# Restructuring: A View from the Bedside

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**Abstract**

This qualitative study reports on the perspectives of hospital staff nurses regarding the recent restructuring of Canadian healthcare. They were the group on the front lines bearing the brunt of the changes. Yet, mostly they had not been consulted, as the decisions were made elsewhere. Twenty staff nurses working in a variety of Toronto hospitals were interviewed and described the impacts on themselves and their patients. While restructuring focused on deficit reduction and increased efficiency, the factors affecting quality of patient care and work life of nurses were neglected. The major strategies employed – increased workloads, casualization and deskilling – changed nurses' work at the bedside. Stable teams disappeared as nurses were hired into casualized positions. Care was reduced to specific tasks and routinized, to be carried out by a "skill-mix" of workers. The nurses' relationships with patients, the "heart and soul of nursing," became largely limited to managing care for a number of patients over one shift. Lack of time and continuity with their patients left nurses dissatisfied. The voices of bedside nurses and their suggestions for change add some novel perspectives to the restructuring discourse.

This study reports on the thoughts and experiences of hospital staff nurses during the recent restructuring of the Canadian healthcare system. The purpose is to bring nursing voices into the discussion about the effects of restructuring and the possible changes that nurses envision.

Over the last decade we heard much about the need for deficit reduction as major cuts were made to social services (Peterson and Lupton 1996). The variety of organizational changes that resulted within the healthcare system are commonly referred to as "restructuring." Beds and even entire hospitals were closed and patient care services reduced. Nursing positions, as large budget items, became cost-cutting priorities. As a result, hospitals' shares of total expenditures are starting to slip, yet overall, healthcare costs continue to rise. Drug costs and physicians' services seem largely responsible for the increase (Canadian Institute for Health Information 2000). For the nurses still in the system, workloads increased dramatically. Another major outcome was an expanding "casualization" of labour, as caring work is now performed increasingly by part-time staff: a flexible "skill mix" of nurses and lesser-skilled/unskilled workers (Huston 1996; Prescott 1993).

The negative effects of restructuring on patient care and nurses' working conditions are now widely documented (Baumann et al. 2001; Burke 2001; Spence Laschinger et al. 2001). Few researchers, however, reported on the perceptions of frontline nurses, who experienced the brunt of the changes. An exception are Gail Mitchell and Mary Ferguson-Paré, both nurse executives in Toronto hospitals. Striving to understand the forces that affect nursing work life (Ferguson-Paré and Mitchell 2001), they began to hold regular meetings with staff nurses to discuss nursing and human resources care. One primary concern identified in these meetings was the loss of crucial support networks. Many nurses also stated they felt devalued and "not cared for." However, they expressed a strong desire to rebuild community among themselves.

As restructuring emanated from and was fuelled by managerial science, its aim was primarily to increase efficiency. Therefore, it was centred around deficit reduction and the introduction of market principles into healthcare through "managed care" (Goode 1995; Lamb et al. 1991; Peterson and Lupton 1996; Smith 1998; Sturm 1998; Wood et al. 1992). Major shifts towards more "routinized patient care" took place through "care map" technologies (Goode 1995) and "deskilling" (Davies 1995). A care map, designed to increase efficiency, is a typical instrument through which care delivery is routinized and standardized. Intermediate goals and outcome criteria are listed. Workloads are broken down into specific tasks, centrally calculated and assigned to workers with varying levels of skills. As patients' collaboration is crucial, they too get a copy of the care map, to know what is expected of them.

Routinized care supposedly allows any health worker to step easily into a situation and perform according to at least "minimum standards," an assumption that underpins the move towards increasing casualization (Davies 1995). Standards of care are necessary, of course. However, indiscriminately applied, they can result in a one-size-fits-all approach. Conflicts arise when the care map's approach is too rigid,

leading to a perceived lowering of standards (Tovey and Adams 1999), thereby causing moral distress to nurses (Mitchell 2001). Patients' individual differences always need to be accommodated, and patient goals should never become subordinate to institutional goals. Within trusting relationships, nurses further patients' well-being precisely by considering their individualities and situations as whole, unique persons.

In the name of efficiency, jobs were casualized. This concept was carried to the extreme through city-wide staffing agencies as "just-in-time nursing" (Gustafson 2000), dispatching nurses to wherever they were needed. Therefore, over- or under-staffing due to last-minute changes was thought to be minimized. However, the effect of this arrangement on nurses was hardly considered. For some time, new graduates were able to land only casual positions. They struggled with unfamiliarity, not only with their patients, but also with staff, hospital layout, charting and all institutional "routines." Statistics show that the stressful working conditions took their toll. Nurses who had sick benefits lost "a whopping 150 per cent more working time than the Canadian average for all full-time employees" (Fletcher 2000: 20). These figures leave out all those nurses who came to work sick or had no sick benefits, such as the casualized nurses. Many left to work in the United States. As a nursing shortage and healthcare crisis loomed, it seemed important to explore the nursing perspective on this issue.

## Description and Method of Study

The findings I draw on here are part of a larger qualitative study that covered aspects not discussed in this paper. The data were collected between late 1998 and mid-summer 1999, as cutbacks were still at their height. Twenty participants, 17 women and 3 men, were selected purposively to get a range of viewpoints and experiences from seasoned to newly graduated, as well as diploma- and degree-prepared, nurses. As all were working in a number of hospitals in Toronto, confidentiality and anonymity for the participants was ensured, amidst the then prevailing climate of fear and job insecurity. This strategy also revealed local variations in implementation. Using a descriptive/exploratory approach, I designed a semi-structured interview guide with open-ended questions. The nurses were asked to reflect on their everyday experiences with current restructuring. This format provided guidance to stay on the topic, yet allowed them to express their thoughts freely on the issues. Probes were used if more information was sought on a subject. The questions relevant to the data discussed here are:

- How has restructuring affected you in your work? Discuss advantages and disadvantages.
- How has restructuring affected your relationships with people you encounter through work: patients, other nurses, members of the multidisciplinary team, administrators?

• How do you think restructuring should be carried out?

All interviews were audiotaped by myself and later transcribed. As I was dwelling on the data, several patterns of the effects of restructuring on nurses' work lives emerged, which I organized into themes. In response to the last question, the participants' recommendations for restructuring are summarized later in this paper.

**Findings**
**Trends emerging during restructuring**
Participants described several trends that had emerged within the restructured system with some positive, but mostly negative effects. The restructuring process itself was seen by a few as a potential opportunity to promote better allocation of the nurses' expertise:

> I think that there has been more of an internal reflection about nursing and what we do. … One could say, if you are doing the exact job of an RPN and at almost 25% more cost … in this day and age cost seems to rule somewhat. … Historically, we always looked at our practice and defined it as medical tasks, yet … one of the challenges of the future is to get RNs to look at their roles in another way.

Many, however, perceived reallocation of some of their chores, in the climate of constant layoffs, as threatening and anxiety provoking: "Each time a new task is given away to another worker some of my colleagues say, 'Well, what is there for us to do now?' I can see our roles vanishing, they could be vanishing."

Most participants welcomed the idea of moving healthcare out of hospitals and back into the community: "With the long-term focus of healthcare restructuring going to the community, I think there are a lot of benefits to that. People always have done better in their own setting." Yet, they also realized that there were problems:

> Well, they cut all the acute care but they never put the community services into place before the shifting … and people are falling through the gaps. … So you have all that, the coordination done by the bureaucrats, and it is like, it is not their world … .

Partaking in selected hospital committees was mentioned favourably by several participants, as it provided opportunities for their input:

> In the past it was only the head nurse, the educator and the charge nurse who made the decisions, not everybody. Now all the staff nurses have

joined a committee, so everybody has a say … and eventually through discussion, through minutes, through voting we come to a decision. … Before we felt on the low end of the totem pole, whatever happened at the top, we did not know. Now we are involved.

Others, however, saw participation in committees as a mixed blessing. The meetings are held during regular hours, yet nurses work shifts and weekends. If not on duty that day, they had to attend on their own time and shoulder expenses such as transportation:

And … see, if they want you to come in for a meeting, well, you are not paid for your time while you are there for the meeting. … If people are commuting from distances, it is like: why should I take an hour to get down there and an hour to get back and attend a meeting for two? That is four hours of my time. … And they can't even put out a coffee for you or whatever! Enough is enough! You don't expect me to be there, and that is how a lot of nurses feel … like, why should I?

Those who were on duty usually found it hard to attend owing to their heavy workloads.

In most aspects relating to quality of patient care and work life, the participants reported experiencing restructuring as devastating. Unanswered ringing call bells were a metaphor mentioned by almost all participants at some point. It seemed to symbolize unsatisfactory care and its effect on nurses: "Bells are not answered, there are much more bells. I don't know if that is because nurses get burned out … but I have noticed that that is happening." Another major criticism was a perceived lack of support for nurses. As care givers, they felt discarded. One nurse recalled:

Nineteen ninety-five, ninety-six … I think that was the point when they were really tightening up on the budget. Our workloads took a major leap. I did not really feel there was any support given to us at all. Some of my co-workers were let go quite dramatically and a couple of girls ended up on leaves for … psychiatric reasons. They just fell apart, it was terrible … a lot of negativity on the unit.

Even those with many years of seniority were laid off: "It really just threw everybody for a loop. And you realize … you were just a number. In the end, these events made everyone take a second look at nursing as a whole."

A perceived lack of input by bedside nurses into the restructuring process was also a recurrent theme:

I have to say [restructuring] has been a frustrating experience, mainly because I am kind of sitting on the sidelines, seeing what is happening … and not really liking it. There has not been a lot of consultation with the bedside nurses, the nurses who are on the front lines.

Another nurse stated:

There has been [consultation] with a lot of people who are in the education system, people who are employing nurses and community members. But I have not seen – nor did I read a lot in the task force report – a lot of feedback from staff nurses who, I think, are taking the brunt of the restructuring. … Nurses are not consulted regarding restructuring. We teach physicians at the bedside, we help run cardiac arrests, we help determine factors in patient care; these are critically ill patients, yet in workplace issues we are ignored. "I [hospital administrator? doctor?] am the elite, the elite group; I will make the decisions, whether you like it or not. The door is always open … we will hire whomever we want." … This paternalistic attitude is so dominant, and society at large is accepting it.

However, on one unit, where the staff were consulted, the changes were perceived much more positively:

When we did restructuring on our floor some staff members were involved, I was involved. There were two nurses with the manager; we did get someone from the outside too. We felt that we should get feedback from all the staff members, because we have services different from other floors.

A gap between what nurses are prepared for and willing to do and their actual jobs frequently became apparent. Despite all the focus on efficiency, many felt this goal had not been achieved: "The delivery of care is still inefficient. Nurses still have to porter clients. Nurses still have to go and obtain materials." Another scenario, too, was typical: "I am looking after the phones, I am making appointments, I enter their appointments into the computer, oh yeah, I think a nurse does everything, change the garbage, you know." Almost all participants commented on chores that took them away from patient care, such as changing garbage bags and disposing of dirty linen. The most hated task was the ever-increasing paperwork. One participant referred to it as "paper care" and further argued:

We probably can do a lot more in nursing, with the staff that we have, without adding more staff, without handicapping them, tying their hands behind their backs, with triplication of all the various documentation that they have to do in their everyday practice. … There is just no time to do

basic patient care, whether it is a back rub, time to do treatments properly, or even listen to patients, find out what other current problems are happening.

One of the degree graduates voiced her extreme frustration: "Four years of theories and all I have time to do is tasks! Will I ever utilize what I have learned in university?" These feelings were echoed by another:

> Coming from a degree program, with my education … I did not think I would have to do everything, do a lot of this stuff, I did not expect that. I could do more, with my education! That is what I feel, like … I need more challenge. I love more responsibility, but something that is more related to nursing. … Some responsibilities are just … not what I was prepared to do.

Several of the nurses felt that, as nursing comprised the highest budget in health care, it was largely blamed for its deficits. One participant passionately proclaimed: "Well, you know what? Nursing is the budget! No kidding! Who the heck do you think is taking care of all these people?" Regarding the overall impact of restructuring on the public, one nurse stated:

> And it is a … George Orwell [situation], where … people are just going to tolerate more and more of a lower quality and lower standard in health care. And as people are more and more conditioned to that, then their expectations will also be lowered, and they won't remember how good it was.

## Orientation and education

Cutbacks also affected the orientation of nurses hired into the highly sophisticated technical environment of hospitals. Statements about nurses, particularly those who were new, being "thrown" into work situations surfaced repeatedly: "There should be more training for the new nurses that come out [of school], not just throw them on the floor like that. I know some hospitals do have good training; not ours." Another participant related how, in her specialized unit, new nurses were trained by the resident staff. There was pressure to speed up their orientation:

> And then, some of the less conscientious staff persons were the ones who were too afraid to pipe up and say what people were saying behind the coffee door. … So, those people got pushed through … and are not coping. … They can't even read a monitor strip! Extremely dangerous.

The situation was further aggravated by the newcomers' own feelings of insecurity:

> I have seen people working alongside me that can't cope. They were too afraid to speak up to say, "I can't do this" and … they were being threatened

that they would lose their job. … the mistakes that were being made were just getting too big … and nobody was listening. … A lot of people were afraid of stepping on toes.

Simultaneously, there was pressure to complete a baccalaureate education, yet little support for it, as noted by this recent diploma graduate:

> They don't even give me time off to go to school. … They are very cocky, telling you how they are education centred, and they want their nurses to upgrade. … Yeah, it's all talk! They want the best qualified nurses they can get, but they are not prepared to give them the time to do it.

Many nurses deplored the perceived inadequacy of clinical preparation in nursing schools today, particularly the universities:

> Problem-solving and creative thinking are best learned in actual situations. … You can study community health principles all you want, you can study transcultural nursing perspectives all you want … those are basic nursing knowledge things. If you are going to have degree-trained nurses as the entry level to practice, you have to give them more bedside clinical hours!

One participant saw the current trend to hire nurses with degrees over those with diplomas, ostensibly to promote professionalism, as cleverly exploited by others to further the "bottom line":

> But, you know what, now they are laying off people with seniority, because it is costing them more than hiring new grads. And telling you they want degree nurses. … They are not getting degree nurses, they are getting fresh grads with degrees … and they are using the degree as cover to get rid of [the senior nurses]. They are mostly young nurses that are being paid less. Hospital administration does not care whether you have a degree or not. The professional bodies do, but not the administrators.

One nurse described how, in the acute care hospital setting, the much-hailed nurse practitioner role, instead of promoting an independent nursing status, had largely been assimilated into the existing power structures: "Our acute care nurse practitioners are basically physician assistants with all their knowledge." She advocated instead for raising nursing's profile in the areas of prevention of illness and health promotion, as "they are more suited to nursing's focus on the whole person."

### Impact on relationships among caregiving team
Restructuring destabilized the previous organization of nursing work. To reflect the

focus on the whole person, nursing is widely referred to as "total patient care." One participant stated:

> While now, you may look after that patient today, tomorrow there is some-one else. There is no … there is some consistency but no responsibility for any particular patient. You are just going to work and that is it! Total patient care for 8 or 12 hours.

Team nursing once denoted a group of staff who rotated together and knew each other well. Now, as new nurses everywhere were hired chiefly into part-time posi-tions covering at least two units, this social support network no longer exists. Yet, most worked more than full-time hours. It was felt that this format was chosen to decrease some costs, such as sick-time:

> Because they figured that way you would not call in sick as much … because 12 patients means … stress … and during stress your resistance is low, you get a cold. So restructuring, I wish they would give us less patients, so … we can give 100% of ourselves. … And you see nurses who say, because that is my fifth day and I have had it! … the morale just goes down. … But then again, the nurses who work full time, they are exhausted, they are tired … and I am glad I am doing 8 hours [as opposed to 12]. Sometimes I have to miss my breaks, just to make sure I am on time to do everything.

The part-time arrangements seemed particularly hard on junior nurses. One new graduate reported that

> my friends all have [graduated from] degree programs. … They'd rather be unemployed than work in the hospital. I'll be honest with you. I mean it is a shame to see that my friends are working at Sears, getting $16 an hour, and they are a lot happier than working at the hospital for $2 an hour more.

Others, who were registered practical nurses (RPNs) before becoming RNs, contin-ued in their old positions after graduating:

> I could not find a job on graduation, none of us, none of my classmates did. The majority of the girls in my class in the part-time program were RPNs and they were working at the time. And they often remained RPNs, because they could not find a job.

One nurse reported on how scheduling was changed when a different unit manager was hired. In this particular unit, before,

more or less, the charge nurse was quite flexible. … With shifts for people with families, you need to sometimes juggle things around a bit, and I don't think people would ever leave the floor unstaffed or unsafely staffed … and so this [function] was totally taken over by an administrative assistant, and there is not much flexibility.

Others, too, described increasing rigidity in shift assignments and, like this participant, concluded: "We need more ways to allow better scheduling, such as time sharing and self-scheduling, to prevent burnout, which starts to show in decreased quality of patient care."

On a typical day shift, the participants reported that their patients numbered up to 10 or 12, which meant that nurses mostly held a supervisory position. All of them strongly voiced their dissatisfaction with managing others, who did the actual caring:

So now they have sort of pushed the envelope, they have stretched the boundaries and they are giving people more responsibilities and put them in areas, and they have sort of made the nurse a glorified manager, so that she is doing very little hands-on. She is servicing machines and running up and down and she is responsible for the work and the performance of a whole lot of other people … absolutely more of a management position. I am looking forward to getting out, because it's been so many changes in the last 10 years, my head is spinning. Truly!

### Relationships with the multidisciplinary team and management
Closer collaboration with the multidisciplinary team was a universally welcomed change. The nurses reported that it enhanced coordination of patient care and increased understanding of and respect for one another's roles:

Pharmacy, social work, they are much more on the floor. … We see them much more frequently, you know who they are and you can access them a lot easier. … Things get done, we figure out what the problems are and work things out right away … like, everybody is listening.

However, there was also a down side to the enhanced partnership. Some participants expressed concerns that nurses tended to go along with team members' decisions even if they were not in the best interest of patients, whom nurses knew best:

Because the nurse is part of the team, it is good … but that he or she aligns with the client and not the team, which we initially thought would happen, but it has not [happened]. So, the nurse is still very much a team member and espouses the team's values and directions. Very few times do you hear a

nurse say, "This is not what should happen, because this is us [what we want as a team]. … [The patient] wants to do it this way." I think we need to try that.

With regard to administration, many believed that there was a "tightening of control from centralized positions in an office somewhere." Most of the nurses felt that they were treated with disrespect:

> But when management, like the other year, tell us we are not valuable, and we may be laying off, or we may get rid of you, that affects you too. Even though I know in my mind that is not true! But it is a way of kneeling people down and controlling.

The representatives of administration with whom the nurses had the most contact were the unit managers. In the past, unit managers were also considered support persons for staff. As nurses, they were familiar with nursing care. One participant remembered working with a manager, years before, who had left post-it notes to her staff for "little things they had done well." She had kept and cherished them to this day. Yet, the unit managers now were seen by some as distant and generally nonsupportive. A repeated observation was: "You always hear about things you have done wrong, but never about what you have done right." Another comment was:

> All I ask is don't book me Sunday night, so I can go to school Monday morning. … I have written to her, I have talked to her on the phone, I have talked to her in person. And the new schedule came out and she had me down to work every Sunday night.

To be a unit manager, a nursing background is now no longer required. The consensus was that nurses encountered the greatest difficulties with managers from other disciplines. Statements such as "If nursing care is what patients are in for, why are [the unit managers] not nurses?" were frequently voiced. Managers from other disciplines were seen as lacking understanding of specific issues, particularly those arising from shift and weekend work:

> She forgets that we are humans first and nurses second. … It is about having the experience of being a nurse and having to fit your life around shift work. She gets every weekend, every holiday off, while I work, it seems, every holiday going.

### Relationships with patients and their families

The most devastating effects of restructuring were felt by nurses in their relationships with patients and families, the heart and soul of nursing. They all stated they

needed "more time to be with them." As one nurse observed:

> I know the nurse's relationship with the clients and their families is intense. I listen to nurses talk so much about the relationships. I think nursing is still highly regarded. But at the same time, I do fear that people's experiences of patient care are sometimes not very good … and it is due to the nurses experiencing shortages. … But this excuse of, "Well, we are short tonight" wears thin after about the third time. Initially, if they sense they are busy, people understand that … but now, it becomes too much.

Participants reported that patients' families often stayed at the bedside and nurses frequently relied on them to monitor their sick relative. One nurse explained that families should not be expected "to cover our jobs." This practice may even endanger patients' safety, as she illustrated with the following example: Recently the nurses on her unit relied on the help of the relatives of a critically ill patient. Yet later, the patient experienced severe respiratory difficulties. The participant reasoned: "The family did not realize that he was not breathing properly. Why should they? That is not what they are there for."

All participants repeatedly voiced dissatisfaction with their increasingly hands-off roles:

> When I was little, I thought nursing was, you take care of somebody who is sick. And now you are going to end up having a healthcare aide looking after them. … So they end up getting closer with the healthcare aide than the actual nurse. … Sometimes I think it would be better if we got rid of the healthcare aides and have a smaller assignment, but do the entire care.

### Participants' ideas for restructuring

In general, the nurses believed that restructuring of the system was, and continues to be, necessary, but deplored their lack of input. The manner in which restructuring was implemented, they felt, had led to disastrous outcomes for their patients and themselves. Doucette and Boyce (2000) also found that there were few opportunities for the involvement of nurses in decision-making. The number one concern, on which participants all vehemently agreed, was that hands-on nursing care was too important to give away to lower-skilled workers. They insisted that more full-time nurses were needed for consistency of care and that their unreasonable workloads should be decreased. They also wanted to be "well paid and well treated."

The participants recommended

• more input by the bedside nurses in reorganization of work environments and

where and how cuts could/should be made;
- decreased workloads and more time with patients;
- nursing education with a greater focus on practical bedside experience, and longer orientation sessions for newly hired nurses;
- more recognition and support by management for nurses;
- input by nurses into their own scheduling, and more flexible working hours;
- more continuity in assignments, and primary and team nursing with stable staffing patterns;
- more support staff for menial tasks, especially clerical work.

Similar suggestions for improvements were made by Burke (2001), Carey and Campbell (1994), Cooney (1994), Cronin and Becherer (1999), Del Bueno (1993) and McGirr and Bakker (2000). Therefore, the participants' recommendations are in line with, and confirm, those of the researchers. As bedside nurses they are particularly knowledgeable about how their own settings function at the level of care delivery and what changes could be beneficial for their particular units.

## Discussion and Conclusion

The restructuring processes that produced devastating effects for nurses and health-care have their roots far back in time. Historically, nurses, as paramedical workers, were cast into subordinate positions in the physicians' shadows. Imposed changes were traditionally unquestioned and passively accepted. As a typical "feminine" occupation, nursing lacks a clear description of what nurses do (Davies 1995). Much of their work appears natural to themselves and others. It is therefore hard to recognize nursing as professional work in the conventional sense. As nursing remains undervalued and invisible to others, in the name of efficiency, many caring responsibilities have been shifted to the unpaid and untrained public in homes (Coyte and McKeever 2001) and, as we have seen, increasingly also in hospitals. Now and in the past, to cut costs, positions of support workers have been eliminated and their tasks added to nurses' duties (Glazer 1988; Nicklin 2001). All participants complained that menial tasks kept them away from their patients.

Because of their heavy workloads, infrequent breaks and lack of respect and recognition for their work, many nurses are experiencing burnout and dissatisfaction with their jobs. Increasingly isolated from one another because of casualization, many no longer feel loyal to any particular workplace. Although deeply concerned about quality of patient care, they fear becoming less attached to their patients, as they hardly get to know them. Fletcher (2000) confirmed that many nurses are beginning to view nursing as "just a job." She feared that nurses' previously taken-for-granted "selfless dedication" might be vanishing. Similarly, Del Bueno (1998) stressed the importance for quality of nursing of retaining the right people, not just filling positions for the short term.

To nurse the system back to health, one challenge, it seems, will be to show that quality of care and efficiency are not necessarily antithetical but really go together (Smith 1998). To preserve quality of care and work life, nurses need to learn to advocate for what they believe in. Discussing their experiences seemed to make the participants more aware of some issues as they began to explore alternatives. I agree with Davies (1995), who suggested that nurses redefine their "professionalism" around their "sustained encounters" with patients. Continuity in assignments and time with patients to build trust is the key.

Despite disillusions, the nurses in my study overwhelmingly confirmed that the nurse–patient relationship remains the heart and soul of nursing. The public seems to share this view, as they consistently tell pollsters that nurses are the most trusted healthcare professionals (Falk-Rafael 2003). Revaluing caring work is imperative.

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