 Contemporary Nurse (2009) **33**(2): 103–119.

Resisting gender-bias: Insights from Western Australian middle-level women nurses

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ABSTRACT

An integrated feminist postmodernist ethnography was applied to explore the experiences of eight women nurses working in the corporate sector and/or management in public hospitals in Western Australia. Data were collected through participant observation, the researcher's field notes and journal and through semi-structured critical conversations. Data were analysed by the application of a trifocal analytic method (Glass & Davis, 2004; Savage, 2000b). This approach, consistent with the methodology, examined the data at multiple levels by applying realist, feminist and feminist postmodern lens which allowed the data to remain relevant to each participant, avoided objectifying the participants and uncovered knowledge relevant to the nursing profession. The findings revealed what it meant to be a nurse functioning within a corporate setting. Three culturally-constructed discourses emerged: values attributed to nursing, bureaucratic managerialism and medical science. The first was found to be empowering but the other two revealed evidence of patriarchal and oppressive behaviours by both medical staff and senior nurses. The findings also revealed that the nurses were sometimes unaware of the oppression they were subject to. The nurses avoided confronting their oppressors preferring strategies revealed as creep up/creep in.

Discussion focuses upon the implications of the research project findings for senior and executive nurse leaders and managers and which may evoke a sense of commonality for women in general. The implications are that nurses could apply self-managing strategies in order to resist gendered oppression in senior-level workplace relationships. The authors recommend that more research and publications are needed that reveal and celebrate women's every-day exemplar empowering leadership practices.

Keywords: nursing; feminism; postmodernism; ethnography; corporate; management

Introduction

This paper is based on a recent social science research project that aimed to examine gender-bias as experienced by women nurses who practiced as nurse unit managers and/or clinical nurse specialists in two Western Australia (WA) public hospitals. These nurses, defined here as middle-level women nurses (MLWN), had combined responsibilities to achieve their hospital's managerial fiscal agenda with their nursing care professional values. Scant literature was available that explored the experiences of nurses who practised in these kinds of roles. At the time of undertaking the research project the international sociopolitical context for nurses in senior health system organisations, not dissimilar for women generally in western society, was one of gender inequality (see for example, Australian Institute of Health and Welfare (AIHW), 2004; Byers, 2001; Department of Community Development, Government of WA, 2004; Furst & Reeves, 2008; Glass, 2000). For nursing, the change in governance focus, from medical dominance to managerialist fiscal control in the health services in the United Kingdom, Australia, New Zealand, Canada and other Western economies (Powell, Brock, & Hinings, 1999) further marginalised nurses (Glouberman & Mintzberg, 2001; Wigens, 1997). This shift revealed that care, which forms a central value in nursing, continued to be absent in the health economics equation (Turkel, 2001).

The paper begins by explaining the impetus for the research, the research question and objectives for the ethnographic approach used in the study. The next section outlines the gap in knowledge within which the project was positioned. This is followed by an introduction to ethnography, informed by feminist postmodern perspectives, and the selection of the participants. The subsequent presentation of the findings and their implications are then discussed. The authors' concluding remarks contend that the application of the research methodology and methods have the potential to contribute to the body of professional nursing knowledge that not only reveals the oppression of women nurses but also the optimistic emancipatory practices by nurses and other women.

Research impetus, question and objectives

Middle level nurse managers hold senior positions in hospital hierarchies as ward managers or clinical specialists. They practice in the confluence of corporate and nursing professional values where they are expected to be expert practitioners, leaders, and managers. Their roles integrate responsibilities to achieve their hospital's corporate fiscal agenda, foster the values and practices of effective nursing care and undertake nursing workforce management. However, little is known about how they experience their roles and so the initial research question was *what meanings do middle level women nurses attribute to their experience of practicing in Western Australian public hospitals?* The intention was to reveal the ways in which women nurses empowered themselves in their work role and the network of power relations present in their practice settings. In doing so the researcher sought to contribute to the professional nursing dialogue related to recommendations from state and national reports into nursing practice and education. For example, The Report of the West Australian Study of Nursing and Midwifery '*New Vision, New Direction*' focussed on internal nursing issues, such as career progression, professional education, workforce improvements and where *'nursing and midwifery leaders must ensure a cultural change occurs that empowers nurses and midwives to value each other within the profession'* (Pinch & Della, 2001, p. 27). The National Nursing and Nursing Education Taskforce Report 2002 (N³ET) (Department of Education, Science and Training, 2002) was established to implement recommendations of *Our Duty of Care Report* (Department of Education, Science and Training, 2002). The key focus areas identified in *Our Duty of Care Report* was the *'need for a national focus, a coherent voice on nursing issues, nursing leadership and recognition and affirmation*

of nurses' (Department of Education, Science and Training, 2002, p. 108). However, no reference was made, in either of these significant initiatives, to the impact on nurses and nursing of the emergence of rational-economic changes or of the traditional medical cultural dominance as embedded within the Australian health system. Further, the emergent insights aimed to extend the international literature related to gender-bias for nurses and women generally, especially contexts where women's ways of knowing was patriarchally subjugated (Attridge, 1996; Chinn, 2000; Glass, 1998, 2003a, 2003b; Heckman, 1999; Speedy, 2000).

Relevant literature: Sociopolitical cultural context of the research

The gap in knowledge within which to position the research project was identified by an extensive international and national literature review. Pertinent literature related to this paper is presented in this section of the paper including international literature that revealed middle-level women nurses were not an isolated group experiencing gender bias.

At the time of the research the broader sociopolitical context in which public sector senior nurses were employed revealed evidence of significant gender-bias within the Australian cultural context. The Women's Report Card (Department of Community Development, Government of WA, 2004), for example, revealed that in Australia less than 30% of corporate executive public sector roles were held by women, some of whom were hospital executive nurses. Furthermore, Merritt (2008) revealed that lip service was paid to the national equal opportunity policy by Australian law firms where there was an unequal disproportion of women to men barristers. Gender-bias was further shown by some exclusive Australian men's clubs which had denied '*honorary membership to the highest office-holders in the land because they are women*' (Stewart, 2008, p. 1). In this sociopolitical context was situated the nursing workforce comprising 92% women (AIHW, 2004). Similar findings were revealed in the United States with American women among middle and executive level non-health related positions. Furst and Reeves (2008, p. 372) revealed that 'only eight women hold Fortune 500 CEO positions, less than 8% are Fortune 500 top earners, and only 14% hold board director positions'. In another American survey of 269 healthcare executives, only 8.7% of nurse executives had a vote at governing board levels (Byers, 2001). A plethora of literature revealed that nurses were a subjugated group dominated by the patriarchal medical model existent in the health care system (see for example, Chiarella, 2000; Glass, 2000; Johnstone, 1994).

A review of international literature revealed minimal research that reflected the voice of nurses or other health professionals' experience in senior managerial/specialist type practice (Forbes & Hallier, 2006; Ogle, 2004; Ogle & Glass, 2006; Pannowitz, 2007). For example, Hewison (2006) raised awareness that this level of nurse had been somewhat hidden and that publications were needed that showcased their contributions within health care organisations. The few qualitative research projects which focused on nurses in senior and executive nursing practice roles, most of which were conducted in Australia, showed that the nurse participants lacked the power to make change and experienced strong tensions between their bureaucratic fiscal and nursing agendas (Irurita, 1990; Lewis, 2001; Ogle, 2004; Paliadelis, 2006). In the United Kingdom, nurses who were new to their executive role were found to adopt a *muddling through* approach and were not supported to achieve their professional and corporate service agendas (Cameron & Masterson, 2000). In an earlier American study, executive nurse turnover was related to limited power to effect change, tension between the nurses and their CEO, low nursing workforce numbers, and lack of peer support (Kippenbrock, 1995). In contrast to the study projects noted above, Brandi and Naito (2006) found that Japanese nurse administrators did not experience tension in their role, yet it was noted that the women nurses

held markedly less authority compared to their Western counterparts. For example, they were not responsible for nursing workforce budgets.

No nursing literature showcased and celebrated nurses' empowering managerial and leadership practices. Nursing management and leadership texts, based on male-biased theories, subjugated women's ways of knowing by telling them how the job should be done whilst excluding the embodied expert, practice-based knowledge of nurses themselves (Marquis & Huston, 2006; Yoder-Wise, 1999). From a more optimistic and different perspective Furst and Reeves (2008) explored and revealed practical ways that some American women broke through the glass ceiling to be in executive organisational positions. They argued that the women's emergence as leaders more often occurred during times of business turbulence and related to perceived specific characteristics of the women. For instance, they communicated openly, encouraged collaborative decision-making, took risks, shared burdens with subordinates, focused upon internal and external customers' needs and demonstrated integrity.

Several Australian national and state reports were critical in reviewing the sociopolitical context for this research (see Table 1). These reports contributed to an understanding of the external cultural contexts for the research participants. For example, the AIHW (2004) identified that 9.3% of the national gross domestic product expenditure was spent on health. Whilst hospital admission rates in Australia were increasing significantly, the number of nurses in the health system was falling, thus creating a crisis (Armstrong, 2004). As nursing workforce numbers across Australia were critically low, the challenges to recruit and retain nurses was addressed by state and national Australian governments. Research by Jones and Cheek (2003) on the complexities of nursing practice informed the National Nursing and Nursing Education Taskforce Report (N^3ET) (Department of Education, Science and Training, 2002). Nursing workforce issues in WA also informed the *Report of the WA Study of Nursing and Midwifery – New Vision, New Direction* (Pinch & Della, 2001). In some areas of the WA public hospital system, nursing workforce improvements were immediately evident following the ruling by the Australian Industrial Relations Commission (Nurses [WA Government Health Services] Exceptional Matters Order, 2002; Mantell, Twigg, & Kelly, 2005). An economic nursing workload model of 'Nurses Hours Per Patient Day (2001)' (NHpPD) emerged from this ruling and in WA it was used at the ward level, not at nursing executive level, to cost effectively align nurses' workload and patient care provision (Illiffe & Blake, 2004). However, the shortage of nurses continued to be problematic (Guest, 2007). These reports and taskforce actions, notwithstanding, literature did not provide understandings of how nurses in

TABLE 1: FEDERAL AND WA STATE REPORTS AND DECISIONS PERTINENT TO THE ETHNOGRAPHIC CONTEXT

Pertinent Federal and WA state reports and decisions to the ethnography
• The Report of the West Australian Study of Nursing and Midwifery '*New Vision, New Direction*' 2001 (Pinch & Della, 2001).
• National Nursing and Nursing Education Taskforce Report 2002 (N^3ET) (Department of Education, Science and Training, 2002).
• Nurses (WA Government Health Services) Exceptional Matters Order 2001. Australian Industrial Relations Commission, Justice Munro ruling Sydney 11 February 2002.
• Australian Institute of Health and Welfare, Canberra (AIHW, 2004).
• Department of Health Western Australia (DoHWA 2004 Report of the Health Reform Committee: A Healthy Future for Western Australians.
• Nurses Board of Western Australia – Scope of Nursing Practice Decision-Making Framework (2005).

middle-level positions, accommodated the tensions in their corporate and professional roles or why they stayed or did not stay in their jobs.

In contrast to workforce problems, there were significant advances made within the clinical nursing arena in terms of changes in Nurse Practitioner legislation in various Australian states (Anonymous, 2006). This is an historically important development that has legitimated the role of nurses who hold a specialty postgraduate nursing qualification.

Conduct of the study

Aims of the study

From the literature search there appeared to be a gap in knowledge which revealed an absence of understanding of the local sociopolitical culture for nurses in public hospital middle-level positions. The study set out to examine this topic from the perspective of women nurses. Specifically, the research aimed to explore and reveal common, different, unique and exceptional experiences that empowered, disempowered and/or oppressed participants' personal, professional and corporate efforts towards their own empowerment, emancipation and transformation. Further, it sought to reveal ways that participants' created opportunities within their work setting for enhanced self-management. Integral to these aims were two other objectives, one being to describe and critique the participants' perceptions of the impact on them of the power relations embedded in the hospital's organisational culture and the other to review and critique the common cultural assumptions, as discourses, that framed their practice role.

Research methodology

Ethnography that used an integrated feminist postmodern methodology was selected. This was viewed as an innovative way of finding out about nurses and their practice through a deep understanding of the culture in which participants practice (de Laine, 1997; Roberts & Taylor, 2002). Specifically, the ethnography embraced the features of Glass and Davis' (2004, p. 83) integrated feminist postmodern nursing research perspectives that:

> [a]cknowledge[s] each woman's individual and unique sociopolitical experience within their own particular context, validating the difference and diversity of perceptions within that context, recognizing the impact of the 'oppression narrative' within each woman's 'every-day life'; and 'creating opportunities to deconstruct' each individual woman's stories regarding her experience.

Data collection methods

Three data collection methods were used with each nurse by the researcher as ethnographer, (Pannowitz, 2007): participant observation, field notes and critical reflective journalling by the ethnographer, and an audio-recorded semi-structured critical conversation based on a question guide (see Table 2).

This approach meant that by being *with* each nurse in her practice setting the ethnographer was able to gain a deep understanding of the nurse's culture as she experienced it (Lareau & Shultz cited in Hodgson, 2001). The role of the

Table 2: Question guide for critical conversations

- Tell me of experiences in which you felt empowered (and inhibited) to achieve your personal, professional and corporate goals within this position. Why do you think this happened? How did these experiences feel for you? What would you do differently next time?
- Tell me of experiences in which you influenced the shaping of nursing practice or other health professionals' practice within this hospital.
- What are some examples of work experiences that you have found exciting, empowering, devaluing, confronting, controlling? Why?
- What cultural changes do you think are needed to enhance your role in the hospital? Why?

ethnographer was not to try to *be* the nurse but rather, aligning with feminist research principles (Cheek, 2000; Glass, 2007; Heckman, 1999), to experience the culture *with* the nurse. Data were transcribed and to protect anonymity all identifying features were removed and pseudonym names created for participants.

Participant observation was undertaken by the ethnographer with each nurse for three shifts and included informal conversations about the participant's experiences in her role. Field note-taking and reflective journaling occurred close to the time of participant observation in order to capture the ethnographer's observations, emotional responses to being in the field, and critical internal conversations about the research setting. These methods supported understanding of the interconnected features of the research objectives and the multiplicity of power/knowledge relationships (Foucault, 1980) as discourses that were politically interwoven in the nurses' ways of being and the nurses' own views of their subjectivity (Lather, 1991a). It also helped to identify taken-for-granted and the unacknowledged self-managing strategies participants used towards their own empowerment and/or accommodated oppression, if this existed. Semi-structured audio-recorded conversation was conducted in privacy with the focus on understanding the work-related experiences that each participant felt were empowering and/or disempowering to her. Conversation with each participant was different and provided a unique and potentially first time opportunity for her to listen to her own words (Glass, 2003a; Reinharz, 1992).

Data analysis methods

The analytic process for the research project was informed by the trifocal analytic methods previously used by Glass and Davis (2004) to theoretically re-position vulnerability. Other scholars such as Savage (2000a, 2000b) and Coffey and Atkinson (1996) supported multiple levels of analysis because it could reveal alternate interpretations to the same data. The innovative analytic method was developed to align the research question, objectives, methodology and findings. The method is shown in Figure 1.

The three lenses through which the research was analysed included realist, critical feminist and integrated feminist postmodernism. Realist experiences of participants were identified from the transcripts. Then, utilising Foucauldian (1980) and feminist postmodern analytic criteria (Lather, 1991b) discourses and subjectivity states were aligned with the realist exemplars, as shown in Table 3. The analytic process, as shown in Table 4, provided an audit and validity trail and involved nine phases. Analysis of one participant's data provided a common approach for subsequent participant's data.

Multiple member-checks

In keeping with feminist research practices each participant was invited to undertake three member checks of the emerging insights as specific only to her (Lather, 1991b). These checks sought to authenticate her transcribed data, centre her authority to critique the data analysis and emergent insights pertinent to her, and affirm that her identity and the hospital's identity were protected.

Participant selection

Eight middle level managers consented to participate in the ethnography following health service and university institutional ethical approvals. Participant selection was based on the following criteria: women nurses who were registered in Division 1 with the Nurses Board of WA and had a minimum of three years experience in an appointed middle-level senior nursing position in a WA public hospital. Consenting participants were employed in two of thirteen public hospitals in the metropolitan area of Perth, the capital city of WA. The multi-sited approach aimed to understand the broader cultural context within which the participants' practiced from their perspectives and was not aimed to compare or contrast individual hospitals.

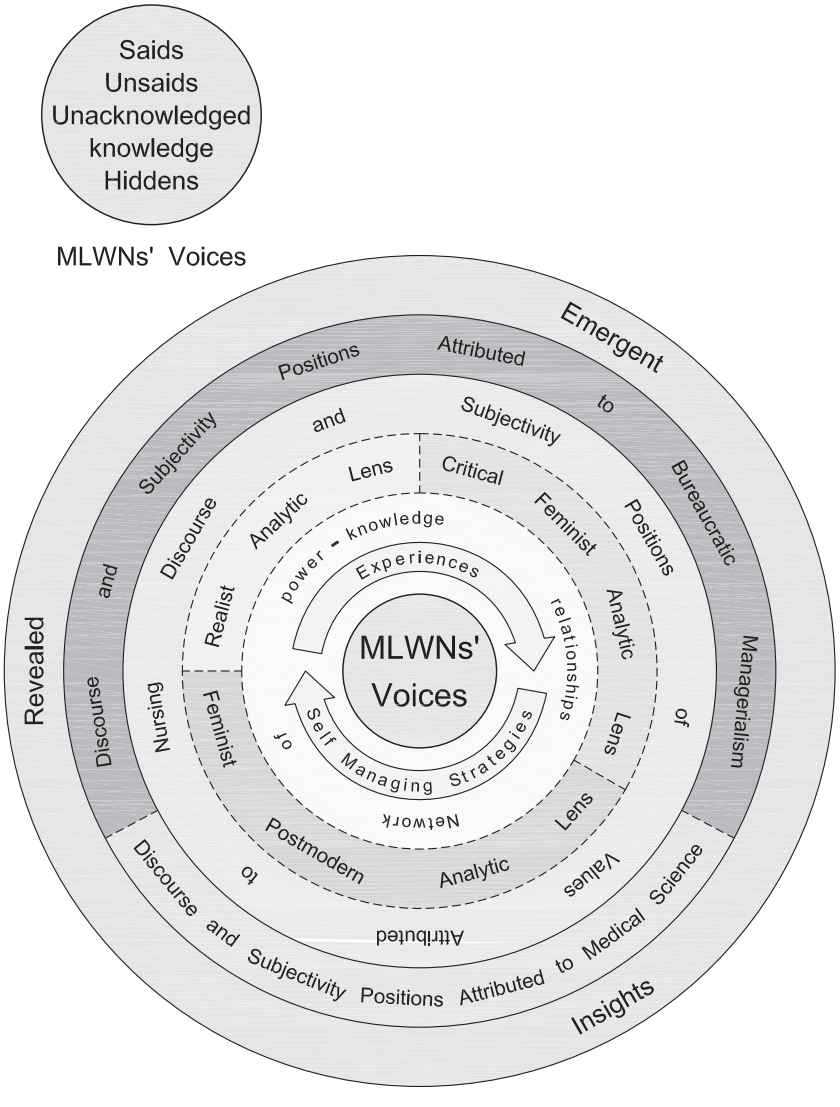

FIGURE 1: ETHNOGRAPHIC RESEARCH ANALYTIC METHOD

The snowball (Streeton, Cooke, & Campbell, 2004) technique was used to invite participants into the ethnography. An informant in each hospital, known to the ethnographer, agreed to refer colleagues who might be interested in the research. The research aim and format were explained in person and by an information sheet and those who agreed to participate signed a consent form. From both hospitals, about twelve women nurses who came to the informal meetings chose not to be participants. Participants' scope of practice incorporated management of up to sixty or more nurses at the clinical level, a mix of clinical and managerial functions, or clinical nurse specialist role providing expert consultancy across their respective hospital. Participants reported to a nurse executive who was a member of the hospital's corporate team.

FINDINGS

Analysis revealed many insights related to the cultural context in which the participants practiced.

Table 3: Alignment of emergent insights with exemplar participants' comments of their experiences

Discourse	Subjectivity state	Participant's realist exemplar
Values attributed to nursing – Between a rock and a hard place	Nurse advocate – Passionate connection	I've always seen my role as one of a caring nature towards the staff. I just want to do the best I can for the patients and nurses who care for them. Sounds corny I know but it is the truth.
	Patient advocate – Prime focus	The philosophy between corporate management and nursing management is different. This whole thing of money versus [nursing] ethics requires a lot of negotiation and dialogue to get what is best for patients. Money versus patient rights – where do they intertwine?
	Self – Different in the moment	I feel as though I'm constantly trying to put out fires, be a fix-it person for all sorts of things to support the staff.
	Relationship with nurse executive – An invited voice	We're very fortunate because our supervisor is very aware of the impact that our roles make and collectively how we impact upon quality of caring.
Bureaucratic managerialism – Absence of care	Relationship with nurse executive – An uninvited voice	I think if you raise it [a proposal for change], as a group, you've got a better chance of being successful. It's having strength in numbers. Also, if they [nurse executive] see that it's a useful strategy and it's not just one person, then obviously it makes that person think, 'Well, there's value in this,' rather than, 'Who in the heck does she think she is? How dare she suggest such and such…?'
	Limited authority – Marginalised expert	There was a function to celebrate the hospital's accreditation. I didn't get invited. So, I just invited myself. I introduced myself to the auditor and s/he just sort of looked at me like I had two heads, but I thought, 'Too bad. I did a lot of work to help the hospital achieve that award. I felt that I deserved to be part of the celebration.'
	Government employee – One of the silenced majority	[Executive level restructuring, and the loss of a director of nursing] will affect standards, the effect of trying to achieve good patient care – there won't be any local leadership and influence for nurses in particular – a role to retain rather than to lose. Nurses lose their voice.
Medical science – Working the margins	Medical dominated unit – Unchallengeable sovereignty	The senior medical officer made so many decisions 'on the run' which affected me and my staff considerably. As a result we were expected to make changes where we had no authority. The message I got later from my nursing executive was not helpful. I wasn't supposed to challenge doctors!
	Professional frustration – Fear of future loss of nurses	The graduates are educated in university to be autonomous practitioners and to be creative, but, when they come out, the nurses in the wards are hospital trained, and they tell them how to do their job, make beds, do the medications, rush to get everybody showered before 8.30 regardless of what the patient wants, and that's antiquated…' That's the traditional mind-set and I don't know how you get over that… it's all centred around the doctor… That's why a lot of junior nurses get really disillusioned.

Table 4: Ethnographic multi-phased analytic process applied to the data

Phases of data analysis	
Phase 1	Authentication of Transcribed Realist Data and 1st Member Check
Phase 2	Realist Analysis of Realist Data
Phase 3	Critical Feminist Analysis of Realist Concepts
Phase 4	Postmodern Foucauldian Analysis – Emergence of Discourses in the Participant's Cultural Context
Phase 5	Alignment of Realist Exemplars against Emergent Postmodern Discourses
Phase 6	Integrated Feminist Postmodern Analysis of Realist Experiences
Phase 7	Emergent Feminist Postmodern Insights of Participant's Self-Managing Strategies and Implicit Knowledges
Phase 8	Draft Data Analysis – 2nd Member Check
Phase 9	Preparation for Discussion – Chapter 6 The Voices of Participants Experience and 3rd Member Check

It also revealed participants' unique self-managing strategies that they used to deal with experiences revealed as empowering, disempowering and/or oppressive. The main themes common to the participants are summarised in Table 4.

Participants were found to practice within three always-present competing cultural discourses: *values attributed to nursing*, *bureaucratic managerialism* and *medical science*. Whilst the participants experienced being in these discourses differently it was found that the discourse of *values attributed to nursing* was empowering to each, whereas, the discourses of *bureaucratic managerialism* and the traditionally gender-biased *discourse of medical science* were found to be generally disempowering. Further, the taken-for-granted cultural norms evident in the disempowering discourses were shown to patronise and subjugate their professional nursing values, nursing knowledge, managerial expertise and their nursing leadership endeavours. For the participants, these three discourses were always present but they fluidly, and at times simultaneously, moved between them. However, their intentions and actions were principally to act in empowering ways in their role and to actively resist becoming embedded within the disempowering discourses. More detail of the findings is presented in the next three sections.

Discourse of values attributed to nursing – between a rock and a hard place

Optimistic insights were revealed in that the participants were found to be deeply embedded and practiced within their nursing values discourse, passionately connected to caring about and speaking up for nursing knowledge, nursing colleagues and being patient advocates. For example, within this discourse, participants spoke about and described experiences of their respect for humanity, ethical practice, role modelling and mentoring, caring-based relationships with other staff and the importance to them of informal conversations with like-minded colleagues. Participants also spoke of feeling empowered when their nurse executive openly valued their voice, in nursing forums or on nursing workforce issues.

Each participant used empowering, self-managing strategies consistently in her nursing practice. These personal strategies reflected their resilience and decision to staying in their job. Being self-empowered also influenced the participants' ability to foster self-esteem and confidence among their nursing colleagues and team members. Importantly, each participant actively resisted being subjugated by the oppressive discourses of *bureaucratic managerialism* and

medical science. Their resistance was reflected in their determination to have nursing values and knowledge acknowledged as valuable and legitimate contributions to health care practices. The actions they took in this respect were viewed as 'creep up/creep in' rather than confrontational strategies for embedding nursing values as taken-for-granted cultural ways of thinking and behaving within their health arena, which were viewed as forms of feminist political activism.

One participant's comment demonstrated the kind of empowering, trusting, emotionally-based and inclusive nursing practice culture (Brown, 2002; Maak & Pless, 2006) that the participants sought to create:

> Chloe: Nurses have often said I am very fair and even-handed. I don't favour any one person over another. I try to do my best to make sure they're happy in what they're doing. I'm a great believer in ensuring that people get praised. I think we're all equal, you're still a person the same as they are. They've got expert skills and I don't think we should boss people around.

Discourse of bureaucratic managerialism – absence of care

The discourse of *bureaucratic managerialism – absence of care* was revealed to be extensively evident in the local sociopolitical contexts of the participants' professional arenas. Related to their scope of work responsibilities, participants' experiences revealed that this discourse featured high-level, centralised cost constraint policies where fiscal values overrode the care value of nursing. Example experiences included restrictions on employing experienced nurses over that of graduates which put at risk appropriate skill mix needs for patient care, no authority to employ agency nurses when staff shortages were critical, poor provision of staff development opportunites and preceptors for new graduate nurses, lack of funding availability to support important professional ongoing nursing education, preparation of budgets but no authority to manage those budgets on a day-to-day basis and orders to close beds and increase patient turnover.

Disturbing insights were also revealed. Disempowerment was experienced by many participants in their relationships with nurse executives. Participants spoke of nurse executives using oppressive behaviours towards them causing them to feel isolated, invisible, marginalised, unseen, unknown, undervalued, silenced, trapped, humiliated and bullied. Many participants were also not mentored by their executive nurse and were often rejected when it came to participating in special project opportunities or higher duty experiences. Their disempowerment showed that the cultural context was one of oppression by nurses upon nurses and reflected unhealthy workplace cultures.

Practicing within this discourse brought out unique self-empowering strategies used by each participant. When they recognised an experience was disempowering, they actively sought to resist being subjugated by it or becoming dysfunctional in their job. They found personal ways that they could re-establish their sense of confidence and re-engage in their professional interest to achieve in their job, and focus on advocating for nurses and patients.

In addition to ways they empowered themselves, other self-managing strategies were also found. Examples of self-managing empowering strategies within this discourse included the following. They refrained from speaking up about issues in senior nursing forums. Instead, they raised issues and potential solutions as a group because a group proposal was more likely to be heard. Some participants ceased attending some forums because of the open hostility towards them by the nurse executive leading the forum. All participants informally met with like-minded colleagues with whom they could speak about disempowering or oppressive experiences, be heard, understood and supported in a caring way viewed as emancipatory consciousness-raising opportunities. Mentors were also found outside their work culture. The nurse manager participants actively protected their nursing

subordinates from the tensions evident in their role or with their relationship with corporate executives by refraining from speaking about their experiences at their local unit level or outside of their working culture. Even within the context of this disempowering discourse the participants also protected their respective nurse executive by their silences as ways of respecting their nurse leaders' position and the integrity of the nursing profession.

Discourse of medical science – working the margins

Several participants had direct contact with all levels of their hospital's medical staff whilst the others were in contact with medical staff via their respective practice-based senior clinical nurses. Analysis, however, revealed a perpetuation of medical dominance within each participant's culture of nursing practice. There continued to be an imbalance of power/knowledge relationships between nurses and doctors. Thus, as a second disempowering discourse *medical science – working the margins* was also revealed to be always-present and taken-for-granted in participants' workplace culture.

Not all doctors related to nurses in oppressive or disempowering ways. However, no participant's experiences revealed where doctors had actively or indirectly endeavoured to empower nurses as professional equals. Dominating medical behaviour was evident in their day-to-day practice. Doctors' behaviour was viewed as an absence of care or interest in the importance to patient care of nurses' knowledge, competency and patient-management. The sovereignty of the medical model of health service was showcased by the traditional medical ward round being conducted to suit the doctors' time-frame rather than being scheduled around nursing or patient needs. This was also exemplified by nurses stopping their practice to attend to doctors upon their arrival to the patient unit and which showed nurses subjugating their nursing practice priority to be with the doctor. Doctors did not accompany nurses on patient care rounds.

Other examples of medical dominance included lack of nurses' formal authority to question a doctor's decision, nurses enacting doctor's decisions but not vice versa, doctors who asserted team leadership but did not function as team players, patient admission/discharge determined by doctors and not nurses, senior doctors controlling the unit's budget, the absence of nurses' involvement in the development of unit strategic/operational planning, doctors holding the role of unit director but with no managerial expertise and the personality of the doctor, as unit director, being embedded as the local workplace culture. There was also a lack of interest, care or advocacy by many medical staff toward nurses' educational interests. For example, for many participants there was a lack of advocacy support for nurses' specialty courses.

There was limited evidence that the medical staff acknowledged expert nursing knowledge. Two participants experienced excellent relationships with and recognition as expert nurses with a number of medical consultants but one of these participants did not realise the subjugated nature of her role when she stated feeling 'privileged to be invited' to give medical consultants her nursing opinion about patients' needs. Other participants were required to re-negotiate their nursing knowledge and practice expertise with doctors who were new to their unit. Other disempowering experiences included medical staff's lack of inclusion of nurses in the development of patient education material. The criticism by the participants was that doctors incorrectly believed and functioned as though they knew best about nursing expert knowledge.

The participants tried to make sure that nursing care values, nursing expert knowledge, and nursing's practice contributions to patient care were accepted as legitimate by medical staff. Participants quietly tolerated situations when their expertise was not acknowledged and resisted internalising such criticism. Their self-analysis and critical reflections affirmed their own capability and expertise; practices viewed as emancipatory self-managing strategies. However, as in the

other oppressive discourse they pursued a policy of creep in/creep up rather than tackle the situation directly.

Discussion

These ethnographic insights are important contributions to understanding ways that nurses resist being enculturated into disempowering discourses. The three themes showed how the nurses remained embedded in their nursing values but also revealed that patriarchal-bias was present in their every-day practice settings. The ethnography also revealed numerous exemplar experiences, not previously published, through which participants could express the meanings they attributed to being in their roles. The findings, therefore, may be relevant to other nurses, especially those in middle and executive health organisation positions and women generally.

Overall the findings from this research project can be viewed optimistically and worthy of celebration. Analysis of how the participants experienced being in middle-level senior nursing roles showed they actively resisted being overwhelmed or disempowered by various tensions present in their day-to-day working culture. Their efforts were principally focused on actively practicing within the discourse of their nursing care values by using unique and empowering self-managing strategies. Their embeddedness in the *values attributed to nursing* was fundamental to their staying in their jobs and remaining passionate about nursing. In their ordinary daily practice their self-knowledge reflected awareness of their expertise as practitioners and managers. What was extraordinary was that the participants knew they functioned in complex cultures where their contributions to effective patient care and nursing workforce problems were often thwarted by other senior staff who seemed to function within discourses disempowering to nurses. Further, the participants' informal connections with like-minded colleagues were critical. Such informal relationships provided opportunities for them to speak confidentially about experiences which were either empowering or disempowering and be heard, understood, acknowledged and validated. Such supportive relationships were revealed to align with the feminist perspectives of consciousness-raising opportunites.

Findings from the ethnography were also timely in considering what nurses seek from their leaders in the wider professional arena. For example, the American Association of Critical-Care Nurses (AACN) published an evidence-based and relationship-centred set of standards for nurse leaders (AACN, 2005). These standards differ from theories presented in text books and encompass many principles more akin to nursing/feminine values (Chinn & Wheeler, 1985; Glass, 2000; Glass & Davis, 1998; Lawler, 1991; Ogle, 2004), such as *true collaboration, meaningful recognition of nurses* and *authentic leadership practices* (AACN, 2005, p. 189). Nurse theorists, such as Benner, Watson and Leininger (Marriner-Tomey, 1994) and nurse scholars (Chiarella, 2002; Chinn & Wheeler, 1985; Glass, 2000; Glass & Davis, 1998; Lawler, 1991; Ogle, 2004) aligned nursing's values with those of feminine values, such as *caring*, *nurturing, healing*, and *holism*. From an extensive literature review, Peter, Lunardi, and McFarlane (2004, p. 404) contended that nursing ethics embraced 'the values of care, social justice, freedom from exploitation and oppression and the maintenance of relationships and community'. Further, honesty and other ethical values of nurses were shown to be highly important to the community in comparison to other health and other non-health professionals (Gallop Organizational Poll, 2003).

What was disconcerting about the discourse of *bureaucratic managerialism* was that participants revealed numerous disempowering experiences, related to their respective nurse executive deploying the corporate agenda in ways that reflected an absence of care. Participants experienced high levels of contradiction and tension between the corporate agenda of fiscal constraint and their embedded values of nursing. The participants' limited authority and involvement in important nursing education and workforce decisions belied

their senior position within their hospital. Their professional nursing efforts were overpowered by the patriarchally structured hierarchy which impacted negatively on most of the participants' ability to set and achieve local-level leadership goals that would benefit nurses and provide effective patient care.

The experiences within the discourse of *bureaucratic managerialism* showed forms of gender-bias more typical of the patriarchal subjugation of women's way of being and knowing. Disempowering behaviours exemplified by nurse executives toward participants, as subordinate senior nurses, was more akin with what Freire (1970) proposed about oppression. He ascribed such behaviour as oppressed group behaviour deflecting oppression upon a less powerful group. For these participants, it was nurses disempowering other nurses within and from a hierarchical vantage position.

Within their practice culture, participants also functioned within the *medical model discourse* as the traditional discourse present in the Australian health system. The findings of this study and previous research show that this discourse historically subjugated nursing. Whilst the participants in this study took this discourse for granted, they actively resisted being enculturated or disempowered by it. These nurse participants sought to have nursing values and knowledge embedded as valuable and legitimate within the context of health service practice. The ways they fostered the inclusion of nursing values and knowledge were identified as *creep in/creep up* strategies, or *working the margins* rather than openly confrontational.

Limitations of the research project

There are several limitations to this study. It was not the intention of this project to identify any causal basis for the experiences participants discussed. An underpinning feminist postmodern purpose of the project was to centre the voice of each participant, validate her respective practice-based knowledge, and raise awareness of ways each nurse self-managed the tensions present in their work roles and workplace culture. Thus, the findings were not intended to be generalisable. Further, although the ethnography had an emancipatory intent, this was not measured in any form and was left up to each participant and the researcher to personally assess this. However, it was hoped that the findings may evoke a sense of commonality for other nurses and women whose roles encompass a mix of corporate bureaucratic and professional values. It is also acknowledged that alternative and/or different findings could have been revealed by the application of the same methodology or other qualitative methodological and method approaches.

Conclusion

The perspective of an integrated feminist postmodernist ethnography opened a new and unique space to centre, validate and celebrate the women nurses' voices of their practice reality. The insights revealed what it meant for the participants to function within the corporate and professional agendas. The innovative multi-phased analytic process revealed their experiences as patriarchally gender-biased. This was evident, especially in terms of the dominant always-present disempowering discourses of *bureaucratic managerialism* and *medical science*.

The ethnography incorporated an emancipatory intent. The ethnographic methods included participant observation, field note-taking and reflective journaling, and conversations with each participant, were ways of being *with* participants and not doing research *on* women. The application of feminist research practices, affirmed by the extensive personal accounts discussed with each participant, created a trusting research culture within which the women nurses felt able to speak up, speak out and be heard. Their experiences were worthy of being understood and legitimated in publication.

The whole research process was undertaken through the application of the three methodological lenses of realist, feminist and postmodern perspectives. The multi-phased innovative analytic

process achieved the research question, aims and objectives and provided a validity and audit trail. The analysis revealed new knowledge about the context and practices within which the eight middle-level women nurse participants functioned in WA public hospital cultural contexts. Academic critique of the emergent insights and the foregrounding of participants' experiences provided a revelatory context demonstrating that women's knowledge, as middle-level nurses is valid and legitimate.

The emergent insights also contribute to the state, national and international professional nursing dialogue regarding issues currently confronting nurses in middle-level positions. The period during which the ethnography was conducted was one filled with multiple inter-nursing and nursing professional–governmental political tensions. In foregrounding the participants' voices of their experiences, such as responses to the persistent gender-bias confronting nurses, new perspectives were revealed.

The authors also suggest that the ethnography contributes non-traditional knowledge to the body of nursing, nursing management and social science. In keeping with postmodern notions, the authors acknowledge that alternative readings could be made of the emergent insights and critique. In methodological and practical terms, no generalisations, or closure is posed for this ethnography. It is important to note that the terrain for nurses in middle-level positions is a constantly shifting and dynamic cultural context. However, if the insights resonate with other women and nurses whose role is in management in particular, or evoke a sense of enlightenment, then the project has also achieved an additional positive outcome.

Further research, both qualitative and quantitative, is suggested to expand upon the revealed insights. More understanding is needed of the context and practical ways that could foster middle-level nurses' self-empowerment to achieve their professional and corporate goals within the tensions of competing and different cultural settings. Research that has emancipatory and celebratory intent with nurses in management and/or clinical specialty senior positions may provide much needed practical professional solutions to attract and/or retain nurses in these critically important roles. Further research is needed that aims to support nurses in their advocacy role to legitimate nursing values and women's values.

The authors also agree with the assertion that, unless patriarchal oppression is named and exposed, then nothing will change (Glass, 2000). In concert with the naming of oppressive experiences, transformative possibilites may be revealed, in turn allowing for the celebration of empowering practices, as has been shown in this paper.

Acknowledgements

This paper is dedicated to the eight middle-level women nurse participants whose voices are worthy of public honour. Special thanks are also extended to higher degree research staff and students, School of Health & Human Sciences, Southern Cross University who fostered an empowering, inclusive, learning research culture.

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Received 08 August 2008 *Accepted 06 July 2009*