. Who can you talk to about the use of these instruments?
6. Are there sources of tension in your work related to computerized reporting instruments and if so what are they?
7. Does the use of standardized forms increase work demands on you and does this impact patient care? If so how do you manage this?
8. In what way has the collection of this data impacted clinical decisions, by you, by others, by managers, by administration?

Appendix F: Second Interview Guide

Interview Guide 2

Demographics
AGE: Gender: M F T
MC WC
Occupation/role
Years of experience
Did you work here prior to RAI?
What other computerized documents do you complete?
Who completes the RAI on your unit?

Why did you choose this kind of work?

Training
How was RAI first introduced to you?
Did you receive training?
By whom?
What was that like for you?

RAI
What is purpose of RAI?
Purpose for Hospital/ministry?
Purpose for you?

Walk me through how you use the RAI in your practice with patients?
How did you decide to do it this way?
Do your colleagues complete it same way as you?
Is this the way they were trained to do it?
Do patients get to answer more in-depth or stick to yes/no answers?
Is it helpful to your practice? Examples?
Are there times when it is not particularly helpful to your practice? Examples?
When did it last happen? What did it look like?
What are you thinking about as you complete the RAI?

Workload
How do you see the RAI structuring your work?
How does it generate work for you?
Do you complete another SW assessment/note?
Do you do work outside of work hours – paid/unpaid?
Do you supervise students?
Do they complete the RAI?

How is RAI used by team, management, Ministry?
How is RAI used by the clinical team?
Does it influence clinical decisions/patient care?

Values
What is your priority at work?
How did you come to have a career in social work?
Parents occupations?
Do your personal, professional and organizational values align? Examples
Have there been times when you bend the rules or do what's best for patient?
Rogues/Outliers

Critical thinking
Pretending

Peer/union support
Do you talk to your peers about the RAI? Examples
Do you share stories with peers about how you complete the RAI?
Do you seek the support of colleagues?
Or the union?
Do you leave work troubled?

Magic Question
If you had the power to change 1 thing at work what would it be?

Closing
Is there anything I have missed or is there something you would like to add?