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SYMBOLISM IN AN ORGANIZATION: AN EXPLORATION OF THE USE OF SYMBOLS IN A REORGANIZATION OF A HOSPITAL DEPARTMENT

by

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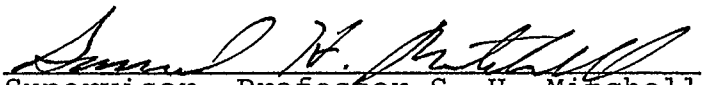
The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "Symbolism in an Organization: An Exploration of the Use of Symbols in a Reorganization of a Hospital Department," submitted by Lynda M. Cherry, in partial fulfillment of the requirements for the degree of Master of Arts.



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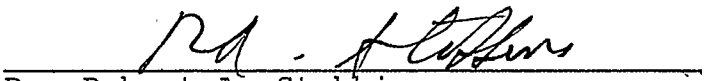

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ABSTRACT

Many organizational studies have employed rational, political, or personalistic approaches. The symbolic perspective adds another dimension to the field of organizational research as it inquires into the social constructions and understandings that participants develop. The purpose of this study was to investigate the perceptions and interpretations of one particular level of an organizational hierarchy during a period of change.

A group of front-line nursing managers (Nursing Unit Supervisors) was observed during a departmental reorganization. Their collective and individual perceptions and explanations of the changes formed the basis of the study data. Also addressed were the features of the organization which influenced the front-line managers' responses to the restructuring of the nursing department.

The organizational symbols guided the perceptions and interpretations of the front-line managers. Ceremonies, rituals, and stories were included in the symbolic features of the organization. Events, structures, and people were also seen to have symbolic value.

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Chapter 1

INTRODUCTION TO THE STUDY

Area

Organizations and organizational life are compelling areas of research. Many theories have focussed on the rational, individual, or political natures of organizational structure and process. Concerns for efficiency, human resource development, and allocation of scarce resources have been based on logical and scientific concepts (Benson, 1977; Bolman & Deal, 1985). As a result, some of the richer and potentially more illuminating aspects of organizational design and behaviour have been ignored (Pondy, Frost, Morgan, & Dandridge, 1983).

The relationships and social constructions of individuals and collectives in organizations add another dimension to this field of study. Variously referred to as a cultural (Deal & Kennedy, 1982; Sergiovanni & Corbally, 1984) or symbolic perspective (Bolman & Deal, 1985; Pondy et al., 1983), this approach investigates the meanings involved in the life and structure of organizations. As Sergiovanni noted, "the emphasis . . . is more on understanding than explaining and on making sense of events and

activities than on describing" (Sergiovanni & Corbally, 1984:7). This symbolic or cultural perspective acknowledges the complex and sometimes non-rational patterns that influence the organizational system (Pondy et al., 1983:4).

Shared meanings and values are central to the construction of an environment or social world that binds together individuals in an organization. The physical and social environments, in turn, influence the thoughts and actions of the group; one should not be separated from the other. Patterns of behaviour evolve out of this dynamic interplay between individuals and environments to form a culture which is an important feature of organizational life.

The term "culture" is contentious. William Taylor stated:

> . . . arguments about the meaning of culture and attempts to pin it down by means of conceptual analysis and clarification reflect not so much confusion as the essential complexity of the phenomena to which it relates. (in Sergiovanni & Corbally, 1984:125)

The culture, with its shared meanings and patterns of behaviour, becomes an integrating force in an organization and communicates what is important for the organization to insiders, newcomers, and certain members of the public. Culture is a means of saying this is "how we do things around here" (Deal & Kennedy, 1984:4).

Focus

There are certain points or times in the life of an

organization when the significance of its culture and attendant symbols becomes more visible than at others. When new technologies, structures, or management systems are introduced, alterations occur in the way "we do things around here." Then, an opportunity arises to reassess the values, beliefs, shared meanings, and patterns of behaviour.

The focus of this research was on the perceptions and interpretations of one particular level of an organizational hierarchy during a period of change and restructuring. The research was concerned with the responses of a group of front-line nursing unit managers to the implementation of a decentralized structure in the nursing department. Morgan, Frost, and Pondy, in reviewing possible directions in which to focus a theory of symbolism, cited several courses of action, among which was one that aimed at "understanding the way in which symbolism creates an opportunity for its 'readers' to re-interpret the symbols and recreate their own patterns of significant meaning" (Pondy et al., 1983: 16). This re-interpretive-recreative process was the underlying purpose of the present study.

Significance

A number of studies have described and explained nursing actions in a hospital setting from a variety of perspectives (Coser, 1962; Davis, 1966; Kramer, 1974; Myers, 1982; Ross, 1961; Strauss, 1971). Educational institutions

have been the focus of rearch that addressed some of the symbolic and cultural features of organizations (Baldridge & Deal, 1983; Daft & Becker, 1978; Lightfoot, 1983; Sergiovanni & Corbally, 1984; Wolcott, 1977). Two examples of popular studies that have emphasized the importance of symbolism in organizational life are *In Search of Excellence: Lessons from America's Best-Run Companies* (Peters & Waterman, 1984) and *Corporate Cultures: The Rites and Rituals of Corporate Life* (Deal & Kennedy, 1984). Health-care institutions can provide a wealth of information about symbolic aspects of daily life in an organization.

Morgan, Frost, and Pondy (in Pondy et al., 1983:4) reported that studies in organizational symbolism have a long and rich history from which can be drawn sources of information. This perspective, however, is not included in more traditional approaches of organizational research. More recent texts have suggested this frame of reference should be part of a multi-perspective approach in studies of organizational design and life (Bolman & Deal, 1985; Pondy et al., 1983; Sergiovanni & Corbally, 1984). An emphasis on this particular perspective could contribute to an increased appreciation of the subjective perceptions that are a part of organizational life and thus contribute to a more fully developed understanding of how organizations function.

Data Gathering

As suggested by Morgan, Frost, and Pondy, there are several approaches to the study of symbolism in organizations, including interpretive approaches. Part of the concentration here was on "how individuals make sense of their situations, and thus come to define and share realities which may become objectified in fairly routinized ways" (Pondy et al., 1983:22). To understand the meaning attached to these situations, the researcher "must 'take the role of the other' and understand the world from the participant's perspective" (Chenitz & Swanson, 1986:7).

"Start with what you know" is an adage frequently offered to potential writers. Lofland and Lofland (1984: 10) delivered similar advice to prospective investigators of social settings:

> "Starting where you are" provides the necessary meaningful linkages between the personal and emotional, on the one hand, and the stringent intellectual operations to come, on the other. Without foundation in personal sentiment, all the rest easily becomes so much ritualistic, hollow cant.

Such a stance can facilitate taking the role of the other and allowing one to be more sensitive to the meanings of the subject under study.

The writer was employed for three years as a nursing education instructor in the hospital selected for this study. Shortly prior to the writer's return to university, the nursing administration announced plans for a decentralized

structure to be implemented at City Hospital* the following year. In the new structure the instructor and assistant nursing director positions were eliminated and a new assistant unit supervisor role was added for each unit. Another nursing director role was also created (see Appendices A and B). The ensuing discussion and speculations about the proposed changes became points of interest. Permission was granted the writer, by the senior nursing administration, to return to the nursing department to observe selected aspects of the new structure's implementation.

All areas of the change in question could not be addressed. The choice of front-line managers (hereinafter called Nursing Unit Supervisors (NUSs)) as a focal group to study was based on several factors. They remained the one consistent group throughout the change process. Many elements of the new system were aimed at enhancing and supporting their roles. They served several important functions in implementing key aspects of the decentralized structure. Finally, with 32 NUSs, it was a manageable size study group.

Contact with NUSs was made in three areas: (1) Committee Structure meetings, where all NUSs met to develop a formal communication system for the new decentralized structure; (2) Sub-department meetings. The nursing

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*The name of the hospital, and all other names in this thesis, have been changed to preserve anonymity.

department was divided into three sub-departments, each with its own monthly or bi-monthly meeting; and (3) individual interviews with the NUSs. These were conducted on a flexible format and general areas to be covered in the course of the interview were drawn up. The open-ended format allowed the individual to contribute additional information.

Comparisons were made among these three forums as well as between the sub-department meetings and among the NUSs. The writer kept field notes on all data collected, a recording method selected after some discussion with nursing directors. Self-recorded journals from the NUSs were ruled out because of their time-consuming nature, and tape-recordings were believed to be potentially inhibiting.

Data were collected from other sources as well. Interviews were scheduled with current and former senior administrative staff as a means of placing the current situations in a larger organizational and historical context, and to provide another form of comparison. Memos, minutes from nursing administrative meetings, and selected documents relating to the changes under review were made available to the writer. Because the writer was located on the research site, it was also possible to make unanticipated contacts. Some valuable data were gathered as the result of informal contacts with nursing and secretarial personnel in corridors, at coffee breaks, and in various offices and the library.

Part of the process of getting at the meanings attached to the events was to reflect back to the participants' observations and reflections from the field notes. This enhanced the potential of the data collected, facilitated the comparison process, and helped overcome the possibility for personal bias and interpretations.

The study was conducted from mid-April to mid-August 1985. Part of the rationale for this designated time frame was simply its mutual convenience for the writer and the hospital staff involved. This time frame, however, marked an interesting period in the process of the organizational changes. The beginning of the study occurred three weeks after the formal implementation of the decentralized structure. The first meeting to establish a new communication system was scheduled shortly after the research project was begun. The final stage of the research was marked, coincidentally, by the announcement of the new vice-president for nursing and proved to be an appropriate finishing point for the study.

Limitations

Certain constraints exist in a study of this nature, one of which is access to information. Various respondents may consciously or subconsciously withhold information that could alter the understanding of the research. As well, access to certain confidential data may be restricted.

A further limitation may result from the various human factors which confine the researcher to particular areas of observation. All or some of these limitations may have been operative during the present research.

Organization of the Thesis

Sarah L. Lightfoot (1983) likened herself to an artist painting a portrait. The difference is the medium--words rather than oils. She observed how,

> . . . on each canvas [is] the backdrop. The shapes and figures are more carefully and distinctly drawn . . . . Using another artistic metaphor, for each portrait the stage is set, the props are arranged, the characters are presented, and the plot develops. Individual faces and voices are rendered in order to tell a broader story about the institutional culture. (pp. 6-7)

The artistic metaphor is an apt one for a study dealing with symbols and expressive elements of organizational life. The format of the present thesis resembles the features detailed by Lightfoot.

The literature reviewed in Chapter 2 provides the framework for this study. Chapter 3 contains a description of the study setting, including the physical, organizational, social, and historical context. The leading characters in the course of this change are described in Chapter 4. In Chapter 5, the more detailed context encountered by the NUSs is defined. Chapter 6 is devoted to the presentation of the NUSs as they were observed in the various regions defined above. Chapter 7 contains the results of the study, and in

Chapter 8 conclusions as well as suggestions for future research are presented.

Chapter 2

REVIEW OF LITERATURE

Introduction

The purpose of this chapter is to provide a general frame of reference for the remainder of the thesis. The first section deals with aspects of the hospital organization that contribute to its present life. The second section addresses pertinent issues and concepts in the symbolic perspective of organizations.

Hospitals

The life and culture of a hospital are influenced by a number of factors. In this section, features of the history, rationalized management, authority structure, and front-line nursing management of hospitals are reviewed.

History

Burling, Lentz, and Wilson (1956) traced the beginnings of modern Western hospitals to the medieval period in European history when their original purpose was to provide shelter for travelling pilgrims. Wealthy lay people supported the religious organizations which supplied this service. Eventually, the homeless as well as pilgrims were

accommodated. Over a period of time, the function of the hospital was transformed so that caring for the poor included tending to their illnesses.

The first hospitals in North America were established in Quebec City and Montreal in 1638 and 1641, respectively (Coburn, D'Arcy, New, & Torrance, 1981:182). Jeanne Mance, the founder of the Montreal hospital, was one of the first lay nurses and hospital administrators in North America. "Canadian general hospitals were usually founded by religious orders, groups of prominent citizens (non-profit lay corporations), or by municipalities" (Coburn et al., 1981:255).

Chronicles of developments in the contemporary health care system were identified in the 1920s as a time when critical transformation occurred in the form and function of hospitals, primarily because technological advances had increased the complexity of care (Burling et al., 1956; Coburn et al., 1981:155; Melosh, 1982; Reverby & Rosner, 1979). According to Reverby, changes were:

> . . . not due to medical science alone, but also to urbanization, competition for patients between physicians, nurses, and hospitals, and a fiscal crisis within hospitals resulting in declines in philanthropic and public charity incomes. (in Reverby & Rosner, 1979:208)

Methods were employed to attract paying clients to hospitals. "What was being created was both a 'workshop for physicians' and a 'modern hospital hotel'" (ibid.).

Other social factors made an impact on hospitals. The "early twentieth century rhetoric and concern for efficiency left a permanent mark on the hospital system" (ibid., p. 213). A new ideology, based on a scientific perspective, entered the hospital system while the initial ideal of charity, with its historical roots and compassionate nature, remained. These two ideologies have co-existed in varying degrees of conflict and co-operation and are recurring themes in this thesis. The application of "scientific management" is the basis for two issues that are integral parts of the current hospital system--the rationalization of health care and the separation of lines of authority--which are addressed here under separate headings.

Rationalization

The work of F. W. Taylor (c. 1911) was the basis for the concern with efficiency in work settings. As Melosh (1982:173) described it:

> . . . rhetoric of efficiency brought critical changes to the pace and organization of hospital work. As defined by rationalizers, "efficiency" placed premium on speed . . . . Although the analyses of efficiency experts never produced a reliable measure of nursing skill, managers still invoked the principles of rationalization to justify the extended use of auxiliaries.

Since rationalized systems of administration and division of labour were threats to the position of nursing in the system and its emerging autonomy, nursing leaders seized the opportunity to establish a special place for

their discipline. They saw:

> . . . nursing's future professional status as tied to a rationalized hospital nursing system with a complex division of labour. It was primarily these women who convinced the hospitals both to upgrade the nurse and to subdivide her work because it would be cheaper for hospitals, would give them a disciplined work force through hierarchy and professionalism, and would improve the quality of care. (Reverby & Rosner, 1979:215)

Nursing tied itself to the emerging bureaucratic structure of the hospital in an effort to protect its own nascent professionalism; thus, a more complex division of labour was created that would serve to enhance nursing's status. Administrators and nursing leaders "began to differentiate between the delivery of nursing care (which only a trained RN could provide) and the establishment of a nursing service (a team of nursing workers on different skill levels)" (ibid., pp. 214-215).

Nursing continued to support the application of scientific principles of management well beyond the 1920s and 1930s. While hospital administrators raised some doubts about the feasibility of efficiency studies in hospital environments from its inception in 1914 until the early 1960s, nurses sponsored "over thirty-four studies on nursing functions in seventeen states" during the early 1950s (ibid., p. 218). Current texts on nursing administration continue to employ scientific management principles (Arndt & Huckabay, 1975:227; DiVincenti, 1977:127).

The application of scientific management in

hospitals was problematic. Among the concerns were:

> . . . the objective difficulty of transforming service work into commodity production, the hospital's unwillingness to use more skilled and expensive labour, and revolts from their own rank and file. (Reverby & Rosner, 1979:219)

Many nurses felt they lost their unique identity by supervising others rather than providing complete patient care themselves (Melosh, 1982:197). This evolving hierarchy placed nurses in an awkward position in relation to other members of the organization. The resulting lines of authority and communication had the potential for being both ambiguous and conflict-prone.

Sources of Authority and Influence

The move away from an exclusive focus on charity and toward rationalization created new ruling forces and groups in the hospital. Hospital administration became a distinct discipline outside the ranks of the "caring profession." Four major categories of influence on hospital administration are described below.

Medical staff. Physicians and hospital administration have always enjoyed a unique relationship. While hospitals were prepared to be "workshops for physicians," the medical doctor never fully joined the ranks of the hospital's organizational structure. Physicians "borrow" the services and facilities of the hospital but are never

under the full jurisdiction of the organization's administration, although their influence permeates all levels of the organization. Administrators and physicians, according to Smith (in Schwartz & Kart, 1978:316-317), represent the hospital's:

> . . . two dominant values or symbols: "money" and "service." . . . Administration is forced to focus upon the contingencies of fiscal survival and the physician more often appears as the person dedicated to the service aspect of the hospital . . . . The employees of the hospital who have to mediate between the often conflicting demands of "money" and "service" are again confronted with a conflict situation which is built into the hospital.

Physicians, due to their mobility in the organization, can exert a powerful influence through all its levels, approaching members of the senior executive as well as staff operating on the "front line" where the main work of the hospital is performed. This type of power has an impact on the nursing personnel. As the largest group of staff working directly with the patient, nurses are influenced by physicians' actions in the organization. Part of a nurse's function is to fulfill the physician's orders for patient care. The physician's power and authority, however, is only one form of control experienced by hospital personnel.

External controls. The funding and support of hospitals have changed over the years. Burling et al. (1956) observed that the charitable tradition of hospitals was the reason members of the public believe the hospital should

assume part of the cost of caring for patients. The advent of third-party insurance plans and government health-care systems helped pay for some expenses and create other demands on hospitals.

Third-party payment allowed more middle-income people to use hospital facilities, which led to overcrowding and waiting lists. More staff was required to meet the increased demands for hospital services. Third-party payers demanded a justification for the costs incurred, which led to a growing effort to achieve:

> . . . more detailed and precise cost accounting. This development, and the forms which must be filled out for each person covered by insurance, have increased the work of the bookkeeping department. (ibid., p. 8)

Finally, increased requests for semi-private accommodations required a different physical design for hospitals that in earlier times were built with large public wards.

In detailing Canada's progress toward universal health care, Shillington (1972:6) argued that:

> . . . we increasingly accept that man has a right to health or, more correctly, a right to all means that medical science can provide for the protection or restoration of his health . . . . The state was pledged to protect the peoples' property and the only property of a poor man was his labour power which was entirely dependent upon his health.

This premise became part of the justification for the provision of a government-sponsored health-care plan. Like third-party insurance, it too created certain expectations. Aside from accounting procedures, the government, in various

forms and at different levels, required the use of other auditing and accreditation procedures. The result of these activities has some bearing on the funding a hospital receives.

Unions. Unions are another external influence that represent large numbers of staff in the organization. Smith (in Schwartz & Kart, 1978) claimed that unions act as counter-forces to management: "The crucially important productive work is performed at the worker level, low in the status hierarchy. Characteristically, conflict in such an organization appears as worker resistance to management" (p. 317).

The resistance of unions is only to management and not to the rationalized perspective used. Unions, in some respects, contribute to the rationalized system. Torrence (1981) called hospitals "health factories" as he compared them to other industrial systems:

> Large teaching hospitals . . . clearly carry the industrial analogy to its fullest extent in their advanced bureaucratic and technological base. Although they are extreme cases, they illustrate the distance the hospital industry has travelled towards becoming a modern, rationalized, technologically complex one. . . . This is manifest especially at the level of industrial relations and collective bargaining . . . . In industrial relations, the trend towards regional and provincial collective bargaining has brought similar wage levels, fringe benefits, and conditions of work to workers in large and small, rural and urban hospitals. In effect, the employer is a very large organization controlling many separate plants; the hospital workers are essentially quasi-government employees. (in Coburn et al., 1981:264-265)

The bargaining process is conducted in an overtly rational manner with both sides of the negotiating team--the government and the union--influencing what happens inside the hospital.

The front-line manager in nursing. The main work of the hospital is conducted on the nursing ward or unit. In larger institutions these units are divided according to medical specialities. The head nurse, or unit supervisor, is charged with the responsibility for the smooth operation of her particular unit. She may have from 5 to 50 nursing staff reporting to her while she reports to a nursing co-ordinator or director.

The unit supervisor is in a unique position. While her position of authority is, according to organizational charts, line management within the department of nursing, she works closely with other disciplines, whose activities directly influence the performance of her own staff. Mauksch (in Davis, 1966) observed how the nurse can be the "representative and delegate of the physician in the hospital. She uses his aura and power as a means of justifying and implementing a coordination function within the bureaucracy of the care structure" (p. 123). This relationship with the physician can be an ambiguous one. Studies have detailed the negotiation of authority between physicians and nurses, including the informal strategies the nurse

employs to fulfill her role as a care giver (Coser, 1962; Davis, 1966; Schwartz & Kart, 1978). The nurse not only represents the physician but mediates for and negotiates with him on behalf of both the patient and the hospital. The unit supervisor has the added responsibility of mediating and negotiating for her nursing staff. The level of interdisciplinary co-operation is related to the abilities of the head nurse.

Burling et al. (1956:118) concluded that:

> . . . the head nurse determines the climate of a nursing floor. She is the one who decides whether the work shall be patient-centered, doctor-centered, or nurse-centered. More than anyone else she sets the pace of the work day. . . . It is within the limits of the floor that many people develop their sense of belonging. Floor staffs sometimes become tightly knit groups, loyal to each other and fierce in their defense of the floor's reputation. They [are] . . . supported more by their belief in each other than through any motivation which top management could possibly supply. It is the head nurse, more than anyone else, who can influence this esprit de corps.

The head nurse accomplishes this sense of team spirit in a multidisciplinary setting where most of her staff are unionized, while she represents the administration of the organization. Mauksch supported Burling et al.'s (1956) assessment of the administrative power of the unit supervisor. He noted senior levels of hospital administration are limited in their ability to enact their decisions at the working unit level. The head nurse, however, has the power to implement and enforce hospital policy "because she appears as a de facto representative of

hospital administration" (in Davis, 1966:123).

The head nurse or NUS is a focal point in the organization of the hospital. Both the physician and the administration rely on her to ensure the implementation of their decisions; thus, significant aspects of organizational functions are dependent on the performance of the unit supervisor. The NUS position can be called a symbol of both the service and the administrative ideologies of the hospital.

The Symbolic Approach to Organizations

Just as hospitals are vast and complex areas of study, so is the area of symbolism. Anthropology, psychology, theology, and literature have all addressed diverse aspects of the subject. Bolman and Deal (1985), Pondy et al. (1983), and Sergiovanni and Corbally (1984) have cited research that applies symbolic perspectives to organizational studies.

Life in an organization is comprised of numerous social interactions. In the process of these interactions, people are continuously constructing their social world (Berger & Luckmann, 1967). This construction is "not a wholly rational-purposeful process" (Benson, 1977:3). Since the symbolic frame is not grounded in an assumption of rationality, another understanding of organizations can develop out of this perspective (Bolman & Deal, 1985:6).

The symbolic perspective is one means of understanding how the mission of a hospital can be achieved in the midst of such a complicated system of communication and controls. March (in Sergiovanni & Corbally, 1984:31) pointed out that:

> The stories, myths, and rituals of management are not merely ways some people fool other people or a waste of time. They are fundamental to our lives . . . . executive rituals and executive life are parts of that large mosaic of mutually supporting myths by which an instrumental society brings hope and frustration to individual lives. Since managerial rituals are important to our faith, and our faith is important to the broader political and social order, these symbolic activities of administration are central to its success.

Before outlining the symbolic perspective, the more traditional approaches--the rational, personalistic, and political--are summarized below, as they enter into the reactions of the NUSs. Stories, myths, and ceremonies are included as elements of the symbolic perspective.

Rational Approach

The rational or structural approach, sometimes referred to as scientific management, was cited earlier in this chapter. The basic assumptions as listed by Bolman and Deal (1985:31-32) are paraphrased below:

1. Organizations exist primarily to accomplish established goals.

2. Every organization has a structure appropriate to its goals, environment, technology, and participants.

3. Organizations work best when environmental

turbulence and personal preferences are constrained by norms of rationality.

4. Specialization permits higher levels of individual expertise and performance.

5. Co-ordination and control are accomplished best through the exercise of authority and impersonal rules.

6. Structures can be systematically designed and implemented.

7. Organizational problems usually reflect an inappropriate structure and can be resolved through redesign and reorganization.

The major difficulty with this perspective is the belief that people always behave in a logical manner; individual differences and preferences are not considered. The individual focus, however, is part of the human resources or "personalistic" approach.

Personalistic Approach

The basic assumptions of this approach are paraphrased from Bolman and Deal (1985:65) as being:

1. Organizations exist to serve human needs.

2. Organizations and people need each other; humans have ideas, energy, and talent; organizations have careers, salaries, and work opportunities.

3. Both will suffer if the fit is poor--there will be exploitation on both sides.

4. Both will benefit if the fit is good--meaningful work for the individuals and a mission accomplished for the organization.

One of the problems with this perspective is the difficulty in defining human needs (ibid., pp. 68-71). Another issue is the tendency to focus on the psychology of the individual and overlook some of the inter-subjective processes.

Political Approach

According to Sergiovanni (1984:6): "the political perspective is concerned with the dynamic interplay of the organization with force in its external environment." The basic assumptions paraphrased from Bolman and Deal (1985: 109) are:

1. Most important decisions in an organization involve the allocation of scarce resources,

2. Coalitions of individuals and interest groups exist in organizations.

3. These groups and individuals differ in their values, beliefs, and perceptions of reality.

4. Organizational goals and decisions emerge from an ongoing process of bargaining, negotiation, and jockeying for position among individuals and groups.

5. Because of scarce resources and enduring differences, power and conflict are central features of

organizational life.

A single focus on this perspective could lead one to believe that every action is based on "power plays."

Symbolic Approach

Morgan, Pondy, and Frost defined a symbol as "a sign which denotes something greater than itself, and which calls for the association of certain conscious or unconscious ideas, in order for it to be endowed with its full meaning and significance" (in Pondy et al., 1983:4-5). The symbol may take the form of an object such as a plaque given as an award; an action, like a handshake; an event, for example, an anniversary; an utterance, like a campaign slogan or an image, such as the ones encountered in dreams, or the ideas associated with work and family (ibid., pp. 6-7).

The symbolic approach is based on the following assumptions, again paraphrased from Bolman and Deal (1985: 149-150):

1. What is important in any event is not what happened but the meaning of what happened.

2. The meaning of an event is determined not simply by what happened but by the ways that humans interpret what happened.

3. Many of the most significant events and processes in organizations are substantially ambiguous or uncertain. It is often difficult or impossible to know what

happened, why it happened, or what will happen next.

4. Ambiguity and uncertainty undermine rational approaches to analysis, problem-solving, and decision-making.

5. When faced with uncertainty and ambiguity, humans create symbols to reduce the ambiguity, resolve confusion, increase predictability, and provide direction. Events themselves may remain illogical, random, fluid, and meaningless, but human symbols make them seem otherwise.

Understanding the meaning of symbols may be the single most difficult issue in the symbolic approach, inasmuch as different interpretations may exist for one symbol. Since these meanings are communicated in yet another symbolic form, language, the problem is compounded. The symbolic approach combined with the other approaches can create a broader, deeper understanding of organizations.

Elements of Symbolism

Some bestsellers have popularized the more conventional concepts of symbols in organizations (Deal & Kennedy, 1984; Ouchi, 1982; Peters & Waterman, 1984) and have emphasized the importance of communication networks, stories, myths, rituals, and ceremonies. Each of these processes or activities has a symbolic value in the culture of the organization.

Lines of communication are important, not only to transmit the instrumental activities required to accomplish

tasks but also to convey key elements of the values, beliefs, and ideologies that are an integral part of the organizations. Deal and Kennedy (1984) suggested that there are times when "working the network can be the only way to get a job done" (p. 86). The informal communication network is one way to pass on stories that relate some of the more expressive elements of organizational life.

Stories. According to Wilkins (in Pondy et al., 1983:83), the value of organizational stories resides in their symbolic nature and controlling force. Stories communicate shared values in a narrative form as well as "present and resolve inherent contradictions" in a system. In an organization, stories can describe what is expected of members in various situations or, as Wilkins stated, a "story is a script employees use to predict the behavior of the company and which managers use to make decisions" (ibid., p. 84).

The value of stories becomes even more evident when they are related to Perrow's (1979) descriptions of organizational controls. He defined three types of controls:

> . . . direct, fully obtrusive ones such as giving orders, direct surveillance, and rules and regulations; bureaucratic ones such as specialization and standardization and hierarchy, which are fairly unobtrusive; and fully unobtrusive ones, namely the control of the cognitive premises underlying action. (pp. 150-151)

This latter one Wilkins categorized as "third-order controls" and included stories under that label. He concluded

that:

> This kind of control works by restricting what decision-makers consider as relevant, the form of logical reasoning that is deemed as appropriate, and the kinds of solutions that are seen as acceptable. Thus, stories from the organization's history may provide not only implicit, shared scripts but also a set of assumptions and implied values which guide and limit decision-makers. (in Pondy et al., 1983:85)

Myths. Myths can be classified as a special form of story or narrative. Pondy et al. (1983) defined a myth as an "extended metaphor, with the implicit assertion that the story told in a myth stands in a metaphoric relationship to real events" (p. 159). This poetic definition can fall prey to some ambiguity, as the term "metaphor," according to Pondy, is frequently disputed among scholars of various disciplines. Bolman and Deal (1985) defined myths in a more functional manner, claiming they serve to: "explain, express, maintain solidarity and cohesion, legitimize, communicate unconscious wishes and conflicts, mediate contradictions and, finally, provide narratives to anchor the present to the past" (p. 153). Since one or more of these functions are employed in other studies, when defining the purpose and value of myths in organizations (Pondy et al., 1983; Sergiovanni & Corbally, 1984), the above will be the operative definition in this thesis.

Rituals and ceremonies. Rituals and ceremonies also communicate, symbolically, certain features of the

organization. Smircich defined rituals as "behavior patterns which are stylized or formalized and which are repeated in that form" (in Pondy et al., 1983:59). Ceremonies are also formal, regulated patterns of interaction that occur less frequently. Ceremonies symbolize more dramatic moments in the life of the organization, such as rising within it or exiting from it. In the view of Bolman and Deal (1985), rituals and ceremonies serve to "stabilize, to reduce anxieties and ambiguities, and to convey messages to external constituencies" (p. 159).

Instrumental and expressive symbols. Stories, myths, and ceremonies are expressive symbols which Daft (in Pondy et al., 1983) suggested represent only one end of the continuum on which organizational symbols can be placed. Expressive symbols, on one side, represent the more abstract aspects of the organization; they pertain to poorly understood phenomena and meet some of the emotional needs of the participants. Instrumental symbols describe concrete organizational phenomena that are well understood within the institution and "help the organization do its work" (ibid., p. 203). Annual reports, organizational charts, and achievement awards are all examples of instrumental symbols, This form of symbol is objective, visible, and supportive of the rational elements of an organization, particularly a bureaucracy. Expressive symbols are subjective, intangible,

and supportive of the human need to explain the incomprehensible or contradictory aspects of life (ibid., pp. 199-206).

Ideologies. Fundamental to any collective is the ideology (or ideologies) it espouses. Dimen-Schein (1977: 145) defined an ideology as being:

> . . . a system of ideas . . . which enables its members to do several different but connected things: to make some sense of the world, to say what is good and bad in it, to justify the actions people take . . . . It is public and therefore shared, but it is also contained in and expressed by individuals. Ideology then has two faces: it represents and often comes to symbolize its culture, and at the same time it becomes a means for the individual to comprehend her/himself.

Organizations can be seen as symbolic structures of their own ideologies, said Myers (in Sergiovanni & Corbally, 1984). His claim took the symbolic aspects of organizations to the other extreme. Not only are certain features in the organization symbolic but the "organizational structure itself is viewed as a symbolic system. The sales-manager role, not the incumbent's idiosyncracies, is a symbolic element; the formal rules . . . are a symbolic structure" (ibid., p. 187). Symbols are not only events, activities, and things; they include people and organizations as well.

Summary of Chapter 2

Hospitals are complex organizations with cultures and ideologies that reflect their history as well as their

current social system. Part of their complexity can be attributed to their intricate sets of relationships and authority structures. This complicated system of operations has the potential for conflict and contradictions.

The meanings attached to events and the symbols created by people are central foci of the symbolic approach. Symbols reduce the ambiguity inherent in any organization and may take the form of an event, an activity, a person, or an organization. In the following chapter the hospital that is the focus of this study is described, including some of its symbolic features.

Chapter 3

THE ENVIRONMENT

Introduction

In this chapter the physical, historical, organizational, and cultural contexts of the hospital in which this study took place, are described. To use Lightfoot's (1983) analogy of a portrait painter, this step in the process is the background scenery of the canvas. The broad strokes provide some dimension and texture to the complete picture as well as draw attention to some themes that are detailed in the finer strokes.

The Physical Plant

The physical structure of City Hospital (the pseudonym allotted to the study institution) was found to be, in many ways, a reflection of its developmental history and numerous organizational changes. The series of additions to City Hospital created a large, sprawling complex that covered four city blocks. Sometimes old buildings were torn down to be replaced by newer models; at other periods new structures were simply added to the existing one, with only minor modifications made to the older wings. Each structural change created a certain amount of upheaval in the

routine work of the institution, but each was tolerated as necessary for the continuing progress of the hospital.

Names of the various wings were changed to letters in the late 1970s. Prior to this change, the names of the different sections reflected some aspect of the hospital's history. One could almost date the time of employment of the staff by the terms they used to refer to the different wings. Each building's interior was colour-coded and included an information map as well as a telephone to use for those not familiar with the premises. Stopping someone in one of the many corridors seemed to be the most popular form of seeking directions, however.

Since the hospital was erected on the side of a hill there were entrances on two different levels: five public entrances plus three more frequently used by staff that were slightly less "scenic." Knowing one's way around the physical plant was one of several distinguishing features between the newcomer and the "local" or "seasoned veteran." The chapel and cafeteria were open to staff and patients at specified hours. A social room and gymnasium, located at the far end of the hospital, were available to the staff through special arrangements.

Part of the long-range plans for the hospital included creating a visually appealing setting. To this end, various landscape strategies were implemented. The entire complex was surrounded by parking lots. Some of these lots

were designated specifically for staff; others were a combination of metered, hourly pay, and staff-assigned units. The doctors had a separate lot for their sole use. The one-block perimeter encompassing the site had either one- or two-hour parking limits. A new lot was opened in 1983 after the hospital purchased the property on the former site of several small stores and single residences.

Parking was a contentious issue between the hospital and the surrounding community. Prior to the construction of the new lot, area residents objected to staff and visitors parking in front of their homes. They also objected to the removal of the local shops and the upheaval created by the demolition of these buildings, concerns which received substantial media coverage. Some resolution was achieved through a city by-law that limited the location and amount of parking in the surrounding area.

At the time of writing, City Hospital was a 933-bed institution located just outside the urban core of a large city. The surrounding area was a multi-ethnic community of predominantly single-dwelling houses. To the south east of the institution there was a local community centre and pool which has been used by hospital employee unions for voting on strike-related issues. Several small stores, restaurants, and a medical-professional office complex bordered the hospital.

In the early 1980s, a study of the future needs of

City Hospital was requested by a government department, and a major project proposal was developed. This document, submitted to the provincial government, recommended a number of physical changes in City Hospital, including replacing nearly half the existing bed capacity with new in-patient units and renovating and upgrading other facilities. The total capacity would be reduced by about 51 beds.

History

The first City Hospital was established in November 1890 after several years of public discussion and committee meetings. This hospital was a two-storey house (in what is now the downtown area) that accommodated eight patients and employed a medical staff of seven. Unfortunately, some disagreements developed that resulted in several resignations, leaving two doctors on staff.

When a 35-bed hospital was built east of the downtown area in 1895, the number of staff increased and graduate nurses rather than trained staff were employed. A school of nursing was developed and the first student was accepted in April 1895. Funds and equipment were donated by prominent members of the community. Over the next ten years the hospital continued to expand. When the city experienced a population increase of 170% between 1901 and 1906, it became evident this second hospital was no longer adequate. In 1910, a 180-bed hospital was opened on the present site,

and it officially became a department of the city in 1914.

In the 1930s, a Nursing Alumnae Association was formed that raised funds for a variety of hospital and community needs. In 1941, this group urged the Hospital Board to improve the hospital's accreditation ratings. An A-1 rating was achieved that year as a result of a number of improvements. Nursing evidently had an influence on the Hospital Board.

During World War II, more additions were made to the existing structure and the city increased its financial commitment. After the war a number of social and medical developments led to even more changes; staff who served in the armed forces did not return to their original places of employment; student nurses demanded better working conditions; the introduction of "miracle drugs" drastically reduced the length of patient stay. These events, along with other technological developments, influenced the kind and amount of nursing care offered as well as the role of the head nurse. The increased turnover of patients added measurably to the paperwork performed by the head nurse.

A Dr. James* was hired as administrator in 1952. He has been described as a visionary in his plans for City Hospital, and was responsible for seeking out Miss Peters,

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*As noted earlier, all names throughout the thesis are pseudonyms to preserve anonymity.

the newly appointed nursing director. Both Dr. James and Miss Peters were nationally recognized and achieved legendary status in the organization. During their tenure at City Hospital, a new main building and wing were built, renovations were completed in other areas, services were added, and standards of care upgraded through improvements in practices and continuing education programs. In 1956, Dr. James resigned.

The provincial government hospitalization plan, in which the federal government returned a portion of tax revenues to the province, was implemented in 1958. These funds, along with income from other taxes, would be used to provide comprehensive health care for the residents of the province. This form of funding marked a turning point in the financial control mechanisms of all Canadian hospitals.

An economy drive in City Hospital resulted in a recommendation to cut the budget by $100,000, which led to the elimination of ten nursing positions. Controversy swirled in the press, the city council, and the Hospital Board room. The nursing director, concerned that the quality of care would suffer as a result of these reductions, resigned from her position. She was followed by the assistant director. Miss Peters had accepted a contract at an eastern hospital, but before leaving City Hospital she presided over her last graduating class of nurses. At this ceremony, she suffered a heart seizure on the stage of the

hospital auditorium and died less than an hour later. This final story of Miss Peters became part of the legend that was created around her and incorporated into the folklore of City Hospital.

The 1960s and 1970s saw rapid increases and changes in technology and services; building expansions continued as well. The first non-medical administrator was appointed in 1969, the same time that significant organizational changes occurred in the hospital.

Organization

This writer found the administrative structure of City Hospital to be a far cry from the small committee of physicians and concerned citizens that founded the organization. The structure and function of the institution were influenced by its size, complexity, and technology, as well as the demands and constraints of a government that supplied most of its budget. Like the physical plant, the administrative structure changed over the years.

With the introduction of increased government funding and lay hospital administrators with specific education in the field, the role of the Hospital Board was altered. Board members no longer needed to be involved in extensive fund raising or be concerned with the details of the daily operations of the hospital.

The Board at City Hospital served several broader

functions: presenting, negotiating, and defending the annual budget to the provincial government. Concerns from the general public and changes in hospital policies that created significant changes in the delivery of health care were passed through the Board. The Board also maintained liaison with the Medical Staff and the local university, as well as a close working relationship with the administrative body. The mayor and two city aldermen, as well as six citizen members selected by city council, were members of the Board. Terms of office were for three years and a member could be reappointed. The president and the vice-presidents of finance and medical services also sat on the Board. The other vice-presidents were called in as they were required.

Since 1980, the hospital administrative structure has undergone several changes. Prior to this series of reorganizations, the most remarkable change occurred in 1969 when a consulting firm was contracted to survey the management structure of the hospital. At the time, the position of administrator was eliminated and the co-equal positions of executive director/medical and executive director/administration were introduced. The late 1970s and early 1980s were also years of frequent and numerous changes. The provincial government charged City Hospital with the development of what was described as a "satellite" hospital. The executive director was appointed to oversee

both hospitals, with two administrators reporting to him in a joint senior management structure.

The assistant administrators, appointed about the same time, were responsible for support services, patient care (nursing), and professional services. The medical director was titled the chief of staff. All reported to the administrator who, in turn, was accountable to the executive director. A subsequent change was made in the names of the positions. The executive director became the president, the administrator the senior vice-president, and the assistant administrators became vice-presidents. This change was in keeping with trends in hospitals across North America and reflected the more corporate nature of hospitals. The chief of staff became the vice-president/medical.

Concurrently with these final name changes, the provincial government removed the responsibility for the satellite hospital from City Hospital. A number of administrative shuffles were made to accommodate the supernumerary senior staff.

Cultural Network

City Hospital employed a number of strategies to foster a sense of collegial congeniality, no small task for such a large institution. Deal and Kennedy (1984) as well as Peters and Waterman (1984) noted successful organizations are managed by people who recognize the importance of both

formal and informal means of communication, who use both systems effectively and who are visible to their staffs. Deal and Kennedy referred to this communication system as the cultural network. Formal and informal means of communication existed as part of City Hospital's cultural network, the most evident form of which resided in the rituals and ceremonies regularly enacted at the hospital.

Rituals and ceremonies. Only large-scale and socially oriented events (i.e., those not directly related to the daily business of the hospital) are addressed in this section. The main purpose of these events was to establish a sense of camaraderie and thus to communicate something about the culture of the place. "Behind each ritual is a myth that symbolizes a belief central to the culture" (Deal & Kennedy, 1984:62). These rituals and ceremonies are excellent means of assessing "how things are really done around here."

Some ceremonies reflected a seasonal characteristic: the Christmas tea for staff with the choir, which comprised employees from all departments and disciplines, entertained their colleagues with carols before they began a journey through the wards to sing with the patients. The choir was organized and directed by one of the hospital chaplains, who began his campaign for participants early in the autumn. The tea was held in the staff cafeteria during regular

morning coffee-break hours. There were, however, features that distinguished the event from a routine coffee break. First of all, it was free of charge and provided a greater selection of food than usual. Secondly, there was a more relaxed pace with less need to leave after the customary 15 minutes had elapsed (except for most staff nurses who had to return to their units to relieve other nurses to attend). Finally, all participants were greeted at the cafeteria entrance by some of the senior administrative staff, one of the few times that most staff saw members of administration.

In the summer, "Old Western" activities occupied the hospital calendar. One feature of the week was attire, since it was one time of the year staff were allowed to wear jeans and similar Western apparel. Again, the exception was certain members of the nursing staff, who remained in uniform but were allowed to add duly sanctioned Western "accessories." A number of departments held barbeques, either on or off the hospital premises.

The one remaining all-inclusive activity was the flapjack breakfast, sponsored and catered by the medical staff. Like the Christmas tea, it was free of charge and a time for the higher-status members of the organization to act as hosts to all the employees. It took a certain amount of power and fiscal control to sponsor these events. Although they were intended to reflect the goodwill of the hosts and fellowship of the total organization, they also

reinforced the power and authority of the top-level members of the hierarchy.

One can only capture the meaning behind these acts if one asks "what if another group in the hierarchy hosted these events?" Sarason (1982:96-97) suggested that the rationale for a regularly occurring activity can be discovered if one adopts a "man from Mars" attitude. The behaviours are observed, assumptions suspended, and questions asked about what is observed. The questions and possible responses can reveal more than the overt rational explanation and possibly uncover the deeper meaning to the course of events. The tea and breakfast highlighted the contrast between the behaviour of the hosting staff during the special event and their routine behaviour. At the tea, the administrative staff were immediately accessible to all employees without the intermediary role of the secretary. At the breakfast, the general staff had the opportunity to give orders for service to a group (predominantly males) who, in all other circumstances, issued orders to them. In a paradoxical way, both ceremonies supported the existing status and structure simply because they were extraordinary events.

Other ceremonial events occurred more frequently than the two described above. Those surrounding the entrance and exit of employees were significant, the former because it was usually the first means to inform the new

member "how we do things around here" and the latter because it announced to everyone in the institution what value was placed on the service provided by an individual and ultimately on the individuals themselves. Entrance/exit ceremonies varied according to the category of the worker. All new employees received a general orientation and were introduced to their individual work environments. Management staff tended to have longer orientations, with a strong emphasis on meeting others in the organization. Their arrivals were generally announced in the fortnightly newsletter or the quarterly magazine, where their past accomplishments, current position, and photograph appeared along with quotes about their expectations of their new roles. Senior administrative staff also received a more social introduction into the community. A conversation between two vice-presidents about the arrival of a third new vice-president included discussing which prestigious private club would be available for a reception so the newcomer could become familiar with the amenities of the city. When management staff left, another article appeared, accompanied by a photograph, citing their contributions to the institution and their future plans, and quoting some of their positive memories of City Hospital.

A distinct phenomenon occurred in the early stages of the changes that form part of this study when a member of management-level staff left City Hospital within a

relatively short period of time. Current and former staff reflected on what each separately referred to as the "disappearing man" phenomenon. These commentators occupied different levels in the organization and, therefore, did not seem to be expressing a bias of one particular level. They questioned what appeared to them to be the sudden and previously unannounced departure of members of middle- and senior-management staff. The reason for termination had not been divulged nor had the terminees' future plans. A former staff member questioned what effect such incidents were having on morale. Currently employed staff repeated the question in a variety of ways, usually adding "what does that mean for me?" The manner in which "the disappearing men" departed represented some important aspects of the climate and culture of the institution, increasing the uncertainty created by the organizational changes. What distinguished the "disappearing man" was the absence of "ceremony" (described above). Only a terse memo was circulated stating that the person had left, or would be leaving within a very short time, and revealing administration's plans to fill the vacancy.

The arrival of non-management staff was publicly acknowledge by posting their names on a bulletin board outside the cafeteria. This board was used to post job vacancies, and once the position was filled the candidate's name was placed beside the unit and category of the job for

which he/she had been engaged.

An event was held to recognize long-term service of employees regardless of the position held. Receptions took place in the social area of the nurses' former residence to acknowledge number of years of service (10, 15, 20, 25, and 30) to the hospital. All staff concerned met with fellow employees with similar years of service to have tea with senior members of the administrative staff and to receive a pin to commemorate their years of employment. On these occasions years of service superseded status in the hierarchy. A group photograph appeared in the newsletter.

If an employee, again regardless of rank, resigned or retired from the organization after long years of service another tea was held. All these events appeared to reinforce the importance of status and length of employment at City Hospital and thus communicated some of the inherent values of the organization itself.

Other social gatherings emphasized the "family nature" of the hospital. The curling club afforded a place for the staff to gather in less formal surroundings. Various gymnasium sports were open to all staff. Several departments and patient care units had established ball teams that played one another as well as other ball clubs representing local business firms.

Several mechanisms were established at City Hospital to facilitate employee/employer relations. An educational

fund was set up to provide financial assistance to employees taking programs related to their area of work. There was an increased emphasis on upgrading the formal education of staff.

An employee relations committee was established as a forum for management and employees to discuss areas of common concern. The committee organized social and recreational activities for the hospital staff and operated the employee suggestion program. A reward was given for any suggestion that improved patient care or procedures, reduced costs, or saved time, materials, or labour. In addition to the reward, the individual's photo was taken and displayed near the cafeteria. This group purchased picnic tables for staff use at break times in a "green space" outside near one of the wings.

An annual tea was sponsored by the nursing alumnae as a means of raising funds for various projects related to the life and work of City Hospital. The most notable use of funds was the regular contribution the alumnae made to an education fund for nursing staff. Two of the former nursing directors participated in these teas as did many of the other "oldtimers." This event became an opportunity to exchange information and views of what was happening inside and outside the hospital.

Communications. The committee structure was an

obvious formal system of communication. Decisions and recommendations made at this level were transmitted to the appropriate administrative level. By participating in a committee, one could gain more rapid access to the information. They were also good forums for the informal exchange of information, particularly when two or more departments or disciplines met. Committee membership could be within one department, one discipline, or include a cross-section of hospital staff. Reports of committee work and accomplishments went to a variety of areas: the departments of the committee members, the sub-units of these departments, and groups or individuals for whom the decisions or recommendations had a direct implication. For example, a decision made by the dietetic department about times for delivering patients' meals would have an impact on the functioning of the nursing units. Therefore, the nursing department would be consulted, the nursing units informed, and, if there were negative implications, the details would be directed to the committee or group responsible.

The above, oversimplified example would seem to imply that everyone in the organization would be aware of all major decisions. Yet, given the size, numbers, and varied working conditions of the staff, communications were missed; thus, the ubiquitous memo entered the system. They were sent by large and small groups to equally large and small areas of the hospital.

The memo system was supplemented by and may eventually be replaced by the computer system. Large-scale use of several computer systems was introduced into City Hospital in about 1982. Some messages were sent to the nursing units through the printers on each ward, making the computer a significant source of information and eliminating some forms of informal communication. Prior to the computer printout, unit clerks on each nursing unit telephoned a variety of departments for requests or information. Many clerks took this opportunity to hook up to the "grapevine" as well. This informal grapevine and two-way exchange has decreased with the advent of computers on each unit.

The hospital's public relations department formalized some of the more social aspects of the internal news. Every payday (i.e., fortnightly) a four-page report was distributed, with information on changes, developments, new equipment, personnel, and forthcoming events. A quarterly magazine was also published with a larger scope of information.

The transcription and printing of such material was the responsibility of the various secretaries and the printing department. This staff became invaluable sources in the informal communication network. Gord, the head of the printing department, had the added advantage of being a long-time employee at City Hospital. His office was also strategically placed at the juncture of three main wings of

the hospital on the main level, facing the elevator which led to the executive offices. Since the hallways were well travelled, staff in transit would stop by Gord's office to exchange news. The high volume of traffic also increased the chance of meeting someone who seemed to be inaccessible by phone or the public address system.

So much has been written about secretaries and clerks as goldmines of information that they, at City Hospital at least, were more taciturn. Nevertheless, news was passed on in a discreet manner, frequently at coffee breaks. Newcomers and outsiders were treated cautiously. Coffee breaks were the final major forum of informal communications: some staff chose to socialize with their own departmental employees while others established a variety of contacts connecting them with other areas of the institution. These people became part of the cultural network referred to by Deal and Kennedy (1984).

Summary of Chapter 3

City Hospital has a long history as a major facility in a growing urban centre. Its numerous structural and organizational changes have reflected the social, political, medical, and technological developments in its immediate surroundings and the larger community. In many ways, the transformations in this setting represented the experiences of other similar organizations.

In the midst of these changes, the hospital maintained some sense of cohesiveness through the use of formal and informal symbolic activities, means of communication, and structures. Even the potentially negative consequences of the "disappearing men" phenomenon were of symbolic value to various staff members. This phenomenon was one manifestation of individuals in (and out of) an organization having symbolic meaning for others. The next chapter addresses some more detailed aspects of the influence and importance of "leading characters."

Chapter 4

LEADERS: CONVEYING VALUES

Introduction

Managers, according to Daft and Becker (1978:205), have:

> . . . continuing impact on the organizational culture . . . . [they] convey a set of values, meanings, and intepretations to organization participants. The organizational direction and values conveyed to leaders have a substantial impact on the perception of problems.

Leaders can help others in the organization's construct of perceptions and a social reality.

In this chapter an examination is conducted into some of the past and present senior and nursing administrative staff who helped shape the perceptions of the NUSs at City Hospital. The responses of the NUSs, to some degree, were influenced by the people presented here because of the latter's functional roles as well as their symbolic actions.

Senior Executive

Physical surroundings can be extensions of the people living and working in them, symbolizing key aspects of the person and the position. The offices of the senior executive at City Hospital symbolized important features of these officials.

The Executive Suite

The executive suite was decorated in soft shades of green and rose with fabric-covered walls, and furnished with comfortable, deep-cushioned chairs and rosy-beige pile carpeting. This suite contained the offices of the president, vice-president of financial services, and executive-assistant to the president, as well as the hospital board room. The design and location of the suite removed it from the regular activities of the hospital, a fact that may have contributed to a problem when a new telephone system was installed. The usual difficulties of getting the right exchanges "hooked up" caused a certain amount of confusion. Throughout this transition, unit and office telephones remained functional, allowing communication with each other and externally. The one area bereft of any form of telephone communication whatsoever was the executive suite.

This luxurious suite was the product of an expensive renovation during the "boom" economic period enjoyed throughout the entire province. In order to attract and retain top quality executive staff, City Hospital had to compete with business firms in the community; thus, the rationale developed that offices similar to those provided for business executives should be available for the hospital's senior executives. Unfortunately, the suite was completed concurrently with a widespread economic recession.

The muted tones and soft furniture of the suite

added to the sense of a quiet, unhurried pace, unlike the rest of the building. Coffee was offered to waiting visitors in an unobtrusive manner, in contrast with the informal spirit of most of the other hospital departments. The luxurious surroundings, the social "niceties," and the efficient yet unobtrusive support staff were symbolic of the control exercised at this level of the organization, all reflecting the value placed on the executive staff.

The relaxed but formal atmosphere symbolized something even more important. As Waller (1932:195) pointed out:

> . . . formality is a compromise, an accommodation, which enables institutional leadership to survive. Formalities, a complicated social ritual and a body of rules and regulations, define once and for all the rights and privileges of all persons involved in a situation.

This formality has benefits for both sides as it allows the superordinate to receive the respect and consideration he/she requires to fulfill his/her role. Concomitantly, the subordinate is required to respect only the position, not necessarily the person holding it. The formality, then, is a symbol of the prescribed set of relationships that are seen to exist in a hierarchy. Although subtle, this formality was evident in the manner of the hospital's president pro tem throughout his 90-minute interview with the writer.

President

Gil was appointed president pro tem during the

lengthy absence of the usual incumbent. He was perceived as a powerful figure in the organization and one of the moving forces in the "push" for decentralization. "Trim" described Gil--from his physical appearance to his social skills, all were well arranged and in good order, as were his views of the hospital organization.

Some people attributed Gil with altering the hospital's negotiating style. For example, the informal lunch-time meeting--held with the director of nursing, the chief of medical staff, and the executive director, where this group discussed the budget in relation to salary increases and other benefits--was abandoned. With Gil's arrival, "across-the-table" bargaining replaced "around-the-table" discussions. A larger and more representative group was delegated to negotiate. Bargaining became more formalized and rationalized.

"Ah yes, decentralization, whatever that is." Gil smiled as he quoted a quip that observed decentralization was a push to "make room for more and stronger centralization." He then explained some of the thinking behind the push for decentralization at City Hospital, from a senior administrative perspective. He was cautious to point out, however, that these were, in part, some of his own opinions and did not always reflect the senior administrative level.

For years, the senior administration realized that changes were required in the organization of the nursing

department but felt constrained by the people in the head nurse role. Gil drew a diagram of the "old structure," indicating there were too many organizational layers in nursing. He noted the NUS should be the manager of the unit, but another unit-level position (with the title of "manager") confused the issue; the current NUS title did not convey the responsibility it should encompass.

According to Gil, both senior administration and nursing were interested in implementing a decentralized structure. Administration, however, was concerned with the need to "maximize resources," while nursing took the "professional tack" in wanting to develop the nursing role.

Gil said the hospital now had the tools necessary for the NUS to fulfill more effectively a management role. By this he was referring to two recent innovations: "a budget system that works" and a staffing pattern system which used standardized times for patient care in order to determine the volume of staff required on each unit.

Decentralization should mean self-accounting blocks but that is not always possible. "Therefore," Gil said, "in operational terms it should mean the unit supervisors have the maximum discretion to use their financial resources within the government overlay." At this point, he expressed some concern about NUSs not appearing to want the responsibility "that goes with the territory." They became engaged in an issue of "my monkey your monkey." This metaphor was

used by Hersey and Blanchard in 1982. Their discussion of "who owns the monkey" was an examination of the ownership of identified problems and the application of the appropriate leadership style to each of

> . . . four potential "monkey business" [problem] situations . . . . If managers can identify who has the monkey, then they are in a position to determine which leadership style has the best chance of success and, thus, when and how to intervene with followers in each of the four problem situations. (p. 225)

Gil followed with an animated description of "the American way"--"when they [the Americans] want something they go after it." Continuing with this enthusiasm, he compared the attitude to that of "cowboys who went after the territory," commenting that he was a "small-c" conservative and thus appreciated the role of the individual. This metaphor and explanation he applied to his current situation. "If that fellow [i.e., the vice-president of finances in the satellite hospital] has to operate under the same constraints as I do then he won't do any better." There was an implicit expression of frustration in dealing with a number of regulations and stipulations placed on him in this position. Gil's choice of metaphors and explanations conveyed an instrumental action orientation.

Toward the close of the interview, Gil mentioned a former director of nursing: "I think the world of June," he said, "but a new age has arrived for nursing and nurses should bury Florence Nightingale." This led to comments

about Miss Peters, who was known to visit a number of patients each day after work. Gil remarked that hospitals were smaller and less complex in her day. "No hospital should be larger than 500 beds; any larger and all the president is doing is knitting it together."

Shortly after this interview, one of the clerical staff, commenting on June Hill and the current changes, reflected that decentralization may have been supported at higher levels for several years but with Miss Hill in charge of nursing it never "took off." This may have accounted for Gil's remarks about nursing, as well as to explain the delay between the administrative decision to decentralize and its actual implementation and the final haste to proceed, despite numerous changes in the position of vice-president of nursing. Gil had said that senior administration felt there was no point in delaying any further and that more delays would have been inefficient.

Maternal Authority in Nursing

Cathy O'Hara, one of the nursing directors, had worked at City Hospital more than twelve years, although she still identified herself as a newcomer. She had previously served in a variety of educational and management positions in nursing. What was notable about her career pattern was the importance of "connections." Several of her jobs were acquired as the result of knowing someone who recommended

her for a position.

Cathy's kind, solicitous manner earned her a reputation as a "mother figure" in the nursing department. This aura was combined with another of her qualities. A former NUS recounted an incident in which one of her staff had requested an extended Christmas break to be with her family who were visiting from overseas. Although it was generally against hospital policy to grant such requests, the NUS felt she could accommodate the staff nurse once the nurse confirmed her plans with Cathy. After her meeting with Cathy, the nurse informed her NUS, "I have never been turned down so graciously and felt good about it." "An iron fist in a velvet glove" was how this NUS defined Cathy.

The bureaucratic nature of the hospital and its impact on employees has been addressed in earlier studies (Kramer, 1974; Torrence, in Coburn et al., 1981). The above anecdote revealed Cathy's reconciliation of a bureaucratic ideology with the traditional feminine, nurturing role of nurses. Another incident, used by Cathy in orientation sessions for new nursing staff, revealed a further dimension of this phenomenon. A new staff nurse was in conflict with her head nurse. An area of contention dealt with the matter of one's rising when a physician entered the work area--a custom the head nurse maintained and the young nurse resented. Cathy noted how the nurse could become more a part of the unit staff, and ultimately supported the head nurse's

right to maintain her methods. All this was communicated in such a matter-of-fact fashion that there seemed no reason to discuss other options. As this story was related to a group of staff during the process of socializing them into the culture of the organization, its full meaning had an even more profound impact; tradition and nursing management were given clear support, as was loyalty to the group.

Cathy described several factors as being important in the evolution of the nursing administration in general, and the role of the unit supervisor in particular. She recalled, with some amusement, how she and June Hill calculated their first nursing budget in 1974: "It was more by gut reaction than anything else. We didn't know how much to put down for some things so we just took a wild guess." The fiscal year of 1979-1980 was the first occasion when the NUSs were responsible for their unit budgets. One feature of the recent nursing organizational changes was the introduction of a nursing budget officer whose major responsibility was the fiscal management of the nursing department. This anecdote of the formalization of this evolving fiscal responsibility was one of several examples of the institutionalization and rationalization of nursing management functions. Cathy related a number of other events that helped transform the NUS role, and these are discussed in the next chapter. Cathy concluded by saying, "But you really should see June [Hill]--she could tell you so much.

You would have a great time with her. She still keeps in touch with what's happening here."

The Former Nursing Director

June maintained contact with several of the nursing management staff at City Hospital and, despite some setbacks in health, continued to pursue an active interest in the hospital's affairs, particularly the nursing department. In fact, June had been, at times, seriously ill in the previous several years. Just prior to her retirement, one of her disabilities made it so difficult for her to move around the hospital that she had her lunch brought to her office.

June was a woman of average height and build. Her golden blonde hair was neatly and stylishly coiffed and her clothes well tailored. Her slow, deliberate walk could have reflected a newly acquired luxury of time as much as it did a physical problem. Her manner was quiet, pleasant and gracious. Like Gil, she had been accustomed to being in control and demonstrated this in her social skills.

"Wholesale change really started in '52," claimed June. From this statement it would appear that one's perspective is clearly influenced by one's historical vantage point. This was the year Miss Peters was brought to City Hospital as the nursing director. Prior to Miss Peters' arrival there were some administrative changes, including the departure of the hospital administrator and the director

of nursing education. "Whether they wanted to go or not I don't know," said June, "but anyway they left." The "disappearing man" phenomenon was not, apparently, a recent development.

Miss Peters had asked that June examine staffing patterns in nursing, employing a method that was popular at the time. This activity was repeated recently, with more formality and technological sophistication, and now termed a "patient classification system." The results of June's findings "left most nurses awed, but not Miss Peters. She was patient-focussed, and felt these numbers were justified to deliver good patient care." Miss Peters approached the Board with these numbers and was told "she wanted Cadillac service on a Ford budget." The whole episode created "quite a furor throughout the province."

Miss Peters sent June to New York in 1953 to investigate the concept of team nursing from one of its originators. As June recounted it, team nursing developed as the result of "the observations of a well-to-do man who was a patient." During the course of his hospitalization, the man had noted the fragmentation of the care given. He subsequently funded a study to examine the co-ordination of care with better utilization of staff. From this study evolved the concepts of team conferences, care plans, and team nursing. June returned to City Hospital with the information she collected. She described the efforts to implement

team nursing at the hospital as "less than a roaring success."

Several interesting features were addressed in June's account of that particular episode of City Hospital's nursing history. First, the impetus for a significant development in the structure and organization of nursing care was attributed, at least from June's perspective, to someone outside of nursing. This reactive stance would seem to reinforce nursing's (and, in many ways, women's) contingent nature. The impetus for change in nursing may be the result of outside forces.

The implementation of scientific management, as described by Melosh (1982), was a large-scale example of nursing's response to external controls and the inauguration of a decentralized structure in the nursing department at City Hospital, a more local example. June admitted that there was administrative pressure to decentralize in the early 1970s. Her only other comment was "this decentralization is a trend that does nothing for morale."

The second interesting feature of the team nursing episode was the fact that it was an "import" from the U.S.A. June had also noted, in reference to another pending change at City Hospital and to major trends in general, "we seem to take American failures and use them here."

Another significant change, in June's estimation, occurred when the nursing units transferred from being

staffed predominantly by student nurses to graduate nursing staff. The head nurses had to adapt their supervisory style to meet the needs of this new group of nurses. "Grads need a different form of supervision," said June. "They already feel they know what to do." Changes surrounding the use and presence of nursing students on the units was identified by several other "oldtime" NUSs as having a more profound impact on the role of the head nurse than any current changes.

In reference to the possibilities for the success of the new patient classification system at City Hospital, June reflected: "Unless nurses see the advantage of it they'll give it a pass. I don't know what it takes to get them to do it." This remark contrasted with Gil's assertion that "We have to maximize resources at that level." Although he was talking about NUSs, and June was referring to staff nurses, there seemed to be a distinction in how the two perceived the amount of control administration had over employees on the "front line."

Comparison. A number of differences existed between the perceptions of Gil and June. Their respective views of the current changes revealed distinctions that also occurred in the interviews and observations of the NUSs. In many ways, these two divergent views and opinions can be regarded as opposite ends of a continuum on which most other

perspectives could be placed.

While Gil argued that decentralization was a way of "maximizing resources," June felt it was nothing more than "a passing trend." Gil claimed the purpose of the change was to maximize resources while June believed that "wholesale changes" had occurred in the 1950s and 1960s which had a greater impact on the quality of nursing service than the more recent ones. The "go get it" attitude of Americans was admired by Gil; in contrast, June noted the tendency to import "American failures" in hospital trends and organization.

Most of Gil's remarks about nurses related to the management level; they were part of the resources to be maximized and needed to take more responsibility ("your monkey, my monkey"). June felt nurses had wills of their own and would implement only that which they saw as useful to them. This difference underscored their contrary views in relation to people and events. Gil focussed on the action orientation and instrumental nature of the situation. He noted that the advantages and disadvantages of continuing with decentralization without a vice-president in the nursing department were weighed and that it was decided that "we had waited long enough--it was time to move ahead." June's focus was on people and the expressive nature of the events. The "disappearing man" phenomenon did not escape her notice and she reflected that it probably "did nothing

for morale" at the hospital.

Gil believed that Miss Peters and Florence Nightingale were part of the past. Miss Hill, on the other hand, remarked how Miss Peters made major changes at City Hospital, demanding the best quality for and of the nursing staff. The stories surrounding Miss Peters revealed one aspect of the subculture that existed in the nursing department at the hospital. The degree of influence which Miss Peters had on June's leadership style was difficult to assess, but one of the stories June recounted about Miss Peters was how the latter "stood up" to the Board to demand "Cadillac service." June may have acquired the strength to resist decentralization, or at least not acquiesce completely to senior administration. She was not alone in her esteem for Miss Peters. Although less prevalent, stories about Miss Peters also circulated during the time of this study. These stories served as third-order controls in the nursing department. The type of stories that evolve out of the more recent changes will be a significant reflection on the quality of the culture as it existed during that process.

Line Management

The retirement of June marked the end of Miss Peters' "descendants." A new image and source of stories was introduced with the arrival in 1980 of Petra Stone, the new nursing director. An attractive woman, Petra generated

comments about her apparent youthfulness, with the consensus on how remarkable it was that someone "so young" held such a high-level position. While the youthfulness referred to her estimated age, it also contained a deeper meaning. Petra's styles in dress, management, and relationship to peers and subordinates were all departures from the "way things were usually done" around City Hospital, at least in the nursing department.

One set of stories about Petra focussed on her wardrobe. The conservative, "dress for success" formula was eschewed by the new nursing director, and the most contemporary items were combined for a "look again" effect. The clothes, however, were symbolic of a more substantial issue -- Petra's leadership style. As Kanter (1977:166) noted, power makes the difference in effective management and is seen as "the ability to get things done, to mobilize resources, to get and use whatever it is that a person needs for the goals he or she is attempting to meet." According to this definition, power requires energy to mobilize resources. Conservative dress communicates a sense of restraint, a wish to be part of the status quo. Petra's dress exuded a sense of self-confidence that transcended the traditional norms of attire.

Petra's career pattern also reflected a sense of self-determination. After serving a brief period as a staff nurse, she moved through several other positions escalating

the hierarchy to her position at City Hospital. Soon after her arrival, the structure of the nursing department was redefined with a change in title for Petra. She was accorded the same level in the organization as other assistant directors and had three nursing directors reporting to her. By 1983, however, Petra was made assistant to the executive director. Within a year, titles were changed again and Petra became a senior vice-president. At this time City Hospital was still responsible for the satellite hospital; this meant Petra was in charge of City Hospital, a counterpart would work at the other hospital, and the president would co-ordinate both institutions.

The "critical path" was the most visible evidence of Petra's leadership in the nursing department. This list of proposed activities was set on a time-line as a sophisticated check-off list of "things to be accomplished," listing goals to be pursued and placing the months of the next two years across the top of the page. Straight lines connected the dots indicating the beginning and ending points of each goal. Some of the itemized areas included revisions of job descriptions, development of nursing standards, and unit philosophies. Even after Petra's departure five years later, a number of these goals were yet to be addressed. This critical path, however, served as a symbol of the systematic, rational form of management that was now to be a part of the nursing department at City Hospital, and Petra Stone was

perceived, by most of the NUSs and nursing directors, to be the responsible force behind it all.

In many ways, Petra seemed to be a good example of Melosh's (1982:169-169) examination of nursing leaders who sought "to locate nurses at the fulcrum of administration." Some staff in nursing felt this was exactly what Petra did; she "put nursing on the map" according to one NUS. "I know there are [others] who wouldn't agree, but she really moved things around here." Petra created an impression of "getting things done," using instrumental symbols like the critical path and ad hoc committees. The critical path supported the image of someone with a plan and a sense of direction. The subsequent activities indicated she was prepared to follow through with the plan. Most importantly, the actions were aimed toward "revitalizing the nursing department," the aim of the Board of City Hospital. All this reflected Kanter's analysis of establishing power in an organization. Engaging in extraordinary activities that are visible and relevant are crucial to defining one's power beyond the usual hierarchical classification.

There seemed to be two sets of opinions about Petra Stone, although neither source was very vocal during her tenure at the hospital, and even less was said once she departed. One source felt she was innovative and represented a forward direction for nursing. The other side believed she was aggressive and personally ambitious. In

fact, Petra worked within the nursing department for less than three years during which time some structural changes were made. Much of her time in that role was spent outside the hospital in labour negotiations. Once Petra moved up to a newer level in the hierarchy, there was no indication she favoured nursing compared to the other departments, nor was she perceived as important to the department once she was promoted. The impact of her decision was now mediated through another level in the organization; she became less visible and, in many ways, more of a "non-person" in the eyes of the NUSs (Waller, 1932). Some of those who interpreted her behaviour and approach as aggressive, did express some relief at her final departure from the organization.

The "disappearing man" phenomenon occurred, predominantly, during Petra's term as senior vice-president. She, in a sense, became the last of the disappearing men. During the course of this field study, a memo announced that since City Hospital was no longer responsible for the administration of the satellite hospital, the position of senior vice-president was redundant. The president offered Petra the position of "vice-president for nursing" which had recently been vacated. This was, in effect, offering Petra her old job, but she declined the offer. After taking some holiday time, which she used to locate another place of work, Petra left. Only a few nursing staff saw her return one day to collect some personal belongings and settle her resignation.

Staff Management

When the nursing director title was changed, two line positions responsible for the nursing units and one staff position in charge of education were created to report to Petra. Education now centralized all staff development personnel in one department. The number of instructors varied from 15 to 18, meaning most covered more than one unit. Orientation of new staff, in-service education, and skill development all resided in the job description of this role.

With the arrival of Jean, the new director of education, a number of changes were made in the structure and process of the activities of the education department. One of Jean's first actions was to provide a common understanding and language of staff education. Thus, she established presentations on program planning and encouraged instructors to take courses in adult education. Those of her staff who lacked degrees were strongly encouraged to make specific plans to obtain them, while those at the bachelor's level were advised to pursue Master's degrees.

This rationalization of the educational process by the new director of education closely paralleled that of nursing management as manifested in the critical path. Phrases like "philosophy and objectives," "competency based education," "standardized care," "performance appraisals,"

and "annual budget reports" all became instrumental symbols of the nursing department.

Both Petra and Jean introduced rational elements of management into the system. Jean was hired by Petra to be the director of education. An attractive woman about the same age as Petra, Jean seemed, in many ways, to be a more conservative edition of her boss. Her manner was interpreted by some as assertive and by others as aggressive, similar to the ascription given to Petra. The fact that Jean and Petra shared a number of common features was a factor addressed by Kanter as the tendency for managers to "reproduce themselves" (1977:48). Both women were highly educated newcomers to a traditional, conservative organization. Both appeared to have similar visions for the future of the nursing department, and both used rational means to set about achieving that vision.

Comparison. There were, however, differences that prevented the two from becoming mutually supportive allies. Petra, as an assistant administrator and lone female in a group of several male peers, was in a position sufficiently unique to garner notice. Jean, on the other hand, held an administrative role in a female-governed discipline. Petra, in comparison with Jean, had more influential associations; her reference group had more power as a result of their gender and hierarchical status. Petra was supervising line

management personnel while Jean was in charge of unionized and exempt staff who had no management functions. This type of staff position, according to Kanter (1977:187), can render such individuals "organizationally powerless. They had to rely on line authority and were dependent on managers to implement their decisions and carry out their recommendations." Jean was dependent on managers who were officially beneath her in the organizational chart.

All the above factors combined to influence how each woman was perceived by the NUSs. Rumours circulated soon after Petra first arrived at City Hospital that her husband was to be transferred out of town and, as a result, she would be resigning. Although this could be interpreted as a case of wishful thinking, there was no indication of any more active level of resistance on the part of the nursing management group. Jean, on the other hand, was the recipient of more active and direct critiques of the direction the education department was taking. Ultimately, the major distinction between Jean and Petra resided in their perceived abilities to "mobilize resources." Their credibility and power rested on that perceived capability.

Sarason (1982) claimed that newcomers and change agents need to establish support groups or constituencies. Establishing constituencies is even more important if one is not initially perceived to have legitimate power or authority. Jean's colleagues did not always credit her

with the power to follow through with her intended actions. Her wish to implement a new role for education in the nursing department, combined with her apparent lack of power, led to a number of disagreements. As a result, she frequently told the other directors that, if their subordinates (the NUSs) did not follow through with their part of the commitment to staff education, her staff (the instructors) could not be expected to meet theirs. This use of "bureaucratic" means to achieve a desired goal is common among groups with less power in the organization (Kanter, 1977).

Part of the decentralization process included the elimination of the instructor positions. This left Jean with two exempt staff who were responsible for general, in-service education. Other positions in the nursing department were placed under her supervision; not all of them were related to the others, except they did not fit in the other sub-departments and all belonged to the nursing department.

The changes in Jean's area were more than structural and functional ones. They symbolized a newly defined relationship with the rest of the nursing department. Her title was revised from nursing director to department head and her office (including her secretarial staff), and her position on the organizational chart, were removed from the mainstream activity of the nursing department. The official, rational explanation was that more room was required in the main

nursing service area for the increased number of nursing directors created with the new restructuring. This switch also allowed Jean to be closer to most of her staff. The subtle and symbolic aspects of this transfer were not lost on the NUSs, who were given the mandate to establish a new communication system through a revised committee structure about the same time as these events occurred. They placed Jean's department in a similar position in the communication structure.

Acting Vice-President of Nursing

Alex was the acting vice-president of nursing during this study and, like Jean, had been hired by Petra shortly after her arrival. (Cathy moved into the position of nursing director from her former role as associate nursing director.) Alex's career pattern was more like Cathy's, however, in his moves through the ranks. Prior to the director's role, Alex had been an assistant director in nursing. Like Petra, he had made some commitment to his career with conscious decisions about what options were open to him. A former NUS recounted how fascinated she was to observe his ascent through the ranks from staff nurse up to his then current position as acting vice-president. Although he had less seniority than Cathy, and less formal education than Jean, he was selected to fill temporarily the post of vice-president. While he occupied that role there

was frequent speculation among the NUSs as to whether he would apply to remain on a more permanent basis.

Alex was a soft-spoken man in his early forties, with an ability to blend into the environment. His unhurried manner of speech with pauses between comments had the effect of causing his listener to stop and think about the implication of his statements, for the words seemed to be deliberately selected. This methodical manner was his equivalent of the more aggressive/assertive style attributed to others in nursing personnel.

Alex demonstrated a sense of loyalty to the total organization; for example, when other departments were reducing their staffing, he sanctioned the use of nursing staff to fill the vacancies on particular shifts and days. This action met the general needs of the organization at some expense to the nursing department.

Organizational Loyalists

The final two personalities who figured in the NUSs perceptions of the organizational changes were the acting nursing directors. Liz and Sylvia were hired by Alex to fill temporarily the extra posts of nursing directors that were created as the result of the reorganization. Both women had long-time associations with the hospital in a variety of positions, nearly all of them in management roles. In many ways their careers over the past few years were made

up of "substitute" positions in temporarily vacant jobs, which had afforded them a more comprehensive understanding of City Hospital.

Sylvia was a quiet woman who gave the impression she knew much more than she revealed. Her serene manner, combined with years of experience at City Hospital, made her an important symbolic figure. She could recall stories from the past and apply them to the current situation. Sylvia seemed to fit Deal and Kennedy's (1982:89) definition of a priest; as someone who maintains the faith and watches the flock:

> To be a priest figure in a culture requires maturity or seriousness beyond years . . . . Mostly, priest figures are human encyclopedias on matters of their company's history, just in the way real priests have mastery of the Bible. The duty they are most often called on to perform is the provision of historical precedent for planned action.

Liz was a combination of "storyteller" and "cabal," again employing Deal and Kennedy's communication types. Sylvia let her staff do most of the talking, while Liz actively participated in the dialogue, exhorting her staff to action and giving them information she felt they needed. "The tales that storytellers tell, like myths in a tribal setting, explain and give meaning to the workaday world" (ibid., p. 85). Liz's information was meant to clarify the current situation. The term "cabal" has to be applied a little more cautiously: "A cabal is a group of two or more people who secretly join together to plot a common purpose

--usually to advance themselves in the organization" (ibid., p. 94). Liz encouraged her staff to take advantage of the opportunity open to them in planning a new committee structure and, in that way, advance their positions more vigorously. This action served a useful if unintended purpose. With Liz's expression of opinion, the NUSs released a barrage of complaints and concerns about the motives of their immediate superiors. In that respect, Liz also served as a priest hearing a communal confession of pent-up sentiments.

Summary of Chapter 4

The administrative and nursing leaders of City Hospital were more than organizational supervisors. Through their words, actions, and, in some cases, their physical surroundings, these people communicated some facets of the organization's values. Rational, instrumental, expressive, and bureaucratic ideals were all represented in varying degrees in these leaders who had some impact on the NUSs' perceptions of the changes. Other factors influenced NUSs' perceptions and are discussed in the next chapter.

Chapter 5

NUSs' PERCEPTIONS: INFLUENCING FACTORS

Introduction

In a large, complex organization an individual can be committed to several situations at the same time, some requiring more of one's time and energies than others. Many situations also provide more satisfaction and self-esteem than others. Waller (1932:194) noted: "every man must have some pride, and he must have some relationship in which he really lives. Defeated on one surface of the tetrahedron, he grows into another." In individual interviews as well as in dialogues in their meetings, the NUSs revealed several organizational factors that influenced their perceptions and understanding of the restructuring of the nursing department.

The issues at City Hospital that influenced the NUSs' perceptions and interpretations of the decentralization process are summarized in this chapter. The changing aspects of the NUS role, the process of introducing the decentralized structure, other nursing department changes, and unit-based concerns all contributed to the NUSs' definitions of the new organizational structure. These factors are outlined here because they influenced the NUSs' perceptions of and reactions to the nursing department reorganization, and

they are discussed in the next chapter.

The Changing NUS Role

According to June, the former nursing director, significant organizational changes occurred in the early 1950s. Veteran employees of the nursing department identified certain points in the history of the institution as times of critical changes. For NUSs with long terms of service at City Hospital, the most recent reorganization was viewed in relation to previous changes, particularly those in the function of the NUS role.

Carol, an NUS with 21 years of service at the hospital, described the cyclical nature of the NUS role. "First, head nurses [now NUSs] did only management work, then they did only clinical work, now it's back to management." Interviews with senior and nursing administrative staff supported this perception of a cyclical process. June identified a major change in the head nurse role as the switch in staffing from mainly students to graduate nurses. "The closure of the School of Nursing in 1972 created another change in the staffing of the units," stated Ann, another NUS, who was a 20-year veteran of the hospital. The loss of the students meant the loss of a group of unit personnel who knew and were loyal to the organization. The staff hired to replace the students required more orientation and another form of supervision that could not assume the same initial

loyalty. Student nurses were full-time residents of the hospital complex while graduate nurses had private lives. Graduates had more options for employment elsewhere while students had to complete their studies and clinical experience before becoming "full-fledged" nurses.

When nursing education was part of the hospital's organization, nursing instructors spent part of their time on the units with the students. This clinical supervision had a side benefit for other staff who could observe the "ideal" as reinforced by the teaching staff. While students learned the discrepancy between the way the instructors taught a procedure and "the way it was really done," the combination of students, grads, and teaching staff provided some balance and integration of theory and practice. Instructors and, more critically, the student nurses were culture bearers of the organization. As full-time residents of the organization, the student nurses embodied the values, norms, and beliefs of the social system and served as creators and tellers of stories which reflected the organization's culture. With the school's closure, the onus for sustaining the culture fell to the head nurses.

This added responsibility for the head nurse at City Hospital required more involvement in the daily practice of her staff. Although it was not possible to identify any connection between the departure of the School of Nursing and the concomitant focus on the clinical aspects of the

head nurse role, it is not an implausible connection. Miller and Friesen (1984:129) noted, "a transition is a package of changes that occurs between the onset of the imbalance or stress and the time when some equilibrium or tranquil interval is reached." The departure of the School of Nursing created an imbalance in the structure and function of the nursing units; a package of changes followed this event. The introduction of the unit manager position and the elimination of the assistant head nurse role occurred about the same time as the school's closure. The unit manager role was meant to release the head nurse from the paperwork that kept her in the office, thus allowing her more time for clinical supervision of her staff.

The nursing strike in 1977 was a significant force in returning the management focus to the head nurse role, according to senior nursing staff who were part of the event. The head nurses were union members at the time but felt divided loyalties to their staff, patients, and administration. To achieve exempt status for head nurses from union membership, administration had to demonstrate the management functions of the head nurses. Thus, more responsibility for nursing staff evaluations and staff scheduling were added to the head nurse job description and the title was changed to Nursing Unit Supervisor (NUS). Concurrently with the above change, unit managers were decreased from one per unit to one covering one-to-six units, and the

title was changed to clerical manager. In Carol's view, the most significant change for NUSs occurred in 1980 when revisions in the job description took the NUSs away from the bedside and added more responsibility for the unit budgets. As Ann noted about the current reorganization, "most unit supervisors could see the writing on the wall." Changes in the role were not uncommon and, to some extent, the position reflected the changing values of the senior executive, a symbol of part of the organization's ideologies. The pending changes may have been obvious for some in the nursing department; for others, the results of the reorganization were a complete surprise.

The Process of Introducing the Decentralized Structure

The manner in which the new structure was developed and introduced to the nursing department was mentioned by several NUSs in individual interviews. The methods employed in the planning and implementation phases appeared to reflect the values of the organization for some NUSs.

Planning for a decentralized structure started when Jill, Petra's replacement as vice-president for nursing, arrived. Jill and the three nursing directors met in day-long planning sessions for several months before releasing the first of a series of proposed changes. By early summer 1984, most of the proposed changes were made public. The

first announcement stated the assistant nursing director position would be eliminated. The instructor's role was also to be deleted while an assistant position would be created to support the NUS on the unit. Two more nursing director positions were to be added to the management structure.

All plans and announcements of the new structure were delivered by the vice-president and nursing directors to the assistant directors, instructors, and NUSs in their separate groups, with all three receiving the information about the same time. In the spring before the announcement, assistant directors were told their jobs were guaranteed for a year, the only advance indication that not all jobs would be secure. The assistant nursing directors and instructors were offered staff nurse positions and the opportunity to apply for any of the other newly created roles. The notice of termination and the subsequent job offers caught most of the displaced nursing personnel unprepared. A few of the assistant nursing directors and instructor staff did obtain other management-level or exempt positions in the organization; most gained employment elsewhere.

The elimination of two levels of the nursing department occurred toward the end of the "disappearing man" phenomenon, thus extending the feelings of uncertainty that pervaded the nursing department. NUSs' reactions to the

departing staff varied, depending on their relationship with the people involved as well as their understanding of the organization. Ann recalled the elimination of the assistant head nurses years before; in that case, the staff affected were offered positions with similar working conditions to ameliorate any resentment. Several of the long-term NUSs expressed regret over the manner in which the assistant directors and instructors were treated. Other activities, however, required their attention.

From January until March 1985, a series of in-house management development courses was offered to the NUSs, covering topics from hiring interviews, disciplining, performance evaluations, and organizational designs. These classes were designed to assist the NUSs in assuming their managerial responsibilities, including interviewing candidates for the assistant unit supervisor (AUS) role. The exempt status of the AUS position was being disputed by the nursing union, a process that led to activities similar to the events in 1977 when the NUS role was redefined. These events are addressed in the next chapter.

Other items pertaining to the implementation of the new structure continued to occupy the NUSs' time beyond the official starting date of 1 April 1985. These change-related activities did not occur in isolation; nursing department and unit-based issues or, to use Waller's analogy, other surfaces of the tetrahedron, demanded the

NUSs' attention.

Other Nursing Department Concerns

The history of City Hospital has been one of frequent changes. As Miller and Friesen (1984) have noted, such transitions produce packages of changes and, during the period of this study, several overtly unrelated ones took place. The activities in which the NUSs participated during their department's decentralization tended to be abstract and rarified; the events cited here were more task-oriented and concrete, and also demanded the attention of the NUSs. These concrete alterations influenced their perceptions of the organizational changes as well as the time they had to devote to the decentralization process. Only events which directly related to the nursing department are presented here.

When a new regional laundry began servicing the nursing units it created some problems. The quality and quantity of laundry returned was not always satisfactory to the nursing staff, thus burdening the NUS with one more complaint to resolve through the bureaucracy. Other housekeeping issues required the attention of the NUSs as well, an issue addressed by Melosh (1982) and Reverby and Rosner (1979) vis à vis the division of labour in nursing. As nurses subscribed to the increasingly rational approach to management, labour on the units became more specialized and

divided, with nurses assuming the responsibility of supervising others who ranked below nursing in the hierarchy.

Technology in administering patient care had arrived on all the nursing units, creating special demands for the NUSs. Patient classification procedures were computerized mechanisms for determining appropriate unit staffing levels according to numbers of patients in the area and the severity of their illnesses. Special forms were completed daily and delivered to a central area for calculation. The NUSs were involved in the initial introduction of the procedure and ultimately responsible for its regular use on the unit.

Computers entered the nursing units in a more obvious way when terminals and printers were installed. The long-range plan was to computerize as much of the patient's record as possible. The system was connected with other departments, such as the laboratory, to facilitate the flow of information. Nearly all nursing staff were trained on the computer system under the direction of several of Jean's staff. The NUSs, however, had to ensure that all authorized staff attended the training program, were employing the correct techniques on the unit, and knew how to resolve as many as possible of the computer-related problems on their own before contacting the technical support staff.

The budget restraints imposed on the nursing

department affected department and unit-based programs and personnel. The full impact of the cutbacks had not been revealed, at time of writing, and uncertainty was created about the future of some programs and staff, including the clerical managers. An announcement issued just after the implementation of the new structure stated that the clerical manager position was secure for one year; this was similar to the statement made about the assistant nursing directors the year before.

All these events were focussed on the nursing units. Each unit, however, had its own particular concerns that were not necessarily common with the other nursing units.

Unit-Based Concerns

Each nursing unit has a culture of its own (Burling, Lentz, & Wilson, 1958; Coser, 1962; Myers, 1982). The speciality of the service, the type of physicians, and the size and diversity of the multidisciplinary team all influence the climate and culture of the unit (Coser, 1958, 1962; Kramer, 1974), but as Burling et al. noted, the head nurse has the most significant influence on the climate of the unit. The unit is "home" to the NUS charged with its orderly functioning (Mauksch, in Davis, 1966) and when she is absent from the unit she loses contact with the main source of her definition as an NUS. The issues that arise on the unit are obviously of concern to the NUS.

A variety of issues faced the NUSs on their respective units during the course of this study. More prominent ones dealt with union disputes, physicians' extraordinary requests, patient complaints, staff grievances, and staff reductions related to budget constraints, although not all were negative. As Waller (1932:194) suggested, everybody "needs a relationship in which [she] really lives." For most of the NUSs, those relationships existed on their units. The nursing units represented the "real" reason the NUSs had become nurses in the first place; thus, the units had a symbolic value for many NUSs.

Summary of Chapter 5

How the NUSs perceived and interpreted the new decentralized structure depended on a number of factors; for example, their understanding of the history of the NUS role, their responses to the process of introducing the new structure, and the importance they placed on other departmental and unit-based situations. In the next chapter the NUSs' reactions are addressed more specifically in their collective and individual responses to the changes under review.

Chapter 6

NUSs' REACTIONS TO THE REORGANIZATION STRUCTURE

Introduction

In the process of constructing the social world, individuals "attempt to make their situations rationally accountable to themselves and to others" (Pondy et al., 1983:24). This chapter is devoted to the reactions revealed by the NUSs to the reorganized structure, with particular attention to how they made sense out of the events--for themselves, their colleagues, and their superiors.

The writer observed three main areas wherein the NUSs' collective and individual reactions developed: the committee structure meetings, sub-department meetings, and individual interviews. The resulting data were supplemented by discussions held with various nursing personnel who volunteered information. Each formal area of observation is addressed below, by section.

Committee Structure Meetings

The new organizational structure in nursing required a revised committee system: practically, because many committee members were no longer in the nursing department,

and ideally, because the committee system should reflect the decentralized structure. The NUSs were authorized to develop this new committee structure and seven of their meetings were observed over a three-month period. During this time most of the groups' mandate was achieved, except for the final senior executive approval which occurred after the writer's completion of the fieldwork.

Alex convened the first meeting in a classroom of the nurses' former residence. Most of the NUSs gathered around low, circular tables while some occupied chairs lining the walls. NUSs from the same speciality areas tended to group together around the small tables.

Alex began by listing the advantages and disadvantages of committees, using an overhead projector to reinforce his points. He told the NUSs they were to develop a new committee structure with the following "givens and goals":

1. The senior nursing management committee (i.e., vice-president, nursing directors, and education director) would remain intact.

2. Decentralization was a goal.

3. The functions covered in the old committee format were needed in the new one.

4. The education department was separate from the clinical areas.

5. The new system must address the communication

needs between senior nursing management and the nursing units.

Alex then rearranged the NUSs' seating pattern into five new groups, with representatives from each sub-department. These were to be the working teams for the remainder of the committee structure meetings. Each group was given a file of the currently existing committees and their terms of reference. The purpose of the first meeting was to begin a strawman of the new structure. The nursing directors and Alex circulated among the groups, offering themselves as resources. A member of the senior nursing management team (except for Jean, who was not present) sat in on at least three groups.

Over the low volume of chatter, comments like "the simpler the better," "I want to be part of the decisions," and "getting the minutes is sufficient for me," were heard. About 40 minutes into the discussion, Alex returned to the meeting room and distributed packages of candy to each table, causing some laughter. He then removed his jacket and sat down at a table. There was a noticeable increase in the volume of discussion which led most members to huddle into their own tables so as to hear their own group's dialogue. More rhetorical questions dominated most group interactions.

After a coffee break, each team reported on its progress. No major changes were made in the structure

except in committee membership. Noticeable by its absence was a group where all NUSs could meet on a regular basis. Petra had disbanded an NUS group when she arrived at City Hospital, to the dismay of many of its members. Given the opportunity, the NUSs did not revive the group, at least in this first committee structure meeting.

At a second meeting six weeks' later, Alex announced he would discuss at the close of this meeting some issues initially dealt with in sub-department committees. The "givens and goals" from the first meeting were displayed on the blackboard. One NUS called out, "Alex, from a practical point of view, what do you mean by 'decentralization'"? to which he responded, "decision-making and authority is at the lowest possible level." Another NUS then asked if policy-making was "at that lowest possible level." Alex's reply was: "Policy-making is at the senior administrative level but policy recommendations should be coming up from committees." No other questions arose.

Alex identified hospital accreditation standards and union contract negotiations as two major influences the NUSs needed to consider when restructuring the committee system. The accreditation team was expected to concentrate on areas related to risk management and quality assurance, while the union was predicted to focus on continuing education for its members. The group was also advised to think about the nursing department's relationships with other hospital

departments; for example, how to extend and retrieve data from such areas as pharmacy and medical administration. Alex concluded his opening comments with: "Disregard constraints put on you in the past--it's all up for grabs now."

As no questions or comments followed this advice, Alex asked the NUSs to list management's needs. One NUS, Lyn, noted that in the last meeting she was bringing a lot of history of other committee structures to the new system and now "would do it a lot differently." Liz, at Alex's request, listed on the blackboard the current needs identified in a brainstorming session: decision-making power, information on which to base decisions, voice in working conditions, direct contact with other people in the organization, and input to medical groups where "their decisions influence us." This latter became multidisciplinary groups: "communication--inform us so we don't become isolated," accountability with decision-making, and shared, standardized practice. One NUS asked, "Can you standardize and decentralize?" to which Alex and Liz responded, "sure you can." Another NUS added, "there are commonalities."

In their small teams, the NUSs worked on the ideas listed on the blackboard. Some comments from the teams included suggestions that information should come up from the staff level, with administration informing the front-line of organizational constraints and the NUSs having direct contact with the vice-president by eliminating the

nursing director role. Another recommendation was that NUSs should have the right to appoint themselves to committees rather than being appointed by the nursing directors. Small-group comments focussed on how nursing staff and NUSs could have more direct influence on the decisions made at the nursing administration level.

The reports back to the larger group were more subdued than were the small-group suggestions. The idea of having a total group of NUSs assuming many departmental management responsibilities was presented. The other area of mutual concern was the role of the AUSs on the committees. Alex stopped the group by noting that, at the next meeting, they would rearrange the committee structure according to the concepts outlined.

The two issues Alex mentioned earlier were now brought forward. The first dealt with a Labour Relations Board investigation into the exempt status of the AUSs. Alex reinforced the fact that AUSs and NUSs should be absolutely clear of their jobs, and AUSs should be refraining from direct patient care or the nursing union could claim they did not qualify for exempt status. The other issue was "flex time" which generated a great deal of discussion among the NUSs. Alex did not want the NUSs to feel they had to account for the exact times they were on and off duty; their job descriptions stated they had flexible hours. This stopped some of the concerns about being legally

accountable for one's time on and off the unit. Alex's final remark was "I'm concerned that if you use the computers to bank time you will lose your flexibility as managers."

The third committee structure meeting began with each team examining the proposed structures of all the teams. Jan, a new NUS who had worked in a number of roles at City Hospital, expressed some concern about the amount of time the NUSs might spend off the units in meetings. Another cautioned, "Be careful we don't organize our time so the whole time is spent away from the unit and committees become a full-time job." Jan rejoined, "Perhaps we should get with it and look at ourselves becoming 'day co-ordinators'." [Note: This term was used before the position was re-named "assistant nursing director."]

This speculation that NUSs would eventually become "mini-assistant nursing directors" was also voiced in the other small groups as well as in some aside comments to the writer. Myra, a veteran NUS, claimed, "In a couple of years we'll see one vice-president, one nursing director, and NUSs supervising two or three areas." Others agreed but did not think it would happen so soon.

Coupled with the thoughts on the future role of the NUSs were reflections on the future of the AUS role which had been forced, through the union contestation of its exempt status, to take a stronger management focus. Throughout the planning of the new committee structure, the NUSs

repeatedly questioned what part the AUSs should play in the communication system. "Somewhere along the line we have to fit them in, but in what capacity? Perhaps advisory." The concern was if the AUSs had no input into the larger communication system, "they'll become like us," that is, isolated from the major departmental decisions.

The total group reconvened and Lyn drew a prototype of the committee structure on the blackboard. A nursing executive committee would be the senior ruling body and was to consist of the vice-president, four directors of nursing, and one or two NUSs per sub-department. Reporting to this senior group would be the education department, the four clinical sub-departments, and the nursing management committee. This latter committee would consist of all the NUSs and have all the nursing department committees reporting through it.

An animated discussion ensued that ranged from the membership of the different groups through their titles and functions. Most NUSs wanted eight NUSs on the nursing executive committee while the nursing directors and Alex felt that was demanding too much of total NUS time. Another contentious issue was the function of the nursing management committee, again with the nursing directors and the NUSs differing; e.g., one of the directors suggested changing the name to nursing advisory. The functions of the committee were redefined to provide: a voice in working conditions,

means of standardization, support and consensus, professional development, advice to executive committee, channel for sub-committees. After displaying this on the blackboard, Lyn commented: "We've watered down the advisory committee."

Earlier in the meeting, several NUSs asked in varying ways: "How do we know what will happen with this?" but there was little response from the nursing directors. At one point Lyn responded, "Let's get on with the task and then get consensus. We need more participation." Lyn, along with Jan, was becoming one of the informal leaders of the group.

About an hour into the meeting, Alex arrived, listened to the discussion for about ten minutes, then went to the board to take over from Lyn, who returned to her seat. Referring to the diagram on the board, he noted that education was concerned with the daily operations of the department yet did not seem to be reporting to management. One of the NUSs, May, interrupted to say he was "going off track" as the whole communication system was not yet shown; that area was to be pursued at the next meeting.

The fourth meeting started with the NUSs, nursing directors, and Jean seated in a semi-circle, with Alex at the head, facing them. He began by apologizing, "for what I was informed was an error on my part," referring to the issue described above. Alex then said he and the directors

would leave the group alone, asked how they wanted to continue from here, and if his earlier interventions had distracted them. Lyn replied: "We're strong; we can take it."

Lyn then redrew the structure on the board as they had left it from the last meeting. A vote decided that eight NUSs should serve on the nursing executive committee. May and Pam then produced a conceptual model of an organization they had received during the management development courses Jean had co-ordinated earlier in the year. Most of the meeting revolved around "how tos," the membership, and functions and frequency of committee meetings. Part way into the discussion, when Lyn asked who was taking minutes so they could be given to Alex, one of the NUSs volunteered. Lyn also asked questions about "what do *you* want?" thus overtly separating herself from the rest of the group.

The NUSs had some difficulty with one component of the education department. Some members suggested inviting Jean to clarify it and one of them went to her office to accompany her back to the meeting. With little preamble, Jean explained the purpose and function of her department. Some questions unrelated to the initial concern were put to Jean, who responded in detail before leaving.

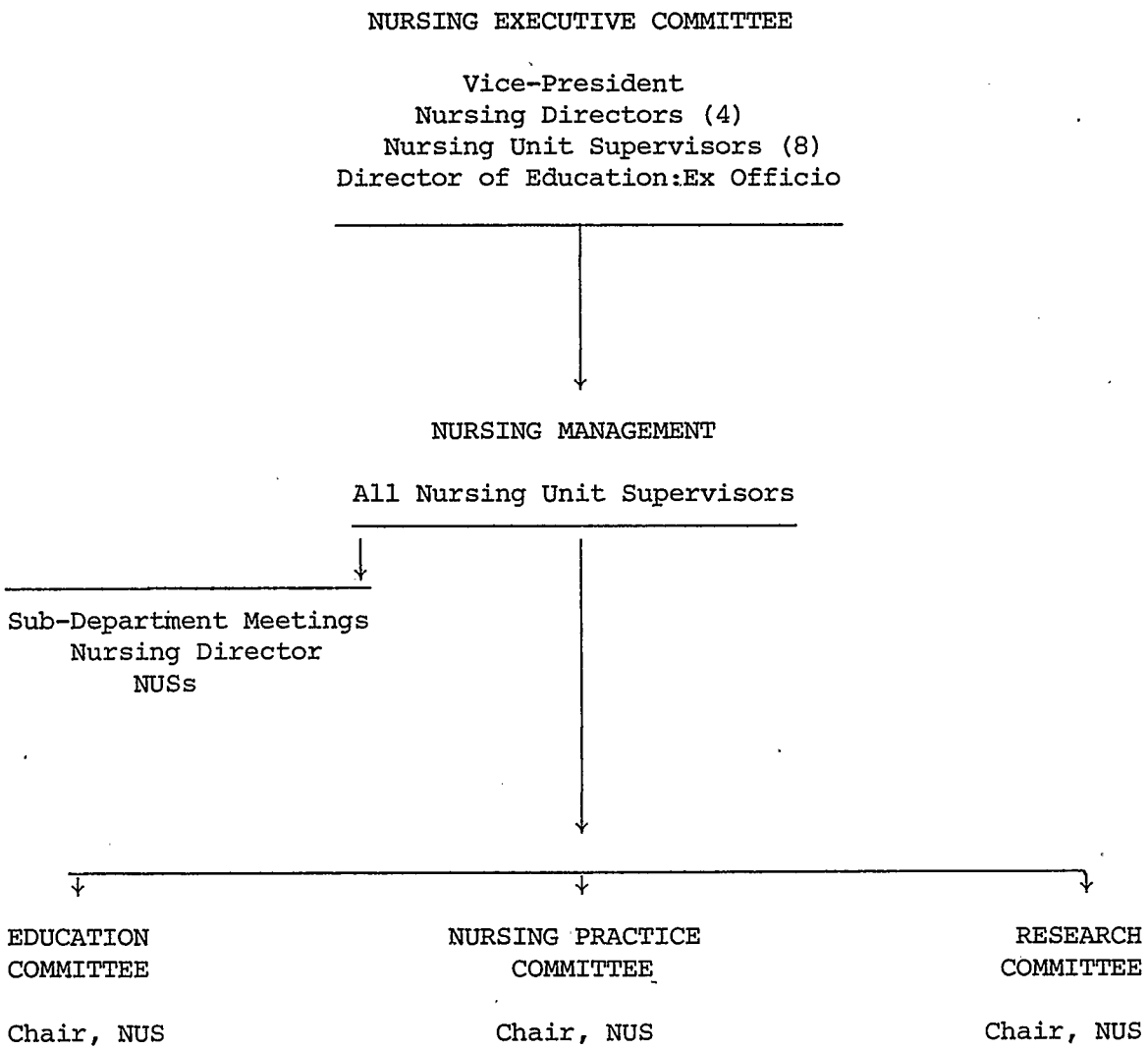
The focus turned to the committee workload of the NUSs and how much they could tolerate. One NUS recommended not having a social committee but just a "social person." At this point one of the quieter NUSs whispered to the

writer: "We'll only have one social person; with all this work the rest of us will be pretty unsocial."

Along with the concern about time commitments away from the nursing units was the issue of numbers and power in the organization. The decision to have eight NUSs on the nursing executive committee represented the NUSs equation of numbers with power. The other way they defined power was in the channelling of information; having nursing committees report through the NUS group (i.e., the nursing management committee) to the nursing executive committee was a means of controlling information and therefore having power.

When Lyn announced she had to leave, the rest of the group disbanded. One of the older NUSs stopped the writer in the hall later to comment on Petra's (positive) influence and added how some of her colleagues "will probably try to 'hog' power" within the NUS group. This notion of in-group power plays was repeated to a limited degree by some other NUSs in individual interviews. Who had power and how to get it was a recurring theme in the committee structure meetings.

Prior to the fifth meeting, a small group of NUSs had reported the results of the earlier meeting to Alex. On page 101 is a schematic of the committee structure as given to Alex. Once this diagram was displayed on the blackboard, the NUSs sought some clarification about the scheduling of committee meetings and the committee workload of the NUSs. Lyn continued to act as an informal leader, keeping the



Schematic of committee structure proposed by nursing unit supervisors

group on track and promoting clarification. Membership in the nursing management group continued to be a concern; the AUSs were eliminated and a recommendation was made to include the evening- and night-shift nursing co-ordinators (a group who represented nursing and hospital administration on the "back shifts").

The group spent some time on achieving consensus on what they would report to Alex and the directors when the latter joined the NUSs after a break. The NUSs wanted to appear as a unified group to their superiors. After a coffee break, the meeting reconvened in a patients' dining area, as the classroom was too warm. The remainder of the meetings were held in this new location.

Kate, an NUS, acted as chairperson when Alex and the directors arrived and she explained the revisions made earlier in the meeting. Alex responded, "Conceptually, we are not very far apart." The policy-making role, Kate reported, was seen to evolve out of the nursing management committee. "Then there we're at variance," was Alex's reply, adding that policy recommendations could come from that group but decisions were to be made at the senior management level, although they may be rubber stamping. This last comment produced some muted vocal agreement among the NUSs, prompting Alex to reiterate: "I said *may* be."

A lengthy discussion followed on the appropriate level at which decisions should be made, particularly where

they directly affected clinical practice. The focus turned to reaching consensus in and among committees. Alex noted consensus was not always possible as, "I don't know what directives will come down or what the next guy [vice-president] will do," adding that senior levels still had a veto power. Jan picked this up and asked if the veto power existed through the position or the personal philosophy of the vice-president, to which Alex replied, "both." A dialogue developed about the importance of personality and position, which Lyn halted by commenting, "We're getting off on a tangent here." No one objected to her intervention.

Two other issues dominated the meeting: the number of NUSs on the nursing executive committee and the role of the education department. An NUS claimed eight NUSs were needed on the executive committee to provide a "balanced representation of all the areas." Argued Alex, "I have a bit of a reaction to that. I would hope at that level you would see more similarities--appreciate the need to grow." This last comment was originally stated as "that you need to grow," but he quickly revised it to "the need to grow." His other comment was, "Education is not ex officio" [see p.101]; and "the only reason someone is ex officio is not to vote, and education will vote." There was no comment from the group; Jean was present. After the meeting Alex informed the writer he was "giving them [NUSs] as much latitude as possible."

The sixth meeting was devoted to defining the terms of agreement from the various committees and was attended only by the NUSs. Kate acted as chairperson, handing out files on the strawmen and writing on the flipchart. There was more participation from all the NUSs in attendance, and when the group agreed on an aspect of one of the terms, an NUS stated, "This sounds like group approval." Concern continued to be expressed about the amount of time spent in committees and how to select NUS representatives for each committee. The group wanted the NUSs to chair all the committees. When the appointment of nursing directors was discussed, one veteran NUS observed: "I doubt nursing administration will let us choose everything," to which a younger NUS responded: "Perhaps we should ask what they will let us do."

Kate called the seventh meeting to order and turned it over to Alex, who repeated that he thought they were "conceptually not far apart, but you are a little bit narrower in your focus than you might have been." Alex thought the nursing management committee could do more than make recommendations to the nursing executive committee about identified deficits in patient care and nursing practice. There was little response from the NUSs.

Alex's other concern was the frequency of meetings. He wanted the nursing management group to meet more often, and this led to some debate but no final resolution. Cathy,

referring to the terms of reference for the nursing management committee, suggested: "that 'receives information from' should perhaps read 'receives information and direction from nursing executive'"; again, no comment from the group. Alex stated: "'Sure too bad if the new boss didn't accept this," which led to some small group chatter. Alex added that, during the interviews for the new vice-president, the message was conveyed that "a new committee structure was being developed which they hoped would be allowed to continue." He expected to hear some notice the following week about a new vice-president.

Jean arrived late and, after half an hour into the meeting, asked if the purpose was information-gathering or "are you getting into semantic details?" Alex immediately replied, "information-gathering." Jean then asked a series of questions about the operational framework the NUSs were using and if they had developed terms of reference for nursing management and nursing executives, which generated some discussion about the labels given to these committees. Jean noted that, "in education there are nine managers, yet they do not seem to be represented on the nursing management committee." Kate replied, "Yes they are," noting Jean was on the committee. When Cathy and Alex pointed out Jean was no longer classified as a nursing director all agreed to add education representation.

The meeting concluded with the decision to have Kate

present the proposed structure to the senior nursing management committee the following day. Kate asked for another NUS to accompany her; again, "numbers" seemed to symbolize some form of strength and power. After the meeting, one of the less vocal NUSs told the writer there was a tentativeness in making a commitment to any one structure until a permanent vice-president was appointed. "Those of us who have lived through a lot of changes know how quickly decisions can be reversed or nixed," was her parting comment. This potential for sudden change may have been the reasons for the relative silence of some of the NUSs; other reasons for "keeping quiet" became evident in the sub-departmental meetings.

Sub-departmental Meetings

During the course of this study, the department of nursing was divided into three sub-departments: medicine, surgery, and speciality areas. Each sub-department included some units that would be assumed by a new nursing director once the position was filled. Therefore, each area was, in a sense, operating in a temporary manner, particularly the medical and speciality sub-departments which were led by Sylvia and Liz--both of whom were acting nursing directors. The writer attended the sixteen sub-department meetings that were convened during the period of this research observation.

Each sub-department met once every two or four weeks for one-and-a-half to two hours. The directors chaired the meetings and usually wrote the minutes. Most of the flow of information was "top-down" with the directors passing on directives, reports, and general information from the senior nursing management group and other administrative bodies in the hospital. Some common concerns from the unit levels were also brought forward in this forum, but more specific matters were dealt with in the individual meetings directors held with each of their NUSs. The membership comprised nursing directors, the NUSs, and the nursing unit clerical managers.

The leadership styles of Sylvia and Liz were described earlier in Chapter 4. Both sub-department meetings attended by the writer were marked by some animated discussion related to the new organizational structure, which is summarized below. Cathy's sub-department was a larger group and its meetings were more formalized, with sheets of paper handed out at each meeting and adherence to an agenda. Several topics were addressed in the meetings that related to the new structure and provided some insight into the NUSs' reactions to the changes. These items concerned the AUS's role and problems related to the NUSs' "banking" time. Two other issues, "working the system" and the possible elimination of the clerical manager roles, are addressed below to demonstrate briefly other cultural features of the nursing

department.

Assistant Unit Supervisors

Labour relations. As noted in the section above, the union was contesting the exempt status of the AUSs. Representatives from the Labour Relations Board were planning to interview the AUSs about their functions. Each director advised her NUSs to be clear in the distinction between the NUS's role, the AUS's role, and the purpose of the team leader on the units. The unit supervisors had differing opinions about the necessity of the team leader (TL) role on the units; some NUSs felt other nursing unit staff could fulfill the functions of the TL while others maintained the role was still necessary. One NUS felt losing the TL position would mean the NUSs were "one foot deeper in the grave."

Reports and meetings. Sylvia reported that NUSs and AUSs should be present at the morning report (summary of the patients' conditions from the previous 12 to 16 hours) on their units. One NUS reacted with "We are made managers so that should be our decision." All the NUSs in Sylvia's group agreed the AUSs should attend the report. Liz, in her meeting several days later, stated that AUSs should attend the report, a variation from Sylvia's comments. No mention of the issue was ever made in Cathy's meeting. Cathy, however, believed that the AUSs should not be sent to the

sub-department meetings in the absence of their NUSs. The other two directors did not seem to have the same concern, as AUSs regularly appeared at their meetings when the NUS from the unit was unable to attend.

Flex Time

The issue of NUSs recording the extra time they spent on duty was addressed over a period of several sub-department meetings before it was resolved at the end of one of the committee structure meetings (described earlier). The senior nursing management committee did not want the NUSs to record this time. NUSs in each sub-department brought forward legal reasons for specifically accounting for their time; several used the example of being called into court where, in the course of a lawsuit, they would have to testify about their schedule. Other NUSs claimed their former superiors (the assistant nursing directors) required this specific form of timekeeping. Cathy simply explained, "it's an order from on high" not to bank time.

A number of NUSs speculated about the reason behind the administrative request not to keep specific accounts of their working hours. Many were baffled while some felt there were personal reasons that Alex or some other senior administrative staff might have had for making such a request. Alex's final explanation about managerial flexibility seemed to stop all speculations, but not until a

month had elapsed after the issue first arose.

Political Insights of the NUSs

The tendency to question the rationale of the senior nursing management was not confined to the above episode. More obvious concerns were expressed at one meeting when Liz was encouraging her staff to take advantage of the opportunity given them in creating a new committee structure. A series of sentiments and concerns was revealed by the NUSs: a sense of lack of authority to fulfill their role; resentment at having to complete endless forms to be signed by higher-level staff; questions about the new nursing director; and, believing power still resided "at the top." One younger and newer NUS stated: "You learn to keep quiet in one area so you won't get it in another--like staff cuts." An older NUS supported this with "you don't feel safe." The discussion evolved into questioning as to which level the issue of power and control extended: to the president or the provincial government. One NUS wryly doubted "whether the government cares if we bank time or not."

The comment that "one learns to keep quiet in one area in order to be secure in another" reflected the political and mediating aspects of the NUS role. Some NUSs termed the function more bluntly as "learning to work the system." This tactic was discussed in each sub-department

committee related to the methods NUSs used to "get around" official policies and procedures, particularly those relating to physicians' orders. NUSs would recount, in a humorous manner, how they would "suggest" a particular procedure to a physician that required a medical order, or how the nurses would cajole a signature from a physician for some treatment for a patient, noting "they'll sign anything."

Clerical Managers

The planned elimination of the clerical manager's role was in response to the budgetary restrictions placed on the nursing department. Although the termination date was a year hence, its anticipation created some heated feelings among the nursing directors and NUSs as well as the clerical managers. All three groups protested the loss, feeling it would add to the ever-increasing burden on the NUSs and AUSs. Speculation also existed about the underlying motives of this episode. Some nursing personnel attributed the staff cut to personal animosity between some administrative staff and the clerical managers. Such attributions were not an uncommon means used by NUSs to reach an understanding of these decisions. Specific steps were taken by the NUSs and nursing directors to prevent total abolition of the position, and these were ongoing at the close of this field study.

Individual Interviews

The content of the individual interview with the NUSs can be divided into four major categories: thoughts on decentralization as a concept or form of organizational design, responses to the implementation process of the new structure, factors that helped or hindered the NUSs' adaptation to the new system, and personal plans for the future. These categories emerged as recurrent themes cited by the eighteen NUSs who were interviewed individually by this writer during the course of the study.

Decentralization as a Concept

Carol, the NUS quoted in Chapter 5, believed decentralization was part of a circular process in the devolution of the NUS role. Jorga felt that she, along with the other NUSs in her speciality area, had started taking more responsibility on their units "years ago" and thus decentralization was "always here." A natural progression of events was how Cathy and Alex defined the impetus for the current changes.

Decentralization, according to Jan, was a trend in the United States which came here, although she did not label it a success or failure. One NUS was clear that she missed the intermediary role of the assistant nursing directors. "This de-organization is doing nothing for the

place," said Myra, a veteran NUS, in a paraphrase of June's comment. Quickly correcting herself, she said, "I mean 'decentralization'" but probably revealed more about her reactions to the concept and implementation process in the first "slip." "Decentralization can only go so far, but I would like to make decisions that affect my own unit without standardization," was Myra's final assessment of the concept. Most NUSs identified their own units as areas where they wanted more control and authority; for instance, Jorga said: "You like to see your place [unit] run well."

For many NUSs, decentralization as a concept was viewed positively. "If decentralization evolves the way it's supposed to, there'll be a lot more satisfaction in the job" was the way one NUS saw the potential of the new structure. Not having to take home extra paperwork was an immediate bonus identified by several. Others expressed this same contingent notion; if no more functions were added to their role, no more positions eliminated from the organization, and if senior nursing management "let go" of some of the controls, then decentralization was a positive move in raising job satisfaction. These contingencies, however, inevitably led to discussion about the process of implementing the new structure.

Implementation Process

Senior nursing management.

"The initial planning

and implementation of this process was too closed and secret," claimed one NUS, adding: "The union could have been brought on board," thus eliminating some of the current disputes. This same NUS felt "the change was dumped on us too quickly when they were still making last-minute changes," an idea maintained by other NUSs, including Kate, who also felt the structure was put in place "too soon."

The initial, closed nature of the planning, the departure of some of the key instigators, and the subsequent numerous revisions after the structure was in place was interpreted in several ways by the NUSs. Myra claimed that "they introduced an idea, not a plan, and there should have been a plan before the implementation." Jorga perceived that decentralization was "floundering right now." A new NUS thought senior management might have had "the big picture" but were unwilling to share it with the NUSs. For others, including Liv and Jan, the former vice-president and senior vice-president may have had "the global picture" but, with their departures, Alex was left with the final responsibility.

Some NUSs noted that the changes must have been very difficult for the nursing directors and for Alex in particular. "The saddest thing," Liv said, "is that Alex is left with it all. Despite what we say sometimes, I think we all know it's not easy for him." Other NUSs were certain Alex would apply for the vice-president's position and was

therefore retaining power at that level.

Each NUS interviewed identified some problem with the implementation process. The frequent changes that occurred after the initial introduction of the new structure and the use of "acting" nursing executive created an uncertain climate, according to the NUSs. This uncertainty led to concerns about trust--in senior administrative staff and other NUSs.

Peer group. Issues of trust, power, and control were not focussed exclusively on the senior administrative levels. NUSs, in subtle ways, expressed some concern about their colleagues as well. Jorga noted, "I hope we don't lose sight that the nursing directors have jobs and a function too. We don't need all the power." Another veteran NUS expressed it this way: "Decentralization means different things to different people, a power trip. [It's] great. I'm really going to run things around here, but they're not. They still have to live with decisions made by higher-ups." Myra simply defined the situation as a "power thing going on right now in the NUS group."

Helping and Hindering Factors

Myra felt the energy spent on "political activity" should be invested in patient care, an area she still enjoyed.

"They don't threaten me. I'll do what I enjoy and what gives me satisfaction, even if I have to stay later to do it." Carol and Jorga felt their long histories with the hospital helped them take this change as part of the "flow." "When so many changes hit you, this is just another one," according to Jorga. However, two more recent NUSs felt their newness in the role made it easier for them to adjust since they did not "have to juggle between the old and new" ways of doing things.

Three of the NUSs credited their former assistant nursing director with facilitating their transition to a decentralized system. They described her as "giving more autonomy" to the NUSs and encouraging "a self-directed approach." Carol, on the other hand, had learned to "work around [her] assistant nursing director," and this new system was relatively better. Only one NUS identified a hindrance--the fact that her group of NUSs had five bosses in the past two years. This group of six NUSs shared the fate of the nursing directors who experienced a similar turnover of immediate supervisors in a short period of time.

Several other factors were identified by the NUSs as helping them deal with the organizational changes. Kate claimed one's response depended on the amount and type of changes one was accustomed to in one's own life and work place, referring to rapid turnovers of patients in her particular area. Jan thought having an inside understanding

of the decentralized structure, as a result of discussions with Jill, helped her adapt. Jan was also part of a small group of NUSs that met between committee structure meetings to develop more refined plans for the larger NUS group. The other members included Liv, Lyn, Kate, and May. Another NUS felt the reorganization must have been more difficult for the younger NUSs who still had long careers ahead of them. The older ones, she reasoned, had only to "tough it out" for a little while longer.

"It all depends on who the new vice-president is," was one NUS's response to the reorganization. She voiced the concern of all NUSs--that the full impact of decentralization would not be felt until a permanent leader was appointed. The current situation and, to some extent, changes were perceived to be temporary. The "wait and see" attitude became a coping mechanism for all the NUSs interviewed. Anticipating the future in other forms was also a means of dealing with the present.

Other Options

While most of the NUSs cited factors that helped them adapt within the organization, over half of them also considered outside options as future possibilities. A couple of NUSs ended their interview with "but I'm retiring soon anyway." Some others mentioned going back to university to obtain Master's degrees or complete their baccalaureates. One NUS thought she would resign and work part

time as a staff nurse in a hospital closer to her home, while others felt they might apply for work at the new satellite hospital once it opened. Working in a flower shop was all one NUS felt qualified to do if she was compelled to leave City Hospital. Others did not think of outside options at all, and relied on organizational supports, like their peers and unit associations, to help them adapt to the changes.

Summary of Chapter 6

The NUSs were provided with and created opportunities in which they defined their social reality. The formal structures of committee and sub-department meetings and the informal associations of small groups of NUSs became the forums in which they made their situations "rationally accountable to themselves and to others." Power and personalities became recurrent themes in the development of the committee structure and the explanation of some administrative decisions. Learning when to speak and when to "keep quiet" were tactics the NUSs had acquired earlier in their careers of "learning to work the system" and which they employed in the committee structure meetings. A more detailed study of the meanings and explanations given by the NUSs is the subject of the next chapter.

Chapter 7

NUSs' PERCEPTIONS AND REACTIONS: EXPLAINED

Introduction

The ways the NUSs perceived, reacted to, and explained the events of the implementation of the new organizational structure are explored in this chapter. Pervading the discussions in the committee structure meetings and sub-department meetings, as well as in individual interviews, were two recurrent themes--power and personality --and these themes are the focus of this exploration.

Power and personalities were dynamic forces for the NUSs; although the two themes are under separate sections in this chapter, that dynamic is addressed in each area. The statements of the NUSs, the strategies they employed during the period of observation, and the influencing symbols and ideologies of City Hospital are the basis of this exploration. During the course of this study, the NUSs developed mutual forms of understanding and explaining the events surrounding them. These explanations became part of the common definition of the situation which bound the group of NUSs together. The two sections on power and personalities each conclude with these collective interpretations or myths

which the NUSs formed in relation to the two themes.

The focus on power and personalities is not meant to suggest they were the only two issues or areas of interest for the NUSs, nor were they the only way to approach an understanding of their responses to the new structure. Some of the other themes and issues that developed over the course of this study were: the NUSs relationships with their units and the larger organization, the role of language and other symbols in the emerging leadership roles of some NUSs during the committee structure meetings, and the creation of mediating myths and rationalized explanations by the NUSs and members of the nursing and hospital administration. Aspects of these topics are addressed in the two themes of power and personalities but each merits a more detailed study of its own. The two themes were selected as they were the most evident and recurrent in the areas of observation.

Power Themes

Although NUSs never articulated a common definition of power, they expressed a mutual understanding of the term through their collective indication of what they wanted for themselves in the new structure. Some NUSs revealed their own interpretations of power through their developing leadership roles in the course of the committee structure meetings. Nearly all the NUSs demonstrated how they

responded to power in their behaviour with their superiors as well as their explanations of that behaviour.

"I want to be part of the decisions" was one of the first comments made by an NUS in the committee structure meetings. The need to have a direct impact on the actions of the nursing department was expressed in a variety of ways throughout the committee structure meetings and, to a lesser extent, the sub-department meetings. The list that developed in a brainstorming session in the second committee structure meeting reflected the interest the NUSs had in gaining more control over their work environment: decision-making power, a voice in working conditions, direct contact with other people in the organization, input to multi-disciplinary groups "where their decisions influence us," and more access to pertinent information "so we don't become isolated," were all cited as important needs in forming a new committee structure. If Kanter's (1977:166) definition of power, "the ability to get things done, to mobilize resources," is used, then the NUSs were stating a need for a larger measure of power.

As a group, the NUSs wanted more direct access to information, people, and decisions. In small-group discussions, some NUSs claimed information should come from the "front-line" with administration advising them of organizational constraints. This format led to speculation of having direct contact with the vice-president of nursing and

thus creating an even more decentralized structure. As Myra noted, "I would like to make decisions that affect my own unit." Two trends in thought seemed to develop out of this collective need to have control over one's own unit: one group of NUSs believed the way to exercise power at the unit level was to gain control within the department, while the other group believed such control would never be permitted by a higher administrative level and was not always necessary. The strategies and comments from each group demonstrated their diverging views on gaining control over their units.

Strategies

Several strategies were employed by the NUSs in relation to their notions of power. The first two identified were group process strategies that developed during the committee structure meetings. A dominant group emerged that guided the direction of the total NUS group while a counterbalancing segment of NUSs acted as a foil to this dominant force. The remaining strategies related to the actions taken by the total NUS group as means of increasing their own power in the nursing department.

Dominant group. One NUS reflected that the nursing directors had a job as well and the NUSs did not "need all the power." The only power this NUS (and others like her) wanted was to control her own unit without a large number of

outside directives. "A power thing" and efforts "to have all the power" were the terms these NUSs used to describe how they perceived some of the group dynamics in the committee structure meetings. The more dominant group of NUSs perhaps achieved a leadership status because they formed a coalition outside the collective meetings.

A group of five NUSs joined together to refine their perceptions of the committee structure and develop means of supporting one another during the course of the meetings. They were the most vocal in the meetings and were accepted by the others as the leaders, both in chairing the meetings and presenting proposals to senior levels. This mutual support created a powerful inner group. The quiet acceptance of the larger NUS group reinforced the power of this smaller coalition. By not overtly opposing the small group of dominant NUSs, the total group developed the appearance of a powerful, unified entity. Silence was as much a strategy for the total group as the small-group discussions were for the dominant group, or "cabal," to use Deal and Kennedy's definition.

This small coterie moved the committee structure meetings ahead with actions ranging from Lyn's directives to "not go off on a tangent" to Kate's provision of files and flip charts. Their mutual support allowed them to resist some of Alex's recommendations and guide the NUS group in creating a new committee structure. In leading

the group, the dominant NUSs were engaging in extraordinary activities which were visible and relevant to the functioning of the organization. Kanter (1977:176-181) noted that reorganizations were opportune times to manipulate the structure to increase one's power. This small group of NUSs took advantage of the changes in the nursing department to redefine their roles in a way that reflected a rational-purposeful ideal and also the action-orientation of Petra. Other NUSs, however, provided some counterforce to this group.

Counterbalancing group. When the NUSs' were deciding the membership of the new committee, one of the older NUSs remarked, "I doubt nursing administration will let us choose everything," causing a younger NUS to state, "perhaps we should ask what they will let us do." Both statements indicated a recognition of the limitations placed on the NUS role, even within the new structure, that contrasted with the group of NUSs that dominated the discussions in developing a new committee structure.

This group of NUSs was generally quieter in the committee structure meetings except for the occasional comments and questions like the ones cited above. Their statements tended to focus the group at large on the limitations of decentralization and the constraints of the organization. One NUS, representing this counterforce,

asked Alex if it were possible to have both decentralization and standardization, in an attempt to point out what she perceived to be the contradiction between the two notions. Although that particular question was overruled by another NUS who argued there were "commonalities" amongst the units, such interjections acted as a means of balancing the dominant theme of the NUSs obtaining department-wide power. Most comments from this section of the NUSs, however, were made in private while the more vocal group led the dialogue through the following strategies.

Power through policy-making. When Alex explained decentralization to the NUSs as being, "decision-making and authority at the lowest possible level," one NUS wanted to know if that included "policy-making." Alex informed them that policy-*making* was a senior administrative function "but policy *recommendations* should be coming from the committee." For the NUSs, however, policy-making was "decision-making at the lowest possible level" and a more powerful mechanism than policy recommendations. Disregarding this early explanation, the NUSs developed a committee structure that included policy-making powers in the NUS-dominated nursing management group.

The NUSs reasoned since they operated on the level where the policies were enacted they should be the group to develop them; that is, as NUSs they knew the need for

particular policies, how the staff would respond to them, and the operational context of the policies. Alex objected to the relocation of the policy-making function in the NUSs proposed committee structure as presented to the senior administrative levels, reinforcing his view that the function was the responsibility of the senior levels. While the NUSs interpreted "decision-making at the lowest possible level" to be policy-making, Alex and the nursing directors defined it as recommendations. The NUSs and directors differed on other interpretations of the functions of their two groups.

During the earlier stages of the committee structure meetings, one of the directors suggested changing the name of the "nursing management committee" to "nursing advisory" and making attendant revisions in its functions. After noting the revisions, Lyn commented, "we've watered down" the committee, noting its function moved from an action orientation to a supportive function. Cathy's request in a later meeting to change the terms of reference of the nursing management committee from "receives information" to "receives information and direction," also indicated a difference in perceptions of where power should reside. The NUSs rejected some of these suggestions but were not vehement in their objections; they had other means of gaining power.

Power through numbers. Along with their decision to have policy-making functions as part of the nursing management group, the NUSs placed eight of their colleagues on the nursing executive committee. With this number on the committee, the NUSs were the dominant category, compared to one vice-president, four nursing directors, and the department director of education, who the NUSs wanted to place in an ex officio position on the committee. Although Alex said decisions were reached through consensus rather than a vote, the NUSs were definite about having eight representatives on the committee. Numbers seemed to represent some form of power and influence over others. Both the directors and NUSs, however, argued in terms of time commitments and "balanced representation" rather than the value of large numbers in group consensus. Alex also noted senior levels retained a veto power, which led to a discussion on position and personality that was stopped by Lyn as being "off track." This episode, however, was one indication of the perceived relationship between power and personality. "Numbers" was not the only other strategy available to the NUSs.

Power through information control. While the NUSs argued more forcefully for eight representatives on the nursing executive committee, they developed other means of increasing their power in the department. In debating the role of the AUSs, the NUS group wanted to ensure the former

did not feel isolated from the flow of information as they had in earlier organizational structures. Access to information and, more importantly, control of information was perceived to be one form of power. The proposed committee structure had the NUSs chairing all the major committees which, in turn, reported to the nursing management committee.

In the proposed structure, the NUSs not only had direct access to data generated in the committees but also controlled their upward flow to the nursing executive. If the NUSs could not have direct policy-making powers they ensured their control of significant information needed to create the policies. The proposed committee structure became a symbol of the anticipated new role of the NUSs.

Symbols and Power

Although power was something the NUSs claimed they wanted, they also demonstrated their current use of it in the context of the committee structure and sub-department meetings. Kanter's definition of "getting things done" seemed to be the accepted use of the term "power" for the NUSs and they did "get things done."

Petra demonstrated her power through the use of the instrumental symbols as described in Chapter 4. The NUSs used similar symbols in their efforts to claim more power for themselves; they created charts and models as visible means to explain the new communication system; they created

powerful alliances and kept the focus on the direction they wished to pursue. Action was used more than dialogue as a means of creating a new system; Petra was perceived to be action-oriented while those in staff management engaged in dialogue and were not seen to be as powerful. Meetings and minutes were concrete evidence of the NUSs accomplishments, and their progress was reported through files of diagrams and terms of reference. A unified front represented the unanimity of their decisions. In this respect, silence from some members represented solidarity and power.

Petra symbolized power in another way; her rise through the levels of the organization demonstrated a means of achieving power. The ceremonies of City Hospital also symbolized the importance of being in a higher-level position, thus supporting the NUSs strategies to elevate their positions. The NUSs sought power by placing themselves as high as possible in the committee structure, both in chairing and in holding membership on influential committees. The committee structure itself became a symbol of the flow of communication as well as the status of the NUSs in this scheme. Other symbolic acts also may have influenced the NUSs actions.

Alex informed the NUSs that it was "all up for grabs" in creating a new structure and then removed himself and the nursing directors from most of the meetings. These actions would seem to sustain the notion that the NUSs had

the power to create a new communication system without interference or constraints. The "top-down" line of communication in the sub-department meetings, as well as the issues of banking time, AUS job descriptions, and elimination of team leaders and clerical managers, all demonstrated the control that still existed at the senior level of management.

Since the initial planning and implementation of the decentralized structure were retained at the senior level of nursing, some NUSs believed the senior level would continue to retain control. The feedback from Alex and the nursing directors about the proposed structure and terms of reference also strengthened the perception of the amount of power that was to be secured at senior levels. Power was a scarce resource that was sought where possible and retained where necessary at both levels.

Power had an instrumental value in helping "get things done" but it also had an expressive value in signifying the importance of the person exercising that power. Power was not only something symbolized in other forms but it symbolized something beyond itself; the value and importance of the people who used and controlled it. The NUSs created a number of myths related to power that served to "explain, maintain solidarity and cohesion, and legitimize" their own actions as well as those of others (Bolman & Deal, 1985:153).

Myths About Power

Myths and metaphors, according to Pondy (1983:164), both facilitate change and reinforce traditional values. In creating myths about power, the NUSs drew upon the existing values and symbols of the organization to help themselves adapt to a new structure. In sharing these myths, the NUSs were able to achieve a common understanding of how they perceived the organization as it was and what they wanted the nursing department to be. Thus, the myths served to explain events, legitimize the actions of the NUSs, maintain solidarity among the NUSs, and express their interests for themselves.

Power was, first and foremost, "getting things done." The NUSs, therefore, actively sought to create a structure that gave them more opportunities to be directly involved in actions and decisions. This led to the second myth.

Power resides at the higher levels of an organization. Although Alex had said the hospital's decentralization meant decision-making at the lowest level possible, decisions about policy-making issues still existed at the senior administrative levels; therefore, "real power" resided at higher levels and the NUSs attempted to place themselves in some of those levels in the new committee structure.

While placing themselves in the higher levels of the communication system, the NUSs created two other myths to

explain and legitimize their actions. Power is related to numbers; the more members of a group represented in a situation, the more control and support available to the members in the situation. Power is also related to the control one has over the dissemination of information. Thus, the NUSs were to chair every major committee and be represented in large numbers on the main decision-making body, the nursing executive committee.

Perceptions about power and who had it inevitably led to speculation about individuals and personalities. Part of the NUSs' understanding of the new structure, and the organization in general, was grounded in their perceptions of the people in the organization. Since power was perceived to reside in the upper echelons of the administrative structure, then the focus on personalities was essentially located at that level as well.

Personality Theme

The NUSs' perspective on power and personalities resembled a political approach to the organization; the coalition of interest groups (i.e., hierarchical levels) were engaged in an ongoing negotiation for power and position in the organization (Bolman & Deal, 1985:109). As the NUSs jockeyed with the acting vice-president and nursing directors for more power, they noted personality issues of the administrative group which could influence their

bargaining position. Personalities also became a means of comprehending the inexplicable.

Interpersonal differences and individual traits were frequently cited explanations for events and decisions that occurred in the nursing department. Most of the personality issues focussed on the senior levels of nursing and hospital administration.

Some NUSs thought the decision to stop recording time on and off duty was related to the personal habits of senior administrative staff who were not prepared to do the same thing themselves. This rationale made more sense to most NUSs than did the statement in one sub-departmental meeting that the new ruling was "a decision from on high." Other administrative decrees were subject to a similar form of analysis and interpretation.

The elimination of the clerical manager role was believed to be the result of a "personality clash" between some senior administrators and some clerical managers. The rational and official explanation of further budget cuts was secondary to the personality issue. Avoiding conflict with senior levels of administration was perceived to be important to one's ability to perform effectively. As one younger NUS noted, "you learn to keep quiet in one area so you don't get it in another." Personality issues were not confined to interpersonal relationships and differences. The NUSs also speculated about the personal motives of

senior levels of staff that could influence the direction of the nursing department.

Throughout the period of observation the comment "it depends on who the next vice-president will be" was frequently voiced by the NUSs and senior nursing management staff. This statement not only added to the tentativeness of the organizational changes but emphasized the perceived importance of personalities in the administration of an organization.

Alex and many of the NUSs made references to the next full-time vice-president of nursing, noting that certain aspects of implementing the proposed committee structure "depended on *who* the new vice-president" would be. Even Jan, one of the NUS leaders, claimed the leadership style at senior levels was "50% position and 50% personality," and Alex concurred. All the NUSs agreed that "*who* was appointed to the vice-presidencey" would affect the overall climate of the nursing department.

The reluctance of some NUSs to become actively involved in developing a new committee structure related to their perceptions that their own contributions could easily be over-ruled when a new vice-president was installed. An older NUS argued that until a permanent appointment was made there was little point in developing a new structure because "those of us who have lived through a lot of changes know how quickly decisions can be reversed or nixed." A

"wait and see" approach was a way of dealing with the tentative and uncertain nature of the current changes. Theories about who the next incumbent would be also revolved around local candidates.

The NUSs felt some power was being retained at a higher level because the acting vice-president (Alex) intended to remain in the position. For the short period of time this speculation lasted, it was employed as an explanation for a number of senior-level actions and was another reason for "keeping quiet." The uncertainty of the next incumbent in the vice-president's position influenced the strategies employed by the NUSs during the course of the changes.

Strategies

Attributing decisions and events to "personalities" was, in itself, a strategy for understanding otherwise inexplicable events in the organization. If a rational, logical explanation did not seem adequate to the situation, then locating the reasons in the "quirk" of someone's personality or in the problem of interpersonal differences seemed to satisfy the need to understand the rationale behind an administrative action.

Current events. Explanations grounded in personalities were thus used to comprehend current events based on past understandings of the people involved. NUSs would

frequently cite past incidents they recalled about an individual to elucidate current issues. Statements like "X has always had it in for . . .," or "Y never liked Z since the time Z . . .," were quoted in an effort to bring meaning to more recent circumstances. Knowledge about the past not only helped explain the present but also helped project the NUSs into the future.

Anticipated events. Speculating about the personality of the new vice-president and nursing directors was a way of anticipating possibilities for the future of the department. Based on their previous experience with various administrators, the NUSs created possible scenarios with different types of personalities in the vice-president's role. This projection was usually done in small groups or individually, rather than as a large collective, but it still served to facilitate the NUSs' transition to the new system and personnel. On the two occasions when Alex mentioned what might happen when the new vice-president was in place ("I don't know what the next guy will do" and "sure too bad if the next guy doesn't accept" the proposed committee structure) he was greeted with silence. This silence, however, seemed to be a means of coping with senior level staff that was part of another strategy to deal with personalities.

Influential others. "Keeping quiet" and "working

the system" were two means of dealing with individuals who were perceived to have influence and power: physicians and senior administrative staff fell into this latter category. NUSs were adept at dealing with personalities, as noted in Chapter 2. In the sub-departmental meetings, the NUSs noted how they learned to keep quiet in one area so they would not "get it in another." Descriptions of how the NUSs "worked around" physicians, assistant nursing directors, and administrative decrees also peppered the dialogue in the meetings and individual interviews. Knowing how to deal with personalities meant learning what to say and when to say it, as well as when not to speak and simply to bide one's time. This latter mechanism became part of yet another strategy.

Individual options. Reference was made in Chapter 5 to Waller's description of the self in an organization. Waller (1932) stated that if an individual feels defeated in one area of his life he will seek growth and self-esteem in another "surface of the tetrahedron." Many of the NUSs created "other surfaces" in projecting themselves into future situations unrelated to their roles in City Hospital. They tolerated the present with a "wait and see" approach. The future options allowed the NUSs to distance themselves emotionally from the organization and were insurance against the possibility of untoward future developments. Individual

options included retirement, going back to school, seeking a less stressful job elsewhere, or applying for a position in another hospital. These other options were like the other heads in Waller's tetrahedron. Although they did not exist as immediate, or in some cases even realistic, possibilities, they were a means of projecting one's self into more pleasant future circumstances, thus making the present more tolerable.

The creation of other options was an individual strategy that counterbalanced the binding forces of the collective myths. Nevertheless, the individual options were developed based on the myths related to personalities. Since personalities seemed to have a strong bearing on the direction of the department, the NUSs believed keeping one's options open was a wise move. Certainly events prior to and during this field study demonstrated the role of personalities in the functioning of the organization.

Symbols and Personality

The "wholesale changes in the 1950s" referred to by June Hill were attributed, in large part, to the strong personality of Miss Peters. The changes that occurred around the time of Petra Stone's arrival were related, by some, to her "youthfulness" and assertive personality. The articles in the hospital's newsletters on management staff generally noted some aspect of the individual's

qualities that had or would (positively) influence his/her work at City Hospital. Some explanation for the "disappearing man" phenomenon was sought in the personalities of the exiting individuals or their bosses. Clearly, "personalities" were perceived as important features of the culture of City Hospital in both positive and negative terms.

The NUSs seeking a rationale through personalities is understandable. There need be no explanation beyond personality. Pondy noted "both metaphor and myth provides a convincing stopping place in the chain of explanation" (1983:163). Myths about personalities are end points in finding a meaning for certain organizational events and decisions.

Myths About Personality

The NUSs created and shared several myths about personalities in their organization. Like the myths about power, these statements served to explain, bind, and legitimize action.

The personality of the leader had a direct bearing on the atmosphere and direction of the department. The NUSs with sufficient years of experience noted the change of climate and purpose in the nursing department when June Hill was the leader compared to Petra Stone's tenure as nursing director. An NUS with a long history at City Hospital was the one to note the change in salary

negotiations for nurses when Gil took over the responsibility; thus, the conclusion that administrative directives were 50% position and 50% personality.

The above statement was also the basis for the next myth. Some organizational decisions can largely or only be explained by the personalities of the people involved. No one in the nursing department could seem to explain Petra's decision to disband the NUS group except by using her personality traits as a rationale. Similar reasons were found in decisions made during the period of this study, including those related to "banking time" and eliminating the clerical manager's position. Relying on such reasoning created a tentative climate at times. Thus, the NUSs developed a personal strategy that cannot be referred to as a myth but was prevalent among the members of the NUS group. Creating other options made working in the current system more tolerable.

Summary of Chapter 7

The NUSs' perceptions, reactions, and explanations of the structural changes developed out of their large- and small-group discussions as well as from their individual plans. The symbols and values of the organization influenced these perceptions and thus focussed the NUSs on particular themes.

The two themes addressed in this chapter, power and

personality, developed out of the NUSs' earlier understanding of the culture of City Hospital and the sub-culture of the nursing department. During the course of the reorganization of the nursing department, the NUSs relied on their past experiences and history with the hospital to reach a mutual understanding of its present state and future direction. Some of these common definitions became myths which served to explain, bind, and legitimize the actions of the NUSs. A concluding review of the role of symbols in the reorganization of the nursing department at City Hospital is addressed in the next chapter.

Chapter 8

CONCLUSIONS AND SUGGESTIONS FOR FURTHER STUDIES

Conclusions

The focus of this study was on the perceptions and explanations of front-line managers of one particular level of an organizational hierarchy during a period of change and restructuring. This time of transition was an opportunity to observe how selected members of a culture redefined the "way we do things around here."

The nursing department of City Hospital was one section of the institution's larger culture and the study group of Nursing Unit Supervisors (NUSs) only one segment of that section. Nevertheless, the NUSs relied on certain aspects of the total culture, including its symbols, to develop their own understanding of the organization and its events; thus they portrayed some of the broader story of City Hospital.

The history of the hospital was a story of nearly constant change, both physically and organizationally. These transformations mirrored the general alterations occurring in the form and function of hospitals throughout North America. The increasing concern for efficiency and

rationalized forms of administration were also incorporated into City Hospital's ongoing restructuring.

The reorganization of the nursing department was explained, by members of the senior administration, as being a means of "maximizing resources" and eliminating a "top heavy" administrative system. The new structure of the nursing department was expected to be a more efficient form of management. The revised organizational chart and structure symbolized an ideology of scientific management, a system of ideas that is grounded in tenets of efficiency and rational actions.

The perceptions and explanations of the NUSs were influenced by the rationale provided by the senior administrative staff as well as by the symbols and events in the organization. Although the NUSs did not overtly connect their interpretations of a decentralized nursing department with the symbolic and ideological aspects of City Hospital, they clearly employed symbols in their individual and collective explanations of the changes.

The committee structure, which the NUSs were authorized by senior nursing management to create, became an instrumental and expressive symbol of the NUSs' beliefs about their own roles in the organization.

In designing a new committee structure, the NUSs were given a qualified opportunity to reassess and recreate their position in the nursing department. Although certain

restrictions and guidelines were imposed on their task, the NUSs used the occasion to redefine their role in the organization to themselves, their colleagues, and their superiors. The new committee structure was a means for the NUSs to present their redefined position to others in the institution. In the recreative process they drew upon earlier symbolic features of the hospital.

The ceremonies and rituals of City Hospital symbolized the value placed on status in and loyalty to the institution. The physical environments of the various levels of management and staff reinforced the importance of the different members of the hierarchy. Individual senior administrative staff members symbolized the importance of both higher-level positions and rationalized forms of management. The NUSs' recurrent focus on power and personalities could be expected to develop out of a culture that rewarded these values and beliefs.

The directives provided by the senior nursing management team, therefore, were not the only constraints placed upon the NUSs in developing a new communication system. The instrumental and expressive symbols of the organization could be interpreted as constraining forces on their perceptions. The organizational symbols took the forms of ceremonies and rituals, organizational structures, leaders, positions, and events in the organization.

Many of the apparent contradictions between having

"power at the lowest level possible" and receiving orders "from on high" were resolved through explanations about power and personalities. Some of these myths or explanations were also employed to justify and legitimize the NUSs' actions in the system as it existed, as well as in the anticipated system. The myths bound the NUSs together in a sub-culture of the department and organization. This solidarity supported claims for more tangible forms of power in the new decentralized system.

While designing means of achieving more obvious forms of power, the NUSs did not seem to acknowledge the power they already had, even when they made oblique references to it in discussions about "working the system."

The head nurse (NUS), according to Mauksch's (in Davis, 1966) analysis, represents or symbolizes the administrative structure on the nursing unit and would suggest that the role is, in fact, a very powerful position. Yet the NUSs at City Hospital, while performing the same functions as described by Mauksch, were claiming they needed a more powerful position in the organizational structure. The NUSs formed this image through the development of an instrumental and expressive symbol--the committee structure.

The symbols helped guide the perceptions and actions of the NUSs, including facilitating the transition from the familiar to the new. Finally, the NUSs symbolically conveyed what they valued as important in their role. The

themes they followed, and the symbols they selected and created, depicted some of the broader story of the organization.

Suggestions for Further Studies

Two limitations of this study were the confined nature of focus and the general overview of the use of symbols in one department of a complex organization during a period of change. Both larger-scale studies and more detailed examinations of symbols in organizations could expand the understanding of the richness of organizational life, particularly during times of transition. Some potential areas of study that arose during the course of field work at City Hospital are offered below.

Collective and Individual Use of Symbols

The NUSs developed collective symbols and explanations of the new decentralized system that differed to some extent from their individual means of dealing with the changes. Dimen-Schein (1977), in observing this phenomenon in other cultures, drew analogies to Durkheim's concepts of the sacred (collective) and the profane (individual). Further studies on the collective and individual creation and use of symbols in organizations may lead to a fuller appreciation of their meaning.

Stories

NUSs with a longer employment history at City Hospital recounted stories about the organization that provided a perspective on the more recent changes by "putting it into perspective." Stories were significant for this segment of the NUSs in dealing with more current transformations. The hospital had a formalized tradition of written accounts of the institution but a narrative form of conveying the organization's "script" was less evident. Further research into the form and function of organizational stories may reveal elements of their changing nature.

Symbols and Identity

The NUSs' perceptions of themselves were sometimes contrary to the power attributed to them in earlier research on the role (Burling et al., 1956; Mauksch, in Davis, 1966). Symbolic interactionism, including dramaturgical models, addresses some components of symbolism in the development of self. A more specific focus on organizational symbolism, including a more precise definition of its myths, may contribute to a fuller understanding of organizational life and add to other approaches of study in this area.

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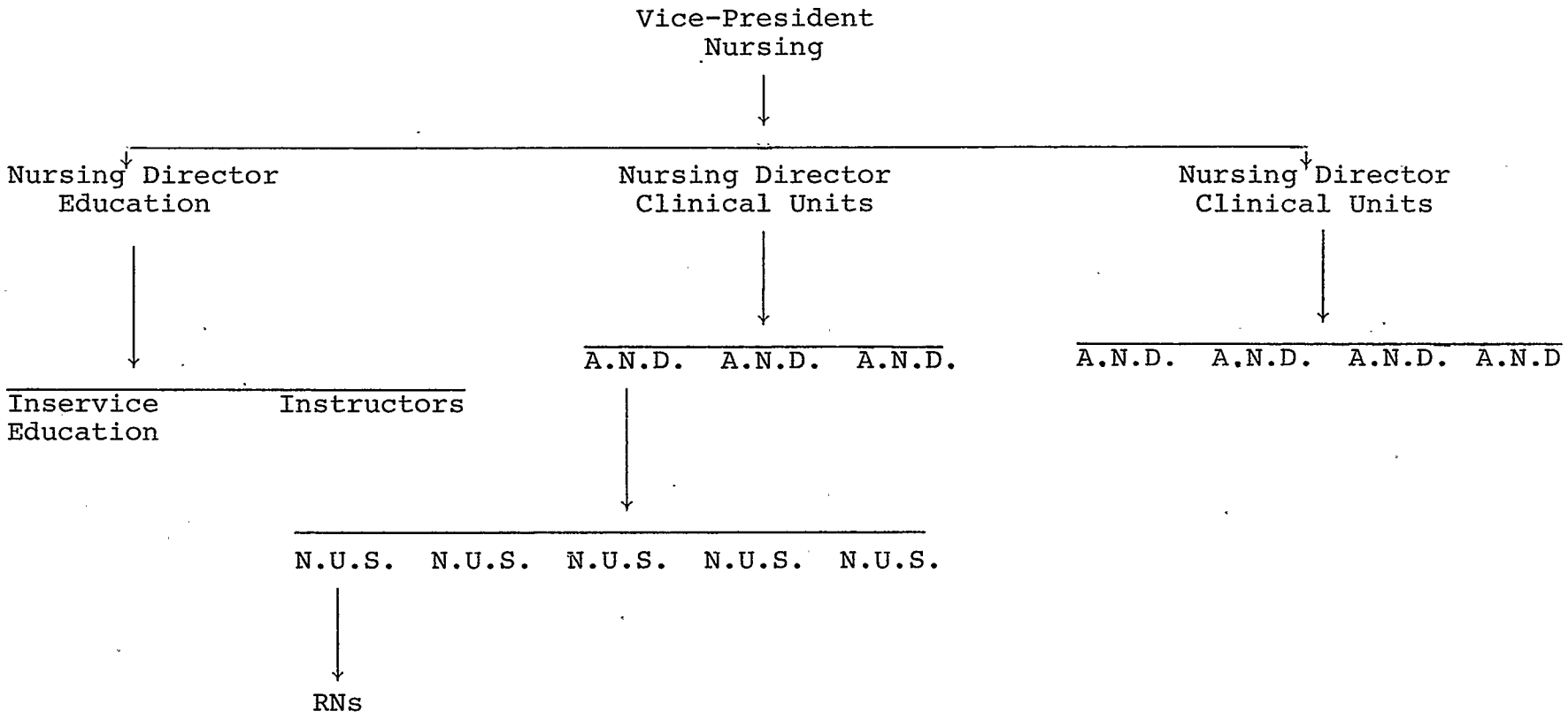
APPENDICES

APPENDIX A

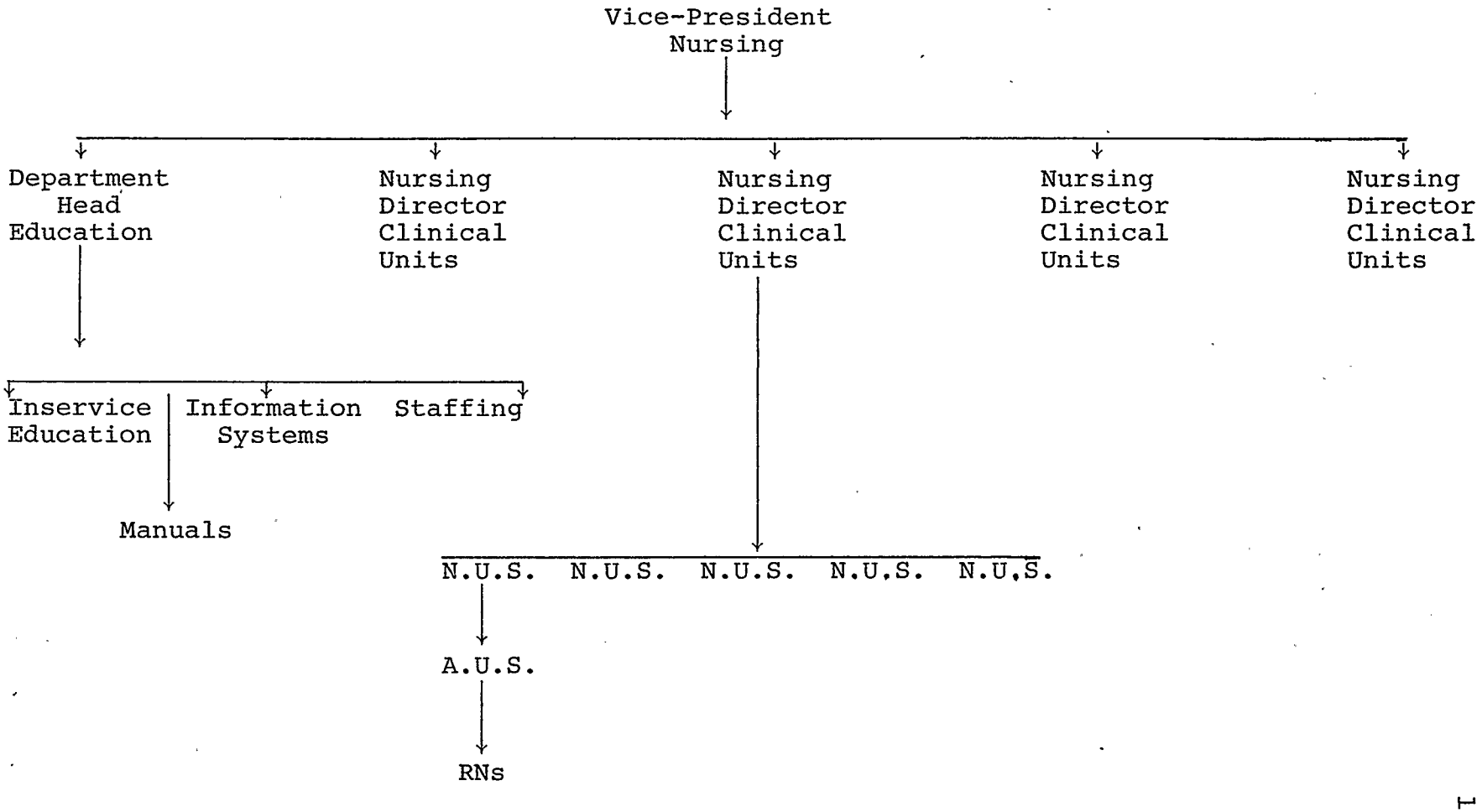
Typical pre-decentralized nursing department



A.N.D. = Assisting Nursing Director N.U.S. = Nursing Unit Supervisor RNs = Registered Nurses

APPENDIX B

Typical decentralized nursing department



N.U.S. = Nursing Unit Supervisor A.U.S. = Assistant Unit Supervisor RNs = Registered Nurses