Management as "Ruling": A Class Phenomenon in Nursing

MARIE CAMPBELL

Nurses don’t have the time. We have to write on the chart “emotional support.” But all we have time to do is ask “How are you?” and leave.... It doesn’t matter what people answer; we have to get on and write “emotional support given.” That’s the priority, not doing it.¹

This paper deals with one of the ways in which restraint has been introduced in nursing — through management techniques. Beginning in 1975, the Ontario government made hospital funding a target for restraint. Cana-
dian health care budgets, like other social expenditures, have grown at a very slow and faltering rate ever since. Among other restraint measures, provincial government funders encouraged hospital administrators to improve their management practices and increase labour efficiency. Specific changes in the management of hospital nursing, such as the introduction of "patient classification" systems, took place in the context of widespread corporate reorganization of Ontario hospitals, itself in part a reaction to the question of government restraint. By the early 1980s, nurses across the province were already experiencing considerable unease with what was happening to patients under their care. My study was designed to explore how changes in nursing management could organize nurses to be part of a government restraint program. These changes were all the more successful in that they were widely viewed, even by the official representatives of the nursing profession, simply as improvements in professional practice.

The organizational methods by which hospital nurses are made more "productive" are the focus of my analysis. Some hospitals are moving to automated monitoring of nurses' work through information generated at bedside computer terminals. Even without advanced computer technology, most Canadian hospitals have implemented information systems for "rationalizing" resource-allocation decisions, especially about nurse staffing. This managerial development is taking place in conjunction with other major changes in nursing, the most significant of which is that nursing is becoming a theoretically oriented and document-based practice. College and university nursing schools now teach nursing from curriculum models strongly oriented to systems theory; they give their graduates training in a specialized use of language needed for the document-based practice of nursing which has replaced the task-orientation of several decades ago. Hospitals are beginning to show a preference for nursing staff with the conceptual skills gained in higher education. The registered nursing assistant or "practical nurse" is losing ground in the labour market to registered nurses with college or even university preparation. Nurses have always kept narrative records of their work, as well as graphic accounts of patient's vital signs and other observations, but the new information systems are different from such earlier forms of "charting," both in form and effect.
The generation of information about nurses' work, through management information systems, does two things; it brings nursing practice into relation with a professional discourse; and it brings nursing under managerial scrutiny in a new way. With the appropriate management systems in place, nursing work can be actively organized, structured and circumscribed in line with centrally determined management policies.

This is not to argue that, in some previous time, nursing and nurses had control over all aspects of their work organization. Their subordination to the medical profession is well documented and need not be repeated here. The present analysis is of a new form of subordination, in which nurses' judgement about patient care is transformed for use in management decision-making in which neither the interests of nurses nor patients is paramount. This technological transformation of nursing knowledge takes place in such a way as to mystify nurses and thus disempower them.

Management processes have held special interest for students of political economy ever since publication of Braverman's *Labour and Monopoly Capital.* By updating Marx's analysis of the capitalist labour process, Braverman opened up a debate about modern methods of work organization which puts "control" and "class" issues in the forefront. One of the powerful impacts of Marx's analysis of capitalist production is its capacity to expose the internal structures of work organization, showing how these structures come to dominate people's lives as "social relations of production" or "class relations." In this vein, analysis of the nursing labour process can help us understand the changing and seemingly contradictory social relations that increasingly dominate the health care field.

In the wake of Braverman, there have appeared in the literature a number of studies of class and domination that are pertinent to an analysis of contemporary changes in hospital nursing. On questions of "control," Burawoy and others urge caution in applying Braverman's proletarianization thesis. Braverman argued that craft work is degraded, and the workers de-skilled, when subordinated to management control. Noble emphasizes the importance of class struggle in both determining and mediating the effects of innovative forms of labour process control. He points out, also, that not just workers, but capitalists too, stand to gain when workers retain skills
or gain new ones: machines may not “work” efficiently unless workers understand how to facilitate the necessary interfacing of technology with work materials. These writers insist that the capacity to control is not simply a technological matter, and the uses to which control is put should not simply be assumed, but rather should be explicated through concrete analysis.

While not specific to nurses, Edwards’ analysis of what he calls “bureaucratic” control adds an important set of understandings about ideology as a control mechanism. The production workers he studied internalized an elaborate set of rules and procedures which were tied to rewards and sanctions, and which, he says, constituted an advanced and effective form of “ideological” labour process control. In the case of nurses and other knowledge workers, where a professional labour process is to be brought under management control, different difficulties arise. Doctors and engineers, although definitely subordinated to new organizational demands and restrictions, still are left with different work relations and superior working conditions to those of proletarianized craft workers. Charles Derber’s work explores this territory. Seeing the need for a theory of “professionals as workers,” he laid the groundwork with some concrete descriptions of systematic changes in the organization of professional work. He stopped short, however, of confronting the issue of “class” in occupations like nursing, where the work relies on an internalized knowledge base but is organized by objective managerial processes.

Various theories have been put forward to try to account for the social outcomes of the contemporary division and organization of labour. Important among them are theories of the new working class, the new middle class, the professional-managerial class, and contradictory class location. In spite of significant differences, these theories share an important feature. That is, they aim to establish the class position of these “workers.” In the analysis I present in this paper, I am attempting to display the class character of the relations established in the corporately organized hospital. The technological structuring of nurses’ work through management information systems, I will argue, brings class relations into public health care through “ruling practices” — “the processes and functions
which reserve and control the means of production in the interest of a class." I will return to discuss this issue at length in the last part of this paper.

Cynthia Cockburn took an early and original step in linking the organizational arrangements of corporate management in a city borough to macro level social analysis. She analysed the techniques by which a corporately organized local council responds to, formulates and shapes the local expression of housing needs. Cockburn develops several points of analysis important to the work on hospital nurses: she identifies the ideological effects of corporate management, and the way its organization of ideas expedites the government's intent to cut social expenditures; she identifies as class-based struggle this local state management work of organizing the consent of working-class constituents to their own domination.

Dorothy Smith has also argued that ideology is a practice, a method of transforming experienced reality into abstractions and, as such, is open to empirical investigation. Smith argues that it is through texts, in which particular abstracted accounts of the world are constructed, that ruling of contemporary society is done. "Texts are to be analysed as constituents of ongoing social relations and as 'actively' concerting those relations." In her view, the social organization of the writing of such texts, and of their dedicated uses, is key to understanding the social relation of which the text is a constituent part. Systematically formulated documents organize and control actions across geographically dispersed sites, as in departments or divisions of a corporation, or government ministries and agencies. "To explore the relations of ruling is to explore an organizational practice which is mediated by texts."

My own study builds on the work of Cockburn and Smith. I am exploring how a capacity to rule is being organized in the contemporary hospital through implementation of textually mediated nursing management practices. I argue that the documentary processes of corporate management provide the means by which nurses' actions are coordinated in such a way as to bring them into line with state policy, itself oriented to capitalist interests. A documentary process (a classification of patients by "need" levels, discussed below) systematically transforms nurses' professional knowledge into cost-relevant terms. This is the foundational work for "rationalizing" costs. Obje-
tive needs can be addressed in management decision-making according to cost criteria, thus displacing reliance on professional nursing criteria which are not cost-driven. That is, nurse staffing can be allocated to meet needs as a budget allows, rather than as nurses' professional judgment about adequacy of care might dictate. These new methods construe nurses' professionalism as inadequate, after the fact. Thereafter, adequacy of nursing care is determined through a management process.25

The management system organizes what appears to be tight control over the efficiency and effectiveness of nursing care. My analysis suggests, however, that "appearances" are precisely what the system organizes and can deliver. Ruling, through documentary processes, is the production of structured appearances.26 The disparity between what the control mechanisms organize and the ground of nurses' and patients' knowledge demarcates a terrain of struggle. However, the ideological impact of the social organization of nursing knowledge becomes critical to this struggle, I shall argue. Systematic information, abstracted from its workplace ground, and constructed on a framework of "official" professional concepts, becomes the authoritative account; it constructs what nurses know, replacing their own ideas and judgment. Any resistance nurses might want to offer to erosion of services is counteracted when their own knowledge is reconstructed in management-relevant terms. They become active participants in the processes through which fiscal restraint is put into practice.

Corporate Management and Nursing

The Study  The study is an organizational ethnography of an Ontario community hospital, analysing the formal management practices that structure nurses' experiences. The data include field notes from observations of various aspects of management, and in-depth interviews with nursing and hospital administrators, registered nurses and registered nursing assistants. As well, I analyse hospital recording forms in which nurses generate information about their work. The analysis develops an account of the operation of the textually organized nursing management processes and of what their routine use accomplishes in the nursing setting. The claim that this form
of management is a form of ruling rests on being able to track policy ideas (e.g., about fiscal restraint) from practice decisions made by nurses back through the implementation of specific management devices to their origins in the state and in professional organizations.\textsuperscript{27} I use government policy statements and other official reports and professional publications to chronicle an historical march of ideas into nursing curricula, professional regulations and, finally, into nurses' accounts of their activities in hospital wards.

The search for the policy origins of the nurse staffing system led me to management engineering studies and reports of nursing work analysis and timing studies. Both private management consulting firms and publicly funded researchers had contributed to these researches. Behind the research and development, and prior to it, were the policy studies and government reports which recommended closer control over nursing labour in hospitals.\textsuperscript{28} "Patient classification," a method of quantifying patients' needs for care, was the device recommended as a basis for workload management. By the mid 1970s, research on patient classification systems was being given considerable attention and funding in Canada.\textsuperscript{29} Following the development of the systems, provincial funding authorities began to demand objective evidence that nursing staff were being used efficiently; patient classification figures were treated as the valid method of making this demonstration of efficiency.\textsuperscript{30} This contributed to the eagerness with which hospitals began to hire consulting firms to help implement these new management devices.\textsuperscript{31}

The Findings: Management as Ruling The study examines two objective (document-based) nursing management decision-making processes operating in the hospital. One deals with nurse staffing and "efficient" staff deployment in relation to "need"; the other deals with a clinical nursing practice and evaluation of its outcome. The latter is the centre-piece of the nursing department's "quality of care" program. Each of the decision-making processes is composed of a set of nursing records, within an information processing system. In each case, management staff make an accounting use of information from nursing records. The accounting procedures for making decisions rationally require that two phenomena be brought
into commensurable relation with each other. The following two sections explain how the documents establish the relation between the two phenomena as a conceptual matter. The crux of “management as ruling” is how, and for whom, this documentarily structured relation is exploited.

1. **Workload Measurement and Control over Nurses’ Time** The patient classification system offers the hospital increased control over the productive capacity of its nursing labour force. “Need” is the concept central to understanding the objective and “efficient” operation of the system. Patient classification is the management device that controls the definition of patients’ needs for nursing care. (See form on following page).

   “Efficiency” in applying a professional labour force to a body of nursing work depends upon management’s capacity to control the nurse-hours expended per patient. The patient classification system helps to establish and enforce “productivity expectations” of individual nurses. Patient classification works as a control mechanism by making objective a heretofore individual professional judgment about patients’ needs for nursing care.

   The construction of an objective statement of needs to replace nurses’ individual professional judgment requires that nurses participate, on a daily basis, in the documentary process of estimating and standardizing their patients’ needs for care. Using worksheets in which the patient’s routine nursing regime is noted, as well as treatment plans, etc., nurses assign each patient to a class by choosing “indicators.” Indicators are features of the patient or his/her treatment which are statistically related to the total nursing time similar patients have required in research settings.

   Standardization is the essential feature of the patient classification system. Classifying patients into levels of need for care helps to create a sufficiently stable data basis for prediction and comparison of work-loads, in a work-setting characterized by the high degree to which front-line workers control the knowledge of the work process. (They control it precisely because of its rapidly shifting and unstable character.) Standardized data pare off the differences among patients within class levels, as well as make it necessary to systematically ignore...
NOTE: This is a form filled out daily by a nurse on each ward of the hospital where the research was conducted. The nurse uses nurses' records, treatment plans, and her own knowledge of the patients. Putting nurses' knowledge of the patients and the nursing work into the form's categories accomplishes first level transformation into indicators of "need," as the concept has been developed in background research. In the next level transformation, the indicators establish each patient's level of care which, in turn, has a standard labour-time allotment. Nurse staffing decisions follow, using a formula that includes budget information, expressed through an important additional factor: the managerially determined proportion of any paid working day a nurse is expected to devote to measured nursing care tasks. The latter determines the productivity expectations for a nurse.
differences among nurses. Each class carries a labour-time equivalent which, once aggregated, determines how many nurses are to be assigned to a nursing unit.

The processes of standardization give management input into how much care is deemed to be enough. This can be done when specific data about individual patients are generalized in the patient classification documents and transferred to management for rationalizing the allocation of paid labour-time in relation to budget "realities." The capacity of the nursing management system to make patients' needs for care fit constrained budgets is a feature of its documentary character. The documents stabilize or objectify patients' need for care, something which in real or experiential terms is not possible. Any disjuncture between documentary accounts and the real world as nurses and patients experience it can be "solved" on paper. Of course, in the real world, as opposed to that on paper, any such disjunctures remain. They become problems to be accommodated in the workplace interactions of nurses and patients. For instance, nurses report that they skimp on the care of one patient to adequately care for another:

You can get through a complete bed-bath in 15 minutes. That's not counting moving, dressing and so on. But some patients take a lot more time. When you see that they need it, you have to take the time from someone else who doesn't know how much care they are getting. It's not really fair (to the unconscious or confused patient) but that's the way you have to do it.32

"Needs," as nurses conceptualize the term (using their internalized professional standards), may appear to them to be the same as "needs" on which staffing calculations are based, but that concept is transformed in ways that remain mysterious to nurses. They do not see that standard times are substituted systematically, based on the indicators they choose in the recording forms. They do not see how work analysis and time studies have provided standard tasks that are timed for such substitutions. Using patient classification categories and concepts places the nurse in an ideologically structured relation to her patient. Reductions in the nursing labour budget, relayed to hospitals from decisions taken at the highest policy levels, are accommodated by reinterpreting the mathematical calculation of "need" and allocating fewer nurse-hours to cover
those "needs." In the process of documentation, the concept "needs" is cut loose from its determination by the mediating work of nurses. In its documented form, it becomes adjustable to management's cost-constrained "realities" precisely because it is an abstraction. How fast nurses are expected to work depends finally on budget decisions.

This constitutes an intrusion of fiscal policy-making into a professional area, with potentially serious consequences for patients. As committed professionals, nurses try to stretch their labour over all the patients assigned to their care. They intensify their own efforts when paid nurse-hours are reduced. Of course, past a certain point, even intensification of their labour cannot make up for reduced allocation of paid working hours. At this point, individual nurses resort, for survival, to cutting out tasks they ordinarily would consider necessary. The net result disorganizes the orderly provision of care and institutes a kind of ad hoc rationing of nursing services.

2. Quality Assurance: Control over Nursing Outcomes As well as an efficiency-oriented nursing management system, my research explores a second nursing management decision-making process which interlocks with the first. By contrast to the categorization of needs and staffing, we now turn to a system that deals with the care patients actually get. This system is one that objectively controls nursing practice (outcomes) through a system of record-keeping, monitoring and supervisory feedback about actual nursing care.

This system aims to organize "effectiveness" in nurses' work through documentary means similar to those used to organize its "efficiency," discussed above. Nurses record each step of their work in specially formatted documents whose categories reflect professional "standards." When nurses translate their work into the recording system, they make it objectively "accountable." The record can be compared to a written standard, offering a method for establishing an accountably adequate level of quality of care (when the forms are filled out properly).

Accountability, here, is a management practice in which records are monitored and words are matched. Because "results" are produced in documents, record-keeping has taken on a new importance in nursing. New emphasis on conceptualizing nursing in the profession has made systematic record-
NOTE: These are two of the recording forms which nurses routinely use to plan and record their progress through a patient's daily care. Monitoring of care makes use of such forms. "Quality assurance" systems are primarily nursing record audits, with scores generated on the basis of the completeness of such forms. At the time the research was conducted, monitoring was done manually, but such systems are designed for conversion to automated monitoring.

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# INDIVIDUAL CARE PLAN

**STANDARD CARE PLANS IN USE:**

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keeping both possible and officially sanctioned. In Ontario, the body with statutory responsibility for regulating nursing is the College of Nurses. It makes “accountability” through record-keeping a professional responsibility. When categories of hospital information systems are developed from the College’s Standards of Nursing Practice, that conceptual structure makes the records useable for monitoring “quality of care.”

The records, however, may be different from what nurses know about their work from where they stand. As one nurse explained:

It's very easy to put [plans] on paper. I know from experience — a chart can look great, but did the patient get the care?

As nurse managers put increasing emphasis on documentary monitoring, nurses find that they must give increasing priority to creating records that articulate definitions of “quality” care. The documenting of “quality” takes precedence over the giving of actual high quality care:

When an IV [intraavenous] is started, they want to know what you cleansed the area with and what size of needle you used.... This takes a lot of time, but when you know this is what they want [in the record], something else has to get left [undone].

The capacity inherent in the documentary “supervisory” system is expected to bring nurses’ activities into line with the documentation (and the standards). My field work indicates that the adjustment may happen that way, but it may not. Nurses may simply adjust their records to the supervisor’s requirement, without altering their nursing practice, especially as time constraints interfere with what they actually can do for their patients.

The system I am analysing is a rather primitive model of the quality assurance systems now available, but even the most sophisticated documentary accountability devices are subject to the same weakness in reliability between the document and the underlying reality they purport to represent. However, the potential for inaccuracy in accountability systems does not detract from their ruling capacity. Nurses reported being reprimanded on the basis of objective information about their
practice which they knew to be inaccurate, and they learned that, to avoid damaging their careers, they must make the records indicate "quality":

All of a sudden, we realized that they were measuring our nursing care by this chart. . . . We had a bad Audit. It was obviously very important to them [the administration]. The Head Nurse was very upset. We realized then that it doesn’t really matter that we’re good nurses, good [by] all other standards. . . . The Head Nurse started checking charts and calling us in about our Care Plans.57

3. Structuring Accountability in Nursing Records

Through corporate management of hospitals, new forms of control are being instituted over nursing and nurses. Document-based management of nursing is not simply an improved technique for accomplishing control over practice. Rather, the character of overseeing the work is altered. Control over nursing has long had a component of self-regulation through the role given to professional bodies by the state. This self-control now becomes linked to control through the institutions and agencies that have been responsible for deploying state funding to the vast majority of nursing activities. The new mechanism for implementing the agency control is managerial accountability. The nursing “field,” once largely self-controlled by a system that gave considerable importance to the professional judgment of nurses, is being brought into an accountable relationship with hospitals’ management priorities, through records and document-based management systems. In practice, I argue, management priorities are those that express the interests of the state. Reducing social expenditures by rationing services has become increasingly important. Change in the control method has provided the opportunity to change the interests being served in hospital wards where nursing care is being given.

In the hospital, it becomes possible for corporate management priorities to be given precedence when an accountability relation is created between two dissimilar and non-equivalent things — nursing care needs and labour-time. These two cannot be brought into harmony in reality — except on paper. When they are brought into relation documentarily, the documentary appearance can be managed in the interests of cost-
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constraint. This management technology brings into the nursing setting, the capacity to shape the definition of “needs” in line with ruling ideas which are expressed in a budget of restraint or a planning document of rationalization. Corporate management control of hospitals relies on engineering of the appearance, or expression, of need and of the fulfilment of need, as I have described here.

The management of appearances is a successful ruling device in that it can make over a real-world setting in its ideological image. That outcome is noted in my field research where nurses report that they tried to accommodate the needs they recognized in patients with reduced resources. As already noted, my nurse informants reported that they intensified their work, and even then had to resort to cutting out services. The construction of “need” by documentary procedures, and the deployment of nurses’ labour to match only those needs, create the work-setting in its ideological (cost-constrained) image, but at a cost to nurses and patients.\(^{38}\)

While generating information is a “cost” to front-line nurses, it is a “benefit” to hospital administration. The appearance of quality in nursing care is all that can be enforced by an evaluation strategy that matches records to written standards; significantly, my research suggests that hospital administrators do (while front-line nurses do not) find this documentary product satisfactory for their purposes. Hospital boards are beginning to feel insecure about their lack of knowledge and control over the quality of nursing care — “as a result of all these . . . inquests and legal cases,” the hospital president in my study explained.\(^{39}\) He uses the management information systems to demonstrate the credibility of the nursing department’s control over the situation:

Nursing Audit and Quality Assurance Programs are being reported to the Board. [The Board’s] real function is seeing that the process is in place. They look at the process and ask “is this a reasonable process?” “Is it likely to prove or monitor the quality of care? . . . The Board functions an awful lot on credibility. It’s important for someone from Nursing to come and tell them directly.\(^{40}\)

A documentary appearance is useful for budget forecasts and for rating performance of staff; it offers evidence to help deflect blame when litigation is brought against a hospital for
perceived negligence. Simply having an objective management system protects the hospital as a corporate entity and it protects individual managers. The recording provides concrete evidence of proper management procedures being in place. However — and this is a crucial point — it does not protect individual nurses who may make a wrong decision about a patient, when they are hurried and under stress. On the contrary, the accountability system helps to pin-point that nurse, making her responsible for the results of care she gives in conditions over which she has no control.

To produce "efficiency" and "quality" — the guises under which the ruling ideas are transformed into organizational realities — nurses' ideas are subordinated to management forms. When the real setting is managed as if it conformed to the documentary version of it, then the real is brought into line with the "ruling" ideal. Put more concretely, when nurses are given only enough resources to meet the objectively defined needs, those are the only needs that can be met. To meet any other needs that nurses might recognize, nurses would have to act unofficially, that is, on unbudgeted time. Control exercised over the timing of nursing interaction works to narrow nurse–patient relationships to the "prescribed" tasks. "Quality" is constructed within those "efficiency-determined" parameters. The broad policy goal of restricting services with a view to reducing costs is thereby implemented. The ruling process relies both on using nurses' knowledge and, at the same time, displacing the authority of nurses' knowledge.

**Theoretical Implications**

**In the Relations of Accountability — Class?** My analysis of accountability relations as "structured appearances" gives new insight into the nature and use of ideology in management. Mine is a different argument about ideology than that made by Derber in *Professionals as Workers*. Derber's concept of ideological proletarianization has the professional complying with company policy because of the individual satisfaction he/she gains from special and satisfying working conditions. Derber argues that the continued capacity to exercise professional knowledge in the workplace is one of the professional's rewards. His argument, drawing on work of Edwards...
others, is that this constitutes “ideological” labour process control, which replaces the need for technical control, leaving professionals “free” to practice relatively autonomously; having internalized their employer’s objectives through the provision of rewards and sanctions, they will voluntarily contribute their work to further the interests of their employer and his class.43

In contrast to Derber’s analysis, I have described the labour process controls through which nurses’ compliance is ensured, not voluntarily, but technologically — nurses’ record-keeping being a condition of their employment. When nurses’ judgment is different from managerial interests, it is made to appear consistent through the use of the documents. This is the sense in which I use the concept of “ideological control.” Ideology here is a definite product of management technology and has been empirically investigated as conceptual practices. Nurses are led to believe that compliance with such “accountability” measures means the same thing as “professional responsibility.”44 Conceptual links between the management technology and the profession’s regulatory statements convert professional issues, such as maintenance of acceptable standards of practice, into managerially defined ones. The management system, in accounting for nurses’ time, also controls its use; under the managed appearance that meets professional standards may lie an actuality that is quite different. If “accountability” means “professional responsibility,” then nurses have become professionally responsible for implementing budget cuts. The work is subordinated to interests that are outside it. These are the relations of class domination.

I am arguing that to subordinate nurses’ work to state policies of restricting health services requires creation of the same form of labour process as capitalist production. Documentary management controls in nursing revolutionize the labour process in ways that result in intensification of the work, appropriation of the knowledge of the worker, and objectification and alienation of the product. Instead of valorization, the “efficiency” being organized in this non-profit hospital is aimed at cost-saving in the delivery of state services. While the labour process that results may be called “analogous” to those found in capitalist production, the relations between people established thereby are not simply analogous to class relations. They are an instance of the extended social relation
through which the class character of the contemporary social formation is realized. The reorganization of social relations in a corporately managed hospital must be understood in terms of class.

Class relations are real and really affect nurses' behaviour. Nurse managers' relation to their subordinate staff is organized through their access to new forms of information about the work and the control it affords them. Their supervisory duties become document-oriented. They are themselves subordinated to the ideas about management and to the management interests that are part of those systems around which they now orient their practice. Interests that previously gave at least some expression to nurses' judgment give way to management interests. Carrying out the management of "quality of care," for instance, means that nurses so engaged must transfer their interest from practical nursing issues, as they previously understood them, to tasks relating to documenting and evaluating "quality." They must attend to record-keeping and insist that subordinates do so as well; interest in patients takes second place to such organizational demands. Even nurses' traditional role of meeting physicians' wishes for personal service may also have to be eschewed. Nurses' careers, now objectively embedded in organizational practices, depend upon success in this new set of tasks. Such organizational exigencies establish and nurture new interests which correspond to managerial priorities and thus to ruling.

This analysis of the nursing labour process helps to make sense of the non-critical acceptance, even the promotion, of this "managerial" direction by professional nursing associations. For one thing, managerialism provides new and needed opportunities for well-educated nurses to be upwardly mobile in careers — an important goal for a traditionally subordinate women's occupation. Also, as the difficulties of actually organizing and regulating a large body of nurses increase, managerial methods derived from the profit-making sector offer themselves as the best available alternative. They are what we as a society have put our faith in. They are the orthodoxy taught in professional schools.

Managerialism is one side of a structural division being established in nursing; proletarianization is the other. For proletarianized nurses, loss of discretion over their use of time,
routinization and standardization of clinical decision-making, and bypassing of professional judgment about quality represent important erosion of traditional professionalism. It is in such practices that de-skilling occurs, and de-skilling of some nurses seems inevitable. This observation would seem to lend support to the view that nursing is becoming class-divided according to nurses' differential relation to control. However, my analysis leads me to be cautious about such a simplistic explication of class. When one focuses, instead, on ruling as a practice, or a coordinated set of practices, class becomes visible as a relation being organized by those practices. Class relations permeate the activities I have been describing. It is in and through the documentary processes that class relations mediate and begin to penetrate the work of both staff nurses and their nurse managers. All these nurses begin to serve interests in the health care field that are not their own.

The ruling practices I am describing are dynamic, as are the relations being organized. This study isolates a moment in a process whereby nurses' traditional work organization is being changed. The analysis shows the power of the systematic organization of nurses' ideas. Hospitals make use of the new document-based management technologies and the increased capacity for systematization of nurses' practice to impose management priorities on nursing decisions. In state-funded public hospitals, nurses and nursing care are brought more fully under the command of the state through the professional and organizational arrangements described. As we see management technology adapted from capitalist industry carrying "class" effects into the not-for-profit sector, our understanding of class relations is informed differently.

Notes

This paper is a revised version of one originally presented at the Learned Societies, University of Montreal, 1985, in the Canadian Sociology and Anthropology Association session, "Marxian Analyses of the Professions." The author gratefully acknowledges funding from two sources: the field research reported here was partially supported by a National Student Fellowship from Health and Welfare Canada; analytic work for this paper was supported by a Social Sciences and Humanities Research Council Post-Doctoral Research Fellowship. The orig-
inal paper has been improved by helpful comments from SPE reviewers and Caroline Andrew, Nancy Jackson, Roxana Ng and Jake Muller.


4. Originally reported in Campbell, "Information Systems." (See n. 1 above.)

5. The Toronto General Hospital's new system integrates nursing care plans, nurses' labour-time expended on individual items of care, and various kinds of clinical information about patients with financial and administrative data. See RNAO News (November 1986), p. 16. Besides timing nursing work, comparison of "outcome" by patient diagnosis will give an indication of the "effectiveness" of the nursing care given, so that nursing plans can be adjusted automatically to improve nurse productivity.

6. A study called RNA Utilization in Ontario (Woods Gordon, April 1985), commissioned by the Ontario Registered Nurses' Assistants' Association, analysed this trend.


10. Noble, "Social Choice," p. 41. (See n. 9 above.)

11. Edwards, Contested Terrain (See n. 9 above.)


13. Derber, Professionals as Workers (See n. 12 above.)


19. Cynthia Cockburn, The Local State: Management of Cities and People (London, 1977). Her work differs from other analyses of the state's role in reproducing capitalist relations in the level of specificity of her analysis. See, for example,
Donald Swartz, "The Politics of Reform: Accommodation in Canadian Health Care Policy," The Canadian State: Political Economy and Political Power, ed. L. Panitch (Toronto, 1977). Cockburn demonstrates not only that the state takes an active role, but how that role is enacted.

23. Ibid., p. 7.
24. Also, see Vivienne Walters, "State, Capital and Labour: The Introduction of Federal-Provincial Insurance for Physician Care in Canada," The Canadian Review of Sociology and Anthropology 19:2, pp. 157-72; and Swartz, "The Politics of Reform" (See n. 19 above.)
25. The point here is not to romanticize traditional nursing work. I do not compare historical accounts of nursing to a contemporary account. I use my nurse informants' own assessment of their functioning before and after new control methods were implemented.
26. See Nancy Jackson, "Class Relations and Bureaucratic Practice" (Paper presented at the Learned Societies, Canadian Sociology and Anthropology Association meetings, University of Montreal, 1980).
27. This point is developed more fully in Campbell, "Information Systems."
29. For example: B.A. Holmlund, Nursing Study Phase One: University Hospital, prepared for Hospital Systems Study Group (Saskatoon: University of Saskatchewan, 1967); J.E.A. MacDonnell et al., Timing Studies of Nursing Care in Relation to Categories of Hospital Patients (Winnipeg: Deer Lodge Hospital, 1968); Phyllis Giovannetti and Laverne McKague, Patient Classification and Staffing by Workload Index, prepared for Hospital Systems Study Group (Saskatoon: University of Saskatchewan, 1973); Equipe de recherche opérationnelle en santé, PRN 76: An Information System for Nursing Management (Département d'Administration de la Santé, University of Montreal, Montréal, 1978).
31. A 1982 unpublished survey by the Ontario Hospital Association revealed that of the 165 Ontario hospitals responding, 64 were already using a patient classification system and 42 others were planning to implement one.
33. Patients' needs for nursing attention arise in diverse ways, including from patients' own requests (nurses answer call-bells, for instance); nurses interact with patients and may observe something of an immediate or transitory nature which must be done; families make requests; other aspects of care are "ordered" or routinely done.
34. For example: College of Nurses of Ontario, Standards of Nursing Practice for Registered Nurses and Nursing Assistants (Toronto, 1976). These standards have been revised periodically.
36. Ibid., p. 115.
37. Ibid., p. 122.
38. Note that total costs are not being compared. The management systems bring new and hidden costs into health care. Even if the nursing labour costs in an individual hospital were reduced in a particular year, the costs of implementing and operating the systems, of new management and technical personnel, as well as research and development costs, would need to be considered. Such financial accounting is technically possible, although difficult. What cannot be costed is the labour unrest created by the changes in managing nurses objectively, nor the cost to patients in deteriorating care.
40. Ibid., pp. 144-5.
41. Derber, Professionals as Workers.
42. Edwards, Contested Terrain.
43. Derber, Professionals as Workers, pp. 172-4.
44. The professional associations actively encourage this interpretation of meaning of accountability. For instance, the definition of "accountability" in a position paper prepared by the New Brunswick Registered Nurses' Association and used authoritatively to instruct nurses about their roles and functions is "full acceptance of the consequences of one's actions" (p. 1).