

**ACTS OF RESISTANCE:  
NURSES' PERSONAL NARRATIVES**

**by**

**Maryanne Garon**

**A dissertation presented to the  
FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING  
UNIVERSITY OF SAN DIEGO**

**In partial fulfillment of the  
requirements for the degree  
DOCTOR OF NURSING SCIENCE**

**November 1998**

**Dissertation Committee**

**Jane M. Georges Ph.D., R.N., Chair  
Kathy Shadle James D.N.Sc., N.P.  
Alex Kodiath Ed.D.**

**Copyright by Maryanne Garon 1998**

**All Rights Reserved**

**APPROVAL PAGE, DISSERTATION**

**UNIVERSITY OF SAN DIEGO  
Philip Y. Hahn School of Nursing  
DOCTOR OF NURSING SCIENCE**

**UNIVERSITY OF SAN DIEGO**

**CANDIDATE'S  
NAME:**

**Maryanne Garon**

**TITLE OF  
DISSERTATION:**

**Acts of Resistance:  
Nurses' Personal Narratives**

**DISSERTATION  
COMMITTEE:**

**Jane M. Georges, Ph.D., RN, Chair**

**Kathy Shadle James, D.N.Sc., NP**

**Alex Kodiath, Ed.D.**

## **ABSTRACT**

Acts of resistance can be expressions of creativity, protest or non-cooperation by oppressed groups. Resistance is seen as always present in the face of domination. Acts of resistance can help us to understand how the powerless mediate power relations, and they can actually give hope to the powerless. This study looked at the issues of power and resistance through from critical and feminist perspective. A central concept of feminist theory is that women, and thus nurses as members of a women's profession, are oppressed. This study looked at female nurses' acts of resistance, which were defined as speaking up or taking action about injustice, oppression or unequal power relations in their work setting. No previous studies have explored this area.

The purpose of the study was to relate and interpret female staff nurses' stories of their experience in the of resistance. By conducting this emancipatory inquiry, I sought to understand how nurses respond to oppression through their acts of resistance. The ultimate goal is social change and transformation.

The study used a feminist participatory approach and qualitative narrative method. Eleven female nurses were asked for their stories of acts of resistance. The narratives were analyzed using an approach that combined the methods of other narrative researchers.

The narratives of these eleven nurses revealed their experiences in the hierarchical world health care. The nurses recognized the concepts of acts of resistance and oppression, even if they did not use that language. They told of their acts of resistance with unjust managers and abusive physicians. Some of them took action

immediately, while others weighed the consequences for a long period, before acting. All the participants agreed that they would take similar actions again.

The issues of power, oppression and resistance become real when related by these participants. The underlying hope is that their words will spark nurses and the public to examine the inequities existing in the health care system and demand real change.

## DEDICATION

This dissertation is dedicated to my dear friend, Valerie Seech R.N. Valerie and I met, as very young nurses, when we were staff nurses in the Outpatient Department at the V.A. Medical Center, San Diego. As I look back on that time now, I know that Valerie and I were continually “resisting”. Valerie had a strong sense of nursing, and spoke up and took actions for what she thought was right. It was that sense of the essence of nursing and her willingness to stand up for it that drew me to her. Because of mutual support and nurturance, we were both able to speak up about the injustices that we saw. I think that those concerns eventually led me to doctoral study and this dissertation. Unfortunately, I wasn’t ever able to share this topic with Valerie or to tell her about her role in shaping it. For Valerie, after fighting for years against cancer, left us in the Spring of 1997. This dissertation is committed to her memory, and to all the nurse who have the courage to stand up for what they believe in.

## ACKNOWLEDGMENTS

It is traditional, at this point in the dissertation, to thank and acknowledge all of the people who have played a role in supporting the candidate toward the completion of the degree and the dissertation. I will not alter that tradition. First of all, I must thank the Chair of the Dissertation Committee, Dr. Jane Georges. From the first time that I sat in her office, tentatively offering my work and hoping to hear a "yes" (to Chairing), she has been unfailingly supportive, always knowing just the right time to encourage, to push, and to back off. She has allowed me to explore this topic that is so dear to me - with never a discouraging word! I also offer sincere thanks to Dr. Kathy James, for her support, encouragement, and feedback, and for agreeing to take me on! I am truly grateful to Dr. Alex Kodiath, the only non-nurse and non-faculty member on the committee. Despite the demands of a busy work life and a bustling family, he gave unselfishly of his time, always meeting my imposed deadlines and giving his honest and insightful input.

The collegiality of my fellow doctoral students has provided unending support and rewards. Special thanks to my VA colleagues, Dr. Judy Heggie, who went just before me and was therefore able to pass on all sorts of wise advice, Sue McAdory, who never failed to listen and offer ideas during our daily commute, and Carole Hair, who often lent an ear, as well as her transcription machine to the efforts.

I would acknowledge all of my colleagues at work for their help and encouragement. I thank all those in Nursing Service who have allowed me the flexibility to pursue this degree, especially Lauraine Dwyer, my immediate supervisor,

who was soooooo sick of hearing me say, "I can't meet that day . . . have to work on the dissertation!" The other Clinical Service Directors have also been a great support system throughout the process. In addition, without the loyalty, independence, and hard work of all the staff in the Outpatient Department, I would not have had the flexibility to finish this.

A special acknowledgment to my good friend and colleague, Mary Kodiath, who has nagged, prodded, pushed, supported, consoled, and cheered me on through all nine years of study. She has been a true friend throughout.

And finally, my special thanks to all my family, who put up with me through all these years. Thanks to my parents, who nurtured in me the love of learning that led me in this direction. Thanks to my two wonderful sons, Gregg and Colin, the world's best daughter-in-law, Holly, and grandson, Cade, who provided much needed respite from the dissertation work. But, the greatest thanks are saved for my husband, Dennis, my partner of thirty years, who has provided the financial stability for me to pursue this degree and the love and encouragement to see it through.



## **PREFACE**

### **Starting with my own experience**

Finding one's voice is an essential part of feminist research and writing. To begin the task of writing, I had to identify my own experiences and how I came to be interested in the subject of resistance. I was drawn to this topic because of my own struggles with existing power structures in nursing and health care. I now recognize that my first attempt at nursing research ("M.D. and R.N.'s Perceptions of Selected Activities in the Role of the Registered Nurse" with Valerie Seech R.N.) was generated because of my frustration with the relative status of the nurse in the healthcare setting. I began to understand the basis of these frustrations after I took several courses in the doctoral program at the University of San Diego, including "Feminist Perspectives in the Helping Professions." Once I looked at nursing through a feminist lens, I would never see the world in the same way again.

I began to see the influence of gender and class on nursing in my daily work and in the relationships between nursing, medicine, and healthcare administration. I could see that many of my actions and those of my colleagues were clearly reflective of oppressed group behavior. Even though my position was as a nurse manager, my heart remained with the practicing nurses. I have created my own acts of resistance over the years, but I have also been in that marginal place. Because of this, I have planned a study that will present the voices of practicing nurses in their struggle in this difficult world of healthcare.

I believe that a feminist approach is the most appropriate for this study because of the tenet that gender is the most basic unit of oppression. I also believe that a

feminist narrative research approach, which values women and their stories, is the most appropriate method for this potentially sensitive topic.

I have struggled to explain my feminist voice, then decided it could be best described a "transformational" feminist, based on the writings of Eisler (1987). A transformational feminist values all people regardless of gender, and seeks transformation of the current dominator system to a partnership model. My hope is that by giving voice to the stories of these courageous nurses, some of the injustice and inequity of our current healthcare system can be revealed. Making visible the oppression is the first step in making the transformation.

## TABLE OF CONTENTS

DEDICATION.....	ii
ACKNOWLEDGMENTS.....	iii
PREFACE.....	v
LIST OF TABLES.....	xii
LIST OF APPENDICES.....	xiii
CHAPTER I        STATEMENT OF THE PROBLEM.....	1
A. Introduction.....	1
B. Perspectives on Oppression.....	2
C. Traditional Reactions to Powerlessness.....	3
D. Type of Study to be Conducted.....	4
E. Theoretical Approach.....	5
F. Purpose.....	7
G. Research Questions.....	7
H. Assumptions.....	8
I. Significance.....	8
CHAPTER II        REVIEW OF LITERATURE .....	10
A. Introduction .....	10
B. Power, Oppression and Resistance .....	11
1. Definitions .....	11
2. Philosophical approaches to knowledge development.....	12
3. Discourse .....	13

## TABLE OF CONTENTS (Cont'd)

4. Habermas .....	14
C. Theories of Domination and Power Relations.....	15
1. Systems of oppression.....	17
2. Gender based views of oppression.....	19
3. Development of systemic oppression.....	21
D. Resistance.....	23
1. Political resistance.....	24
a. Civil disobedience.....	24
b. Hidden and everyday resistance.....	25
c. Rightful resistance.....	28
2. Foucault and resistance.....	28
3. Resistance theories in education.....	31
4. Feminism and resistance.....	32
5. Conclusions.....	35
E. A Critical Perspective of Nursing's Historical Development.....	35
F. Research in Nursing.....	39
1. Power research.....	39
2. Critical and feminist methods.....	40
3. Related studies.....	42
4. Critique and reflection as resistance.....	44
5. Power study.....	46
G. Summary.....	47

## TABLE OF CONTENTS (Cont'd)

<b>CHAPTER III</b>	<b>METHODS .....</b>	<b>49</b>
A. Epistemological Assumptions.....		49
B. Methodology .....		51
1. Selection criteria .....		51
2. Data collection.....		52
3. Interpretation of the narratives .....		53
C. Protection of Human Subjects.....		55
D. Summary of Research Methods .....		55
<b>CHAPTER IV</b>	<b>CONTENT ANALYSIS AND FINDINGS .....</b>	<b>57</b>
A. Introduction .....		57
B. Preliminary Findings .....		59
1. Description of participants .....		60
2. Introducing the participants .....		61
C. Frameworks of Meaning.....		64
1. Setting the stage .....		66
a. Context .....		66
b. Definitions .....		67
2. System of relationships .....		70
a. Management/administration and staff .....		71
b. Nurse – physician relationships .....		79
c. Staff – staff relationships .....		85
d. Nurse – patient relationships .....		87

## TABLE OF CONTENTS (Cont'd)

3. Turning points .....	89
4. Creating meaning .....	97
a. Self reflection .....	97
(1). Inhibiting factors .....	97
(2). Reaching the limit .....	100
(3). Looking within .....	101
b. Coming to resolution .....	102
(1). "I made it!" .....	103
(2). Negative consequences.....	104
D. Discourse .....	106
1. Who can talk? .....	107
2. Where can people talk? .....	08
3. What can be said? .....	109
4. Public and hidden transcripts .....	109
5. What do words mean? .....	110
E. Summary .....	111
CHAPTER V - DISCUSSION AND CONCLUSION .....	114
A. Implication of Study Findings.....	114
B. Contributions from the Literature.....	116
1. Resistance.....	117
2. Oppression .....	119
C. Importance to Nursing .....	120

## TABLE OF CONTENTS (Cont'd)

1. Education .....	121
2. Nursing practice and administration .....	122
3. Research .....	123
D. Conclusion .....	126
REFERENCES .....	128
APPENDICES .....	38

## LIST OF TABLES

Table 1:	<u>Comparison of Narrative Analysis Methods</u> .....	55
Table 2:	<u>Frameworks of Meaning</u> .....	62



## LIST OF APPENDICES

Appendix A:	<u>Interview Guide</u> .....	134
Appendix B:	<u>Demographics</u> .....	135
Appendix C:	<u>Human Subject's Approval</u> .....	136
Appendix D:	<u>Consent to Act as a Research Subject</u> .....	137
Appendix E:	<u>Glossary of Healthcare Terms of Abbreviation</u> <u>Used in this Study</u> .....	138

## CHAPTER 1

### Statement of the problem

#### Introduction

Within any oppressed group, there are moments of both creativity and resistance (Street, 1992). It is in these acts of resistance that the "fleeting images of freedom can be found" (Giroux, 1983, p. 108). Whether it be the creative expressions of African Americans in jazz, the revolutionary expressions of the young Chinese in Tianamen Square or the peace movements in the 1960s, individuals and groups seek ways to let their voices be heard and to express hope. Nursing, like other oppressed or powerless groups, has produced numerous examples of creative and revolutionary expressions. The creative expressions can be seen in diverse ways, from the nurse who works with a family to develop a unique plan of care that allows a severely ill child to go home to the nurse theorists' development of highly original conceptual models. The revolutionary expressions range from collective labor actions to scholarly writings of feminism and critical theorists to individual acts of resistance in practice settings. The richness and diversity of such acts reframe the presumed passive role of the powerless. It also points to the importance of resistive acts, as they benefit both the oppressed group and society as a whole.

The focus of this study is on nurses' acts of resistance. For the purpose of this study, I defined an act of resistance as speaking out or taking action, openly or

covertly, about an injustice, oppression, or unequal power relationship in the nurse's work setting. The need for and meaning of resistance provides important underpinnings for this study. Merriam Webster's Collegiate Dictionary (10th edition, 1993) defines resist as "to take a stand; to exert force in opposition" (p.996). Resistance can be overt and political, as in the case of civil disobedience, or covert or disguised, as in the case of private conversations and certain folktales. Giroux (1983) wrote about resistance and theories of resistance in education. In his view, "the notion of resistance points to the need to understand more thoroughly the complex ways in which people mediate and respond to the interface between their own lived experiences and structures of domination and constraint" (Giroux, 1983, p.108). In any society or group in which structures of domination have developed, there will be resistance (Scott, 1990). Acts of resistance can also give hope to a subordinate group that has seen itself as powerless. Studying acts of resistance of nurses is a starting point for better understanding of how nurses live with and respond to the oppressive system in which they work.

### Perspectives on oppression

Because resistance is linked with domination and power, the concept of acts of resistance achieve particular salience when viewed through a critical or feminist lens. A central concept of feminist theory is that women are oppressed (Chinn & Wheeler, 1985). Since professional nurses are 97% women and nursing is identified as a women's occupation, the oppression of women is linked with that of nurses (Roberts & Group, 1995). Susan Roberts (1983) published one of the first critical analyses of nurses as an oppressed group. In this model, dominant groups outside of nursing hold

greater prestige, power, and status. Dominant groups are able to establish their norms and values as not only predominant, but as the only "right" ones in society. When members of the subordinate group measure themselves to the dominant group's values, they find themselves lacking. Typical oppressed group response is self-hatred and disdain toward their own group. Roberts (1983) demonstrated how nursing has been controlled by the dominant medical profession and has exhibited typical oppressed group behavior.

#### Traditional reactions to powerlessness

Because members of oppressed groups begin to identify with the dominant group, they internalize their values in the belief that this will lead to greater power and control (Freire, 1990). Persons who are successful at adopting the norms of the dominant group are known as marginal. Many nursing leaders represent an elite and marginal group that have been promoted because of their allegiance to the status quo (Roberts, 1983). Because most nurse leaders and scholars can be identified as marginal, articles and research studies about power relationship have taken the dominant perspective and concerned themselves with how nurses obtain and use power. The dominant discourse in nursing has been from the perspective of those with power. Research studies about power looked at nurses and others who were successful in obtaining, maintaining, or wielding power in the current system. Other studies looked at the powerlessness exhibited by nurses and attempted to explain their behavior.

Few studies, if any, have looked at working nurses who have attempted to alter the current power structures through acts of resistance. Whether it was by speaking up,

taking a stand, or passively or actively resisting, nurses have found ways, at times, to resist the power structure. By giving voice to nurses who have resisted, a different face of their approaches to power can be presented.

#### Type of study to be conducted

This study was a qualitative study using a narrative method and a feminist participatory approach. A qualitative, narrative approach uses the participants' stories to provide insight into the whole of an event, object, idea, or lived experience (Parse, 1996). The feminist approach views the research subjects as co-participants in the research (Fonow & Cook, 1991). Because of the feminist value of replacing previously hierarchical approaches to knowledge development with a nonhierarchical, partnership approach, a participatory method is essential. This participatory method involves a non-hierarchical approach to interviewing, and a sharing of the research process with the participants.

In developing this topic for study, I was also influenced by critical theory and postmodern perspectives. These perspectives bring multiple views on oppression, recognizing the influence of social status, culture, race, and economic position on power relations. Additionally, discourse is of central importance in these traditions. How language is used, whose voices are allowed to be heard, who defines what topics are important or will even be addressed - all influence power relations in politics, organizations, and everyday life. "Dictate the terms of the discourse and you are able to dictate the relations of power" (Lincoln, 1989, p. 178).

Women's talk, women's voices and, thus, women's narratives have been traditionally devalued. Because the participants in this study may have expressed views in opposition to the dominant views, encouraging them to relate their stories in their own voice is paramount. Speaking up, telling stories in their own words, interpreting their own experiences, gives the power and ability to create meaning to the participants. Meanings of truth and knowledge are important considerations in a feminist study. Narratives are meaning-making systems. Allowing the narrator to shape and make her own meaning is an important consideration in this feminist study.

#### Theoretical approach

Feminist research draws upon the philosophical tenets of feminism. Feminism is defined as a worldview that values women and confronts systemic injustices based on gender (Chinn & Wheeler, 1985). "Traditionally, knowledge, truth, and reality have been constructed as if men's experiences were normative, as if being human meant being male." (Personal Narrative Group, 1989, p.3). In the feminist view, women's experience can be a legitimate source of knowledge, subjective data are valid, informants are experts on their own lives, and knowledge is contextual and relational (Campbell & Bunting, 1991). Unlike other research approaches, feminist research is openly ideological and claims an emancipatory intent (Guba, 1990). Feminist researchers do not consider feminism to be a distinctive research method, but consider it a perspective. Just as there are multiple definitions of feminism, there are also multiple feminist perspectives on appropriate research methods (Reinharz, 1992). A central tenet in feminist research is "a valuing of women and a validation of women's

experiences, ideas, and needs" (Hall & Stevens, 1991, p.17). Feminist research needs to be guided by the assumptions and beliefs of feminism.

One of the foremost beliefs underlying feminist research is that past research methods, which have been objective and reductionist, are not adequate to understand or explain the lives of women (Reinharz, 1992). Instead, the values of subjectivity and personal experience are essential. Furthermore, the researcher and her experiences are central to the study. The feminist perspective has at its core the belief that there is no one truth or one authority. Women's voices and women's narratives or stories bring forth some of the multiple truths of women's lives (Personal Narratives Group, 1989). Retelling and interpreting these stories can help to increase understanding of how women and, in this study, nurses, experience the world.

Women's personal narratives are considered essential primary documents for feminist research (Personal Narratives Group, 1989). Narratives present and interpret women's life experiences. The Personal Narratives Group (1989) highlights three areas for which the personal narrative approach is especially suitable: "the construction of a gendered self-identity, the relationship between the individual and society in the creation and perpetuation of gender norms, and the dynamics of power relations between women and men" (p. 5). Because this study will look at the power relations in a highly gendered profession embedded in a patriarchal male-dominated health care system, this is a particularly suitable approach.

### Purpose

The purpose of this study was to relate and interpret female staff nurses' stories of their experiences in acts of resistance. For the purpose of this study, an "act of resistance" was defined as speaking out or taking action about an injustice, oppression, or unequal power relationship within the nurse's work setting. The action could be overt or covert, and may or may not have been taken consciously (or for overtly political reasons). Since this was a feminist research project, the intent was to give voice to a group that may not normally be heard. By conducting this emancipatory inquiry, I sought to understand how nurses respond to oppression through their acts of resistance. Through understanding and consciousness raising, the ultimate goal is social change and transformation.

### Research questions

I asked nurses to tell their stories of experiences when they created an act of resistance, as defined above. Because the term "act of resistance" is not a common one to nurses and may be threatening or uncomfortable, I explored alternative terms to arrive at this meaning with other nurses. Some of the words that help them to recognize the concept include "being a troublemaker," "speaking up about an unjust situation," "attempting to right a wrong," and "challenging authority." I also found that giving a real life example was a good tool to help nurses relate to the question. I incorporated these terms and examples into the attached interview guide (Appendix A).



### Assumptions

Assumptions underlying this study are first that healthcare institutions are hierarchical systems, with dominant and subordinate power relationships within them based on gender and class. Nurses constitute a subordinate group, with physicians and administrators being dominant. As members of a subordinate group, nurses' stories may not have been recounted or documented. Consistent with feminism, critical theory and post-modernism, knowledge is believed to be socially constructed and contextual. An additional assumption is that nurses will be capable of reflection on their acts of resistance and be able to relate their narratives on the subject. There is also an assumption that women's stories are valuable, and that narrative is an acceptable research method that can add to the body of nursing knowledge.

### Significance

I believe that this is a new area of study. The majority of nursing studies in this area have used the lenses of the dominant group to look at power or powerlessness, usually by studying nurses who are considered successful in their organizations and in maintaining the status quo. It is time to change the lenses and to look at those nurses who spoke up, acted out, or otherwise attempted to resist oppression. The perspective of this study is that of nurses who may have been labeled trouble makers, nurses who challenged institutional policy or power structures (successful or not) and who created their individual or group acts of resistance. This study will help to gain insight into how and why members of oppressed groups find their voice and the courage to resist. This knowledge could help others in the profession to recognize the universal presence

of oppression in healthcare and the difficulty that individuals have had in resisting it. These acts of resistance may also highlight new ways to make lasting changes in the current system. Finally, studying acts of resistance might give new hope to nurses, as these stories unfold. We might learn more about ourselves, other nurses, and the way that we create the systems in which we live and work.

## CHAPTER II

### Review of Literature

The review of literature for a qualitative study serves to situate the study in its historical, philosophical, and theoretical context (Strauss & Corbin, 1990) . Over the past eight years of doctoral study, I have combined course content, literature from many fields, and my daily experiences as a nurse manager in a large healthcare setting to inductively develop this area of study. The literature review in this chapter includes some of the scholarly information that has contributed to my thinking in the development of resistance as an area of study.

The review consists of two major sections. In the first section, I look at definitions of resistance and the theoretical and philosophical development of oppression and resistance, including perspectives from feminism, critical theory, and postmodernism. In the second section, I relate oppression and resistance to nursing. I first review the historical development of nurses as an oppressed group, then look at some of the consequences of oppression, ending with a look at research in nursing in relevant areas.

## Power, oppression, resistance

### Definitions

The concept of resistance as used in this study is entwined with understandings of power and oppression. Foucault (1978) stated that where there is power, there is resistance. The dictionary definition provides guidelines as to where a given word fits into other words, and serves as a starting point to understanding. The dictionary definition of resistance is:

- "1. The act or an instance of resistance, passive or active opposition;
2. Power or the capacity to resist;
3. An opposing force;
4. Organizational underground" (Webster's Third International Dictionary,

1986). However, dictionaries are canonical texts to be deconstructed. The dictionary definition tells little about how the word is used or understood and could never be an adequate guide for its use in everyday life (Allen, 1986). Because the ability to create meaning is so powerful, definitions themselves are an exercise in power, struggle, and resistance (Allen, 1986). To deconstruct the definition and identify the underlying ideology, we need to specify the purpose or perspective behind a definition.

The purpose of attempting to define resistance is to reflect upon common meanings of the word, clarify how the term is to be used for the study, and direct the literature review. Common understandings of resistance involve an opposition to some sort of force or invasion. They can be found in a variety of contexts, from politics to medicine to management studies to physics, in resistance movements, resistance to

disease, resistance to a force and resistance to change. For the purpose of this study, I was interested in the meanings of resistance as a response to oppression and domination. Domination and oppression have elements of unfair and inequitable distribution of power that engender resistance. Resistance in this meaning has been discussed and conceptualized in a variety of ways in the political, critical, feminist, and postmodern literature. It has been seen as always present (Foucault, 1978), as power itself (hooks, 1984), in small informal ways (Collins, 1990), as well as in organized resistance movements. Within systems of domination and oppression, the dominant groups maintain their position by convincing themselves and their subordinates that these systems are the natural order of things (Freire, 1990). Because of this, the subordinates may believe that nothing that they do will change the power relationships. Yet, despite the pervasive persuasion of the oppressors, the oppressed or subordinate groups find ways to resist. It seems that the very exercise of domination creates resistance among the subordinates. In the following section, I will review the philosophical bases of this study, including the paradigmatic approach to knowledge development, review of oppressed group theory, and multidisciplinary perspectives on resistance.

#### Philosophical approach to knowledge development

Feminism, critical theory, and postmodernism are the three traditions that provide the philosophical perspective for this study. All three challenge the modernist idea prevalent in the natural sciences and nursing of a single fixed view of reality and the importance of the search for objective, value-free empirical data (Reed, 1995).

Feminism and critical theory have been labeled "emancipatory inquiry" by some authors because of their dedication to the emancipation of human beings from oppression and domination (Henderson, D., 1995). Feminists and critical theorists share the perspective that the dominant models of science have been connected with racist, sexist, and class-based oppression. They propose to offer alternative ways of knowledge development that expose oppression and enlighten people. Both (the feminists and the critical theorists) have critiqued ideology (the acceptance of certain beliefs as factual), and have emphasized critique and reflection as tools for creating change. While emancipation from oppression is not an overt goal of postmodernism, it has been cast as a movement toward ways of knowing that analyze and make evident relations of dominance and subordination (Dickson, 1994). Additionally, postmodernism has been placed in the family of approaches within the critical theoretical paradigm (Dickson, 1994). While these traditions have different philosophical origins, they share the goals of critique, reflection, and emancipation. Additionally, each of these has critiqued the role of power in society, theorized on the roots of oppression and made contributions to thought about resistance.

### Discourse

Because these traditions view knowledge as socially constructed, discourse is an important concept in all of them. Foucault saw discourse as an inclusionary/exclusionary system, whose rules determine not only what can be said but who can say it (Palmer, 1997, p. 90). Within these frameworks, language is believed to mediate social reality; therefore, all human experience can be interpreted and understood as text

(Hiraki, 1992). In this society and in healthcare in particular, the predominant discourse has been an empirical, scientific one. The “who can say it” has been mainly limited to white, European-descended males. This has meant that the alternative discourses of women and other marginalized groups have not been “heard.” The ability to speak up, participate in the dialog, to “have voice” is denied to these groups.

“Power is the ability to take one's place in whatever discourse is essential to action and the right to have one's part matter” (Heilbrun, 1988, p.18). Furthermore, when the stories or voices of those in power predominant, it reinforces their hold on dominance and impacts power relationships. By allowing one discourse to dominant, others become trivialized. For example, in organizational cultures, the language of power and autonomy are respected, while the language of caring and connectedness has been devalued (Lincoln, 1989). It is important to present the perspective of women and other marginalized groups in research and knowledge development.

### Habermas

“An understanding of Habermas' concept of discourse is integral to an understanding of the process by which knowledge is constituted with an emancipatory interest” (Street, 1992, p.93). Jurgen Habermas is one of the most prominent contemporary critical theorists, whose theory highlights the importance of communication in the construct of power relations. Habermas (1971) saw the goal of critical theory as releasing the individual from the constraints of domination by creating knowledge that furthers autonomy and responsibility. His views on communication and action are important in considering the role of resistance to oppression or domination.

Habermas focused on both the societal structure of domination and the problems of action to initiate change. Habermas conceptualized a just society in which ideal speech situations could exist. He attempted to develop a theory of society in which people could free themselves from domination (Held, 1980). His ideas about communication are the basis of his theory. Habermas viewed communicative action and strategic action as major analytic aspects of social change. Within his theory of communicative action were two concepts: communicative competence and ideal speech situations. Communicative action is oriented to the idea of a genuine consensus, a discursively achieved consensus that is rarely realized. He wrote that truth, freedom, and justice are possible only when individuals truly understand one another and achieve agreement. Any other communicative situation in which coercion is involved becomes a systematically distorted communication. The process of emancipation entails the transcendence of such systems of distorted communication. This process, in turn, requires engaging in critical reflection and criticism. It is only through reflection that domination in its many forms can be unmasked (Ingraham & Simon-Ingraham, 1992). Habermas' theory is particularly important in considering discourse within systems of domination and when contrasting the public and hidden transcripts of resistance, as described by Scott (1990). His connection of freedom and justice with communication highlights the significance of the study of stories from the subordinate groups' view.

#### Theories of domination and power relations

Two predominant views on power relations in society are prevalent, the pluralist and the non-pluralist (Scott, 1990). Pluralists view power as equally accessible



to all, and tend to ignore or discount factors such as inherent privileges of wealth and class. They believe that a pluralist democracy offers all groups the chance to advance themselves. Therefore, there is no need for social movements or radical politics (Couto, 1993). Non-pluralists recognize the existence of privilege and the ability of the powerful to suppress the powerless and stymie democratic process. If one views the topic of the study from the pluralists' view, acts of resistance may appear as petty acts of disobedience - committed by individuals who may not be content to work in existing political systems. However, if one views these acts from a paradigm that can embrace oppressed group theory, as multiple attempts to rebel against or maintain a sense of individual dignity in an oppressive system, a different view is forthcoming. It is my argument that there is a hierarchical system within healthcare that has created unequal power relationships and dominant/subordinate groups. These inequities adversely impact all members of the healthcare system who find themselves in the subordinate position, nurses most particularly. To understand nurses' acts of resistance, an understanding of oppressed group theory is necessary.

Oppressed group theory contributes an understanding of how one group can develop ingrained and unchallenged power to the detriment of others. Both feminism and critical theory have contributed to oppressed group theory. (Terminology used by Freire refers to oppressors and oppressed; Miller (1991b) refers to dominants and subordinates. I have used both terms in this paper.) Both Freire (1990) and Miller (1991b) describe the theoretical construction of a system of inequitable power relationships. Freire's theory was based on his observation of social classes in Brazil,

and Miller's was based in gender relationships. Additionally, Gaventa's (1980) study of Appalachian miners described graphically how such a system can develop.

### Systems of oppression

Paulo Freire, a Brazilian educator, developed political and social constructs of oppressed groups. Freire (1990) described a system of oppression as one in which one group has the power and privilege and exerts it over other groups. The dominant group, the oppressors, control the oppressed in myriad ways. They may restrict their access to education and to certain occupations. They may characterize the subordinates falsely stereotyping them as lazy, dirty, or somehow less worthy than themselves. Furthermore, oppressors maintain the power structure by dividing the oppressed group members and encouraging them to work against one another (Freire, 1990). The oppressors may even deny full and free expression to subordinates. Most damaging, the oppressors are able to impose their values and norms on the oppressed. Internalizing the values and norms of the dominant group leads the oppressed to disparage and sometimes even reject their own characteristics and values. This makes it easier for the oppressors to further subjugate the subordinates. Finally, the oppressors describe the created oppressive system as the only natural and normal way for things to be, and characterize it as ordered or ordained by higher and better powers, such as natural law or God (Freire, 1990).

As the oppressed internalize these beliefs, they come to view the oppressors themselves as powerful, right, and good. Because the group attributes of the oppressed are not valued, many in the oppressed group strive to be more like the oppressors. As a

result, leaders of the oppressed group may attempt to adopt the behaviors and characteristics of the oppressors, thus helping to maintain the status quo. Members of oppressed groups who have some success at assimilation are called marginal. Marginal individuals find themselves on the fringes of the two groups, no longer a true member of their own group, but unable to be a full member of the dominant group (Roberts, 1983).

Because some members of oppressed groups adopt behaviors that enable and support the system, the oppressive system is very difficult to change. The patterns of behavior exhibited by both the oppressors and the oppressed become so ingrained that *neither sees the underlying oppressive ideology*. Instead, they view the system as the only natural way for things to be. The humanity of both the oppressor and the oppressed are impacted in this system. Neither can be truly free, as long as the inequity exists (Freire, 1990). However, change or reform cannot come from the oppressors nor from the marginalized leaders of the oppressed. Freire (1980) believed that only the oppressed can really change the oppressive system. The oppressed must be conscientized to understand the nature of the oppression and to see themselves as fully human and capable. In Freire's opinion, education was the key to conscientization of the oppressed, and eventually, to revolutionary change. Freire did not use the word resistance in his writings, but he clearly supported unified and revolutionary action by the oppressed as a way to seek change.

### Gender-based views of oppression

Feminist authors, including Miller (1991b) and Lerner (1986) have contributed to the literature on and understanding of oppressed groups, as related to gender. Miller (1991b) described Western society as a largely patriarchal society, organized in terms of the experience of men. Because of the predominance of the male experience, power relations between men and women are described in a construct similar to Freire's description of oppressed groups. Males have been described as the dominant group and have acted destructively to females, the subordinate groups, restricting their range of actions and choices. The dominant group may characterize subordinates falsely, by labeling them as possessing undesirable or unpopular characteristics. They may also discourage or prevent subordinates from expressing full and free range of expression of their experience (Miller, 1991b). As in oppressed group theory, the relationships between males and females, as dominants and subordinates, are characterized as the normal situation - the right or natural way for things to be.

Women's subordination is believed by feminists to be deeply ingrained in society due to the influence of patriarchy. Patriarchy is an identifiable sexual hierarchy that permeates everything (Rich, 1986). A number of authors have reviewed the historical basis of the development of patriarchy, with its views of women as inferior and men and men's values as superior (Eisler, 1987; Lerner, 1986; French, 1985). The ascendancy of patriarchy in Western society contributed to an underlying way of thought that values power and domination, labeled an androcratic or dominator paradigm. Eisler (1987) used prehistoric evidence to support her view that an earlier

partnership society, based on what we now call feminine characteristics, existed before the current aggressive, violent domination-oriented culture. The destructive nature of this underlying hierarchical system impacts everyone in society, dominants and subordinates alike, by limiting full and free range of expression and action.

Lerner (1986) found women's subordination to differ from other forms of oppression due to women collaborating with their own subordination. She saw multiple means by which patriarchy is maintained; because of women's cooperation. Women have been psychologically shaped to internalize their own inferiority. Some of the ways in which patriarchy depends on the cooperation of women includes indoctrinating women to specific roles or expectations based on their gender, dividing women by describing respectability and deviance according to their sexual activities, discrimination in access to resources and political power, and awarding privileges to conforming women (Lerner, 1986). Lerner contended that these factors make it extremely difficult for women to effectively resist the existing power structure. Since most nurses are women, they have been impacted by the experience of gender in this culture. Additionally, they have been educated and socialized to a healthcare system that views hierarchical relationships between physicians and nurses as natural and expected. Therefore nurses, largely female, have internalized these gender-based beliefs. Much of the existing power structure in healthcare also depends on the continued collaboration and collusion of nurses, as will be evident in the review of nursing's development

### Development of systemic oppression

Gaventa's (1980) study of power and powerlessness in an Appalachian community, developed a theoretical explanation of acquiescent behavior of subordinate groups. He was able to illustrate how an oppressive system develops, and how the very thinking of the oppressed or subordinate group is changed. The theoretical basis of his study was Lukes' (1974) three-dimensional description of power.

In Lukes' (1974) dimension one view, power is described as the conflict between two opposing views or interests. The conflict is presumed to be won by the party with more financial support, intellectual ability, motivation, experience, political prowess, or expertise (Dykema, 1985). The underlying assumption is that power can be accessed equally by all, and that those individuals or groups that do not access power are lacking in some way, being lazy, unintelligent, or unmotivated. This view, a common one in Western democracies, assumes the fundamental pluralist notion that all individuals, groups, or organizations have equal opportunities to express dissent and affect decisions (Dykema, 1985). Furthermore, it discounts the idea that some groups are privileged just by their social position, skin color, religion, birthplace, or other factors.

Gaventa (1980) demonstrated how the mining company in Appalachia was able to gain control of resources, wealth, and power in the region, reducing the formerly independent farmers and workers of the region to a dependent and oppressed group. The mining company prevented dissent by appealing to some of the deeply held beliefs and biases of the population, characterizing protesters as communists and outsiders.

The second dimension describes how the dominant group uses values, beliefs, rituals, and procedures to maintain their privileges to the detriment of another (Lukes, 1974). At this level, the powerless elect not to challenge the elite because they anticipate sanctions if they fail. The powerful are able to use the deep-seated fears and beliefs of the oppressed as weapons against them, effectively stifling resistance.

In the final phase of the development of the oppressed system in the Appalachian mining communities, Gaventa (1980) found that, even after the direct threats from the mining companies were removed, the miners remained apolitical and quiescent in the face of injustice and extreme poverty. The miners had come to believe in their own inferiority and in the futility of hoping for change. This third dimension view provides an explanation for such behavior of oppressed groups. It illustrates how dominants prevent the subordinates from becoming politically involved or even voicing their dissent. In the third dimension view, the very consciousness of the oppressed group is changed. The powerful act on the very minds and attitudes of the powerless, "influencing how they view themselves, the situation, and the strategies chosen to deal with the issues" (Dykema, 1985, p. 445). As a result, the powerless see no hope or value in participating or dissenting, and essentially remain overtly passive and quiescent, even in the face of profound injustices.

Gaventa's study (1980) demonstrated how power relationships between dominant and subordinate groups develop and are sustained. However, it raised more questions about how resistance to oppression is able to develop and be sustained. Even within this overwhelmingly oppressive and unfair system in Appalachia, there were

individuals and groups who continued to resist and seek reform. The third dimensional view explains the difficulties faced by a powerless group attempting to unite and seek long-term changes, but it does not help to understand how and why some oppressed group members are able to resist and ultimately enact change.

A review of the theories of dominant and subordinate groups provided an understanding of how systems of domination develop. Additionally, it became evident that overt resistance in these systems is difficult. However, turning to the theory on resistance, we will see that resistance is always present, as domination itself will engender resistance. Furthermore, we will find evidence that resistance may not always be open or overt, but that it is found in unusual places and hidden within the traditions and private conversations of the powerless. Finally, a review of nursing history and literature will clearly demonstrate how nurses have all the characteristics of a subordinate group within a healthcare system that is dominated by male physicians and administrators. This, in turn, gives us clues as to why many actions of nurses have not been successful in effecting significant change.

### Resistance

Resistance has emerged as a topic of interest in several different disciplines, including feminism, postmodernism, politics, and education. The literature in this area ranges from the highly philosophical writings of Foucault (1978) to the specific research of Couto (1993) about the hidden narratives of African-American leaders. I will provide an overview of the literature from each area, and will conclude with a discussion of the relevance to this study.



### Political resistance

How subordinate or marginalized groups resist in political and social organizations has been of interest to a number of political writers. For the purpose of this study, the themes of violent revolution and massive social upheavals are not pertinent and were not explored. However, several types of resistance in the political world have been identified that contribute to this study's area of interest. These include organized political resistance, such as civil disobedience, and less organized types, such as popular or everyday resistance and rightful resistance.

### Civil disobedience

The concept of civil disobedience or nonviolent resistance has been shown to be an effective way of bringing about widespread societal change. While there may be a variety of religious and philosophical roots to this tradition, Thoreau's classic essay on "Civil Disobedience" published in 1849 is credited as the birth of the idea (Herngren, 1993). Thoreau contributed the underlying idea that acting from principle, on the belief of what is right, is above the law. He believed that a country's government is powerless without the cooperation of its citizens. Civil disobedience is defined as a public action, based on nonviolence, that is illegal or defies a command or decision, and that the intent is to preserve or change a phenomenon in society (Herngren, 1993). Civil disobedience is always a political act, with its intent exceeding the personal interests of the participants. Herngren (1993), in his book, Path of Resistance: The Practice of Civil Disobedience, made it clear that he views civil disobedience as a moral imperative. He saw resistance both as a political struggle against injustice in

society and as a struggle — within each person — against violence. Furthermore, he also saw violence and passivity as two sides of the same coin: when we are passive, we actively participate in oppression.

The concept of civil disobedience was prominent in a number of struggles, from India's fight for independence from England, to the U.S. civil rights movement of the 1960s. Gandhi's views of civil disobedience were linked to the concept of satyagraha, which has been translated to mean "truth force" (Sonnleitner, 1985). For Gandhi, satyagraha had three levels of understanding: secular, religious, and mystical. His approach to social change cannot be separated from his religious and mystical beliefs. Martin Luther King Jr. also based much of his approach to change during the civil rights movement on his religious beliefs, incorporating Gandhian nonviolence into the cause of the American Negro (Branch, 1988).

#### Hidden and everyday resistance

Civil disobedience is usually linked to large-scale political resistance that uses a group's dedication to common goals and a willingness to place itself at risk to engender change. In contrast, everyday or covert resistance is less organized and more individual. Scott (1990) developed a series of books on the concept of covert or everyday resistance. Most of his work involved studying the ways in which peasants throughout the world have resisted repressive regimes. He concluded that, while much weight has been given the study of organized, political resistance, covert or everyday resistance is not only more prevalent, but may be more effective in the long run. Petty

acts of resistance can effectively force change because they narrow the policy options available to the state (Scott, 1990).

More recently, Scott (1990) has expanded his theory to incorporate all subordinate or powerless groups. In his most recent work, Domination and the Arts of Resistance: Hidden Transcripts, Scott (1990) contrasted the public and private, or hidden, discourses about power relations. Public transcripts, as he calls them, tell us little of the opinion of the subordinates. His thesis is that every subordinate group creates, out of its own ordeal, a "hidden transcript" that represents a critique of power behind the back or out of the hearing of the dominants. He identified four varieties of political discourse among subordinate groups. The first, a form of public transcript, is the subordinates' flattering characterization of the elites. This is the talk that subordinates allow to be heard in public. The second variety is the hidden transcripts. These are the conversations between the subordinates themselves, when they don't believe anyone from the dominant group is listening. During this discourse, the subordinates can allow their true feelings of rage, anger, desire for revenge, and fear to be expressed. The third variety of political discourse is described as the politics of disguise and anonymity. Within this category are varieties of modes of communication that allow subordinates' feelings to be expressed in ways that keep individual identities hidden (and prevent negative sanctions). Examples include rumor, gossip, jokes, euphemisms, codes, gestures, folktales, and even songs. Scott's fourth variety of political discourse is what he called the "rupture of the cordon sanitaire" (1990, p. 19) between the hidden and the public transcript. By this, he referred to the subordinates

making the hidden transcript public. An example of this would be a peasant telling off the landowner and letting him know how the other peasants feel about him. Scott (1990) found that finally speaking the hidden feelings to the powerful had an almost cathartic and liberating effect on the powerless.

Gutmann (1993) critiqued Scott's ideas of covert resistance. While he found value in Scott's contributions to uncovering hidden popular resistance, he questioned Scott's beliefs on the effectiveness and importance of covert resistance. In his view, Scott's theory diminished the significance of overt forms of resistance in bringing change. Gutmann asserted that, in many parts of the world, revolutionary or transforming actions may still be necessary. Gutmann also cautioned that Scott's view supports resignation (of the oppressed or subordinates) to the status quo. Gutmann believed that everyday defiance may actually enhance the regime's authority and can sometimes serve to reinforce one's subordinate position. Finally, Gutmann believed that Scott's theory was essentially a conservative one in that it did nothing to explain change. Gutmann's critique is included here to demonstrate that Scott's views are not universally accepted in his field. However, Scott's theories seem to be gathering support.

Couto (1993) analyzed narratives from interviews conducted from 1978 to 1988 with more than 50 local civil rights leaders. The narratives analyzed were all from African Americans. He found that hidden narratives nurture political resistance amongst repressed and subordinated groups. These narratives help powerless or marginal people to retain a sense of their identity, offer an alternative explanation of

their oppressed status and provide historical precedents of individual and collective resistance. He also showed evidence that covert resistance may actually prepare people to participate in more overt forms of resistance (Couto, 1993).

Nonini (1988) described everyday or popular resistance in the United States as ways in which the workers or "common men" resist governmental or organizational power and policies. He suggested that a variety of actions, from not declaring some wages to the Internal Revenue Service, to worker absenteeism and employee theft, were actually covert forms of resistance. His underlying assumption was that people don't have to identify themselves as oppressed or to be ideologically opposed to the regimes that they are resisting, nor do they need to be attempting widespread reform. Instead, he saw these everyday resistances as natural acts of the "masses" against the state, which could possibly lead to policy changes. In Nonini's (1988) view, these acts should be considered more seriously as acts of resistance.

#### Rightful resistance

O'Brien (1996) introduced another type of resistance that appears common in many societies, rightful resistance. In his definition, rightful resistance is a form of popular contention that: "(1) operates near the boundary of an authorized channel, (2) employs the rhetoric and commitments of the powerful to curb political or economic power and (3) hinges on locating and exploiting divisions among the powerful" (O'Brien, 1996, p. 87). Rightful resistance asserts claims through approved channels, and is able to use the very values and words of those in power against them. O'Brien (1996) also stated that rightful resistance is "a product . . . of opportunities created by

the spread of participatory ideologies and patterns of rule rooted in notions of equality, rights, and rule of law"(p. 34). Because of its nature, this resistance is not effective in repressive regimes. In fact, it is in the more repressive regimes that Scott's (1990) "weapons of the weak," or covert resistances, are believed to be more prevalent (O'Brien, 1996). O'Brien believes that this is a form of resistance that will emerge whenever leaders make commitments they cannot keep. It works within existing structures and is believed to be more consequential than "everyday resistance," but less risky than overt defiance.

#### Summary of views on political resistance

The concept of resistance in the political world may have a decided overlap with the world of healthcare. Resistance does not necessarily depend on the recognition of oppression nor on unity as a political group. However, there is a divergence of opinion as to the effectiveness of some types of everyday resistance to bring about real transformation. Resistance may differ, depending on the characteristics of those in power, characteristics of the subordinates, and the types of organizational systems in which they interact. In addition, the subordinates' beliefs about the nature of the oppression may contribute to the type of resistance that surfaces. These differences may contribute to the study questions of how nurses resist and the effectiveness of their resistance.

#### Foucault and resistance

Michel Foucault, a French philosopher and postmodernist, developed a unique theory of power and resistance. His multifaceted view of power provides a useful

perspective for studying complex issues of power/resistance. Foucault (1978) theorized that power was diffuse, heterogeneous, and a productive phenomena. Foucault (1978) stressed that power is not a "thing," but that it exists only in its exercise. He described the systemic nature of power and its presence in multiple social relations. "Power is everywhere - it comes from everywhere" (Foucault, 1978, p.94

Foucault (1978) viewed resistance and power as connected. He characterized them as two sides of the same coin. "Where there is power - there is resistance" (Foucault, 1978, p. 95). Because of his idea of power as productive, he also conceptualized resistance as linked with power. The effort to bend another's will is always met with resistance. For Foucault, repression and resistance are not ontologically distinct. In fact, resistance is a form of power.

The strongest critique of Foucault is that, despite his sympathies to the subjugated, he wrote from the position of the dominator. Foucault (1978) contributed the idea of an ever-present resistance in relation to domination, but did not include a perspective of gender and class in society. "Perhaps because power relations are less visible to those who are in a position to dominant others, systemic unequal relations of power ultimately vanish from Foucault's account of power" (Hartsock, 1990, p. 165) . Foucault's examination of power relations tended to be one-sided. His perspective of power relations focused on how they are installed in institutions and not considered from the point of view of those subject to power. Foucault's early writings described a vision of power as a unidirectional, dominating force that individuals are unable to

resist. His thinking in his later works evolved, and he began to see individuals as capable of challenging and resisting structures in modern society (McNay, 1992).

### Resistance theories in education

Giroux (1983) has been interested in developing a critical theory of education. He wrote that resistance theories within education provided another way of looking at domination and oppression, providing a broader frame of analysis incorporating ways that the oppressed/powerless react to dominance (Giroux, 1983). The major contribution of Giroux's work is that it provides optimism to the position of the oppressed and hope for real change. He explained how current resistance theories give an alternative to viewing the oppressed as passive in the face of domination. Resistance theories deepen our notions of relative autonomy, "pointing to non-reproducible moments that constitute and support the critical notion of human agency" (Giroux, 1983, p.102). Giroux (1983) reviewed the range of oppositional behavior, finding both small and large acts of resistance. He also found that not all oppositional behavior is rooted in a reaction to authority and domination, but rather, might simply be a reaction to powerlessness that imitates the acts of the powerful. In other words, rather than being an emancipatory reaction, resistance could be another form of domination aimed at a peer or someone less powerful. Giroux (1983) critiqued current resistance theories noting that the concept has been treated superficially, and that resistance studies have largely ignored women and gender. His work provided alternative ways to view resistance and pointed to the need to further explore the concept.



### Feminism and resistance

Feminism has been defined as a world view that values women and that confronts systematic injustices based on gender (Chinn & Wheeler, 1985). Feminists recognize women's oppression, value women and their contributions, and desire to end oppression based on gender. A central goal of feminism is the development of a nonhierarchical, nonoppressive society (Sampelle, 1990). Feminism developed out of a need for women to challenge the dominant societal power structure. Because of this, feminism itself is a resistance.

Critique and reflection are major tools of feminist resistance. Feminists have used these tools to examine predominant views of power. They have attempted to expose underlying societal values that have led to the development of the power-over dynamic or dominance as the primary view of power in our society (Eisler, 1987; French, 1985). While feminists may disagree on some concepts, most agree that the basis of this dynamic and common definitions of power originate in the establishment of patriarchy. Feminist views of patriarchy and power are important to this study because they demonstrate the prevalence of these concepts in the gendered culture of healthcare as experienced by nurses.

Despite overriding cultural pressures on women to conform and not to resist, feminists have used and advocated a variety of approaches to resistance. Female knowledge exists in resistance to male knowledge and power, although historically there has been an inequality of these forces. Feminist writings, feminist theorizing, and feminist knowledge development are all forms of resistance, as they expose existing

power inequities and develop alternative ways of knowing that challenge the dominant views. The presence of resistance, along with the productive operations of knowledge, represents the possibility for change (Doering, 1992, p. 26). Feminist writers and theorists, while not all explicitly using the word resistance, have proposed a number of ways to resist. Some have suggested that if women truly took control of their own bodies, it would be a most effective resistance (Rich, 1986). Others have used women's support groups, political organizations, and artistic and literary contributions as forms of resistance.

Tisdell (1993) emphasized that all people are capable of producing meaning in their lives and resisting the forces of oppression. Such resistance may take various forms, depending upon a number of factors, including race, class, gender, age, sexual orientation, and ethnicity. However, she also identified that the resistance itself "may sometimes propagate other forms of oppression or domination for themselves or other people" (Tisdell, 1993, p. 96). Examples of this could include retaliation by the more powerful group against the oppressed because one activist resists or speaks out.

Black feminists have written of the many ways that black women have resisted oppression and have added the voices of the margin to the feminist dialogue. Hooks (1984) asserted that black women, who lived daily in oppressive situations, developed multiple strategies for resistance. "Behind the notion of conformity imposed on African American women, acts of resistance, both organized and anonymous have been exercised" (Collins, 1990, p. 91). Collins (1990) identified some of the ways that African American women have resisted. These included self-definition, singing the

blues, writing, and developing supportive relationships with other African American women. Viewing resistance as multifaceted opens new ways of looking at the concept.

For some women, anger may serve as a valuable precursor for resistance. Hooks (1984) wrote that it was her anger that led her to maintain a positive view of self and to resist oppression. Being in a subordinate position, with no ability to change the situation, constantly generates anger (Miller, 1991a). Yet, anger is the one emotion that no dominant group ever wants to allow in subordinates (Miller, 1991a). The suppression of anger is reinforced in a number of ways. The dominant group uses the threat of societal and economic deprivation. Another method is to make the subordinates feel that they have no cause for anger, and if they feel anything like it, there is something *wrong with them* (Miller, 1991a). Scott (1990) demonstrated that the anger of subordinates is not found in the open, but in their "hidden transcripts."

In addition to being denied anger, women have also been blamed for collaboration with dominant groups and for accommodation to oppressive conditions. However, Aptheker (1989) noted that men have reserved for themselves the right to define what counts as significant resistance and what counts as collaboration or accommodation. In their definitions, the kinds of public and political activities that count or matter as resistance are the same ones from which women have, until recently, been excluded. Many feminists have tended toward the same assessments of women's history of resistance. They have failed to appreciate any kind of women's resistance that is not "feminist," "socialist," "radical," or "liberal" but that is nevertheless central to the making of history and a source of social change.

## Conclusions

Reviewing the varied literature on resistance and attempting to make some conceptual sense of it, I was struck by a two thoughts. First, resistance, like power, does seem to be everywhere. I find it interesting that the concept has been virtually ignored in many fields of study, including nursing. Could that be because it doesn't fit in with our popular notions of a pluralist democracy? Or, because the idea of, or need for, resistance is not part of the predominant discourses in most fields? That leads to my second thought. Hidden or covert resistance may be less well known than civil disobedience and emancipatory political movements; however, it remains a powerful tool of the powerless. Consequently, these hidden resistances can give hope (Giroux, 1983), provide meaning (Tisdell, 1993), and help the subordinates prepare to overtly contest power relationships (Couto, 1993). This literature review has provided a more expansive view of the concept of resistance that will help in the development of the study interview and provide a framework for future analysis.

### A critical perspective of nursing's historical development

I found little discussion of resistance as a concept within nursing literature, despite a broad search of library and electronic databases, review of research journals, and my familiarity with work in critical and feminist theory. This deficiency may be because the identification of nurses as an oppressed group needing to resist the dominant group is a relatively new and marginal perspective. Also, it may be because nursing's history has been one of divisiveness within its ranks, coupled with the necessity of collaborating with physicians and health administrators. Nursing has not

identified the dominant forces that have impacted its development and its discourse. Predominant discourse within nursing has been that of the dominant or more powerful groups. While few have made open the hidden discourses of nurses, the voices of resistance can be made evident with a critical review of nursing history.

Little can be found in nursing literature about overt resistance, and resistance does not seem to be a commonly used term among nurses. When I have brought up the term among nurses, there has usually been a look of puzzlement and a need for an explanation. One reflective nurse thought about it overnight and presented me with two written pages about the multiple ways that nurses resist, from dispensing dressings to indigent patients to appearing to acquiesce to their nurse managers when they had no intention of doing so. From her observations and my own, I believe that resistance is prevalent in nursing, but for a variety of reasons, it has not been identified as such.

The roots of nursing's issues with power and oppression can be seen in its historical development as an occupation, in the United States and other Western nations. The place of nursing in health care is historically related to the issues of class and gender in the broader society. Street (1992) notes that these class-based relations of domination are power relations, distinct from authority relations, which also enact domination and subordination, but are not based on class. "Interrelating with and pervading class relations in the social construction of healthcare are gender relations" (Street, 1992, p. 26). The profession of nursing has been historically and traditionally gender-linked since its inception. According to Oakley (1986), "nursing needs to be

looked at within two forms of the division of labour: the division of labour in healthcare and the division of labour between the sexes."

Nursing's prominent myths and stories about its development disregard issues of oppression, classism, racism, and sexism. The traditional view of nursing history is that Florence Nightingale virtually single-handedly created the profession of nursing (Oakley, 1986). However, the alternative view holds that, while she did remove some of the cruder household tasks from nursing and endowed it with more respectability, her emphasis on obedience and subservience led to the development of nursing as a subordinate part of the technical division of labor surrounding medicine (Street, 1992). In fact, some believe that nursing was more independent before the onset of Nightingale's reforms, and has struggled ever since with the legacy of medical dominance (Ashley, 1976).

Nightingale also brought the roots of classism and sexism to nursing. Nightingale was a daughter of the upper class, and worked to attract a higher class of women to her newfound profession. She helped to forge the strong link between womanhood and nursing, linking good nursing with mothering and being a good woman (Oakley, 1986). The parallel to the household role of the father and mother to the hospital roles of doctor and nurse is often made.

The class divisions within nursing in the United States have had long term consequences for the profession. Ideology and social position splintered nursing from the time of its earliest efforts at professionalization (Reverby, 1987). In the early part of this century, hospitals were dependent on the labor of student nurses to provide the

majority of the patient care. As a result, nearly every hospital, no matter how small or specialized, had a school of nursing. Nursing education was unregulated, unaccredited, and there were no educational standards or state registration in existence. The education and class (status) of students entering these hospital schools also varied greatly. The larger urban and more prestigious schools attracted the daughters of the middle and upper middle classes. A higher proportion of the young women entering these schools had completed high school, and some had college degrees. On the other hand, the smaller, less prestigious schools attracted young women from the lower and lower middle classes, more frequently from rural areas, more often of immigrant or "ethnic" background (Reverby, 1987). As a result, there was division in viewpoints in nursing between the need for professionalization, which included upgrading of nursing education, raising of admission standards, and charging tuition for nurses training and those who favored the status quo. The superintendents and alumni of the large, urban schools of nursing lined up on one side, and the pupils and graduates of the numerous other schools on the other. This frequently was stated as a philosophical difference between the nurses who wanted to advance nursing's status, and those who were just seeking a way to make a living for themselves or their families. At the turn of the century, these differing views could also be seen as class and ethnic differences, with the higher class, native-born nurses on one side and the lower class, immigrant nurses on the other. "The sex-segregated labor market crowded working and middle class women into the same field, yet tracked them into differing occupational visions and opportunities" (Reverby, 1987, p. 207). Melosh (1982) saw resistance to

professionalism as one of the ways that rank and file nurses responded to the rift with their leaders. I contend that this rift can be seen in nursing today, although the class issue and ethnicity may have changed somewhat.

Resistance within nursing has largely been within itself; nursing has not been a unified force and has contributed to its own oppression. From the early years of occupational development, nurses in leadership positions have rarely questioned whether their perspectives are true to the experiences of nurses as a collective group. The rank and file nurses have often seen nurse leaders and administrators as their oppressors. Still others view any type of resistance as altering the status quo, and as rejecting any progress toward professionalism that we have gained thus far (tokenism).

### Research in nursing

#### Power research

There have not been any research studies in nursing, to my knowledge, that looked at the concept of resistance. Since power is related to resistance, the literature on power was reviewed. The majority of the nursing studies about power have been grounded in the tradition of empiricism, with a pluralist view of power. These studies, in general, found that nurses who were higher in the hierarchy had a more positive view of power and a less negative feeling of powerlessness than staff nurses. Heineken (1985) looked at power orientations of nurse managers; Farley (1987) used the power orientation tool to look at differences between staff nurse and managers power orientations; Reimer, Morrissey, Mulcahy and Bernat (1994) compared power orientations of nurse and non-nurse managers; McMahon (1989) found a correlation



between primary nursing, collegial relationship, and more positive power relationships. Prescott and Dennis (1985) found differences between staff nurses and administrators' opinions of staff nurses' ability to influence policy. Sands and Ismeurt (1986) found that hospital staff nurses felt more powerless than nurses in supervisory or education positions. None of the researchers recognized the systemic effect of oppression, nor did they ask about or find evidence of resistance among staff nurses.

If power is conceived as a characteristic or trait of an individual or group, lack of power would be attributed to ignorance or inadequate socialization to its use. For this reason, a number of power studies in nursing have been concerned with nurses' orientation to power (Heineken & Wozniak, 1988; Farley, 1987; Reimer, Morrissey, Mulcahy & Bernat, 1994). Additionally, this view presumes that individuals can be taught how to gain and wield power. For example, in an article outlining how they teach power concepts to nursing students, Heineken and McCloskey (1985, p.40) wrote that power "begins and is actualized through the strength and performance of each nurse." The idea of power as a trait or characteristic disregards the implications of ingrained systematic power and minimizes the importance of resistance.

#### Critical and feminist methods

Recently, investigators using critical or feminist methods to explore nursing issues have uncovered hidden power relations that may be relevant to this study. Attridge and Callahan (1989) sought to explore nurses' experience of power and powerlessness and the relationship, if any, between power, the performance of nursing work, and the degree of work satisfaction. They used a qualitative, critical incident

technique. Their findings showed that nurses felt powerless when giving care to patients, frustrated at not having control over their practice, and in conflict with physicians and administrators. As is consistent with members of an oppressed group, the nurses thought that being powerful would be to have respect and recognition from a more powerful colleague, especially a physician. The nurses in their study did not seek power for themselves, but to improve care and outcomes for their patients. Attridge and Callahan (1989) suggested strategies for gaining power, including consciousness raising, coalition building, and transformation. They acknowledged that the more dominant group is likely to counteract any of these strategies with ones meant to ridicule and divide the oppressed. One of their strategies for consciousness raising included instilling pride in nursing work by telling stories of nurse heroines, and rewriting nursing history from the nursing point of view. Attridge and Callahan (1989) didn't identify outright resistance as a strategy, but were optimistic that their methods could trigger lasting changes.

Street's (1992) critical ethnography of clinical nursing practice helped me to generate the idea for this study and provided a starting point for this literature review. Street, a sociologist, conducted a large-scale feminist participatory research study of medical knowledge and nursing culture in a large general hospital in Melbourne, Australia. For the study, she collaborated with four clinical nurses in an in-depth, long-term engagement in case studies of their clinical nursing practice. The study lasted for over six months. Street spent much of this time as a participant-observer, following the nurses around as they gave care. After the first phase of observation, she conducted

multiple interviews with the nurses based on her transcripts. The participating nurses had access to the research data and could comment on it and make corrections. In this study, Street found multiple instances of nurses participating in acts of resistance and contestation to the existing hierarchy. Nurses were most likely to resist in clinical instances where the nurses believed that the best interests of individual patients were being overlooked, particularly when the ethics of the nurse conflicted with the medical or administrative decisions. Street also found that nurses frequently engaged in passive resistance, such as avoiding things that they saw as unnecessary. For example, the nurses found that much of the documentation for care planning was too time consuming, and preferred to communicate information about their patients verbally. While they did not overtly protest the emphasis on the care plans, they just avoided completing them, despite threats or pleading by their managers. Street's research revealed many important things about the world of nursing work beyond nurses' resistance that cannot be covered in this review.

#### Related studies

Several concepts have emerged within nursing that have been counter to what Scott (1990) had labeled the public transcript. The ideas of nurse abuse and nurse anger run counter to dominant discourse about both healthcare and our idea of a just society. Additionally, studies of nurse abuse and nurse anger have made more visible some of the consequences of the oppressed status of nurses. Nurse abuse is one of the hidden transcripts of nursing that clearly demonstrates the maintenance of power relations within healthcare. Diaz and McMillin (1991) surveyed 500 female nurses (164 actually

completed the survey) in one California county. They found that 64% of nurses in their sample experienced some form of verbal abuse from a physician at least once every two or three months; and 23% had at least one experience of being physically threatened in some way by a physician. They concluded that verbal abuse of nurses by physicians is common. Cox (1991) surveyed readers of Nursing Management to look beyond sociological research on sexism, harassment, slander, and relations between nurses and physicians to oppressed group behavior. She attempted to identify frequency, sources, and nature of impact and possible solutions for verbal abuse. The questionnaire was printed in a 1988 issue of Nursing Management, and 1,168 usable ones were used for data analysis. Cox (1991) found several correlates of oppressed group behavior in her findings. She found that both personal factors, such as self-esteem, competence assertiveness, and initiative, and organizational factors, such as administrative valuing of nursing, management style, control, and autonomy of practice contributed to whether or not nurses resigned due to verbal abuse.

It has been demonstrated that being in a subordinate position creates feelings of anger, but it is one emotion that subordinates are not supposed to openly express (Miller, 1991a). Several recent articles about nurses and anger (Brown, 1996; Smith, Droppleman & Thomas, 1996; Thomas & Droppleman, 1997) demonstrated that nurses are expressing anger at their situation, but frequently are doing it in non-productive ways. Brown (1996) found that 91 % of the nurses in her study did not express anger toward the person who had triggered the injustice. The nurses in her study expressed feelings of powerlessness, that they were not being heard or understood. Smith, et. al.

(1996) used a phenomenological approach to describe work-related experiences of anger among female registered nurses. Their findings showed that nurses saw themselves as "under assault" in a hostile environment. Furthermore, the anger was directed at doctors, peers, patients, and selves. In a subsequent article, Thomas and Droppleman (1997) concluded that nurses must reframe their anger to use it constructively for change, rather than as a weapon against assault.

### Critique and reflection as resistance

If resistance is defined as opposition to domination, another area of nursing literature is applicable to this study. A number of nurses, following the traditions of critical theory, feminism, and post-modernism, have critiqued a variety of sources of domination in nursing. (Some of these can be found in the proceedings from the Critical and Feminist Theory Conferences, 1990-1997).

JoAnne Ashley contributed a number of works and a powerful (if divergent) voice in speaking to the power inequities in nursing. In her articles and her book, she attempted to show nursing's very history as a power struggle. Ashley (1973, 1976) also demonstrated that because of both their history and education, nurses have accepted their unequal status without critical appraisal or public attempts to change it. While not specifically linking nurses' behavior to oppressed group syndrome, Ashley recognized how few nurses over the years have worked to confront or examine the existing power inequities in healthcare. Instead, nurses have used power or influence to "maintain the very system that has oppressed them" (Ashley, 1973, p. 638). And, similar to nursing literature and rhetoric today, she criticized other nurses and nursing literature for

urging nurses to focus on collaborating with physicians and to be cooperative team members, rather than proposing ways to really change the system (Ashley, 1973).

Many other writers in the 1980s brought critical and feminist voices to the nursing literature. Roberts (1983) contributed the description of nurses as an oppressed group to the nursing literature. Chinn (1985) critiqued nursing's relationship with feminism and demonstrated the importance of analyzing women's lives as lived within the patriarchal system. Allen (1986, 1996) has been a prominent writer on the topic of critical theory, critiquing dominant models of research and of sexism and racism in nursing. Thompson (1987) critiqued aspects of domination and oppression in nursing and proposed a critical scholarship.

Hedin and Donovan(1989), Diekelmann (1990) and others (including nurse educators at the 1987 and 1988 National Nurse Educator Conferences) called for changes in nursing education. They recognized that the ways in which nursing students are socialized have contributed to the powerlessness and alienation of nursing practice. They called for a curriculum revolution that would incorporate critical and feminist pedagogy into nursing education (Hedin, 1989). Others nurses writing in these traditions have critiqued nursing theory (Gray, 1992), nursing process (Hiraki, 1992), and professionalism (O'Neill, 1992; Turkoski, 1992). Critical and feminist theorists share a belief in conscientization as a first step in making real change. All of these critiques in nursing are important for self-reflection and conscientization within the profession. While resistance to domination in healthcare is a prominent theme, none has specifically explored resistance or acts of resistance among nurses. The additional

piece, in my view, is an increased focus on the practicing nurse and the ways in which they resist oppression in their day to day lives. (It is one thing to write as an academic, and another to figure out how to actually live with the situation on a daily basis). A little-known magazine has attempted to fill that niche with the practicing nurse and bring resistance into the public discourse. The magazine is called Revolution: The Journal of Nurse Empowerment. The magazine was founded with the expressed purpose of identifying power inequities in nursing, and giving practicing nurses the chance to speak out about them. Revolution publishes stories from nurses and viewpoints that are filled with anger and rebellion.

#### Power Study

As an exploratory study to this dissertation, I worked with a group of colleagues to conduct a phenomenological study of power and powerlessness among VA nurses (Garon, Kodiath, Laverdiere, Magruder, Newell & Joyce, 1998). A nursing research committee composed of staff nurses, nurse practitioners, and myself conducted the study over the past three years. Twelve nurses were interviewed, and the analysis is still in process. Because this is a group project, the analysis process has been both slow and stimulating. The discussions about power, powerlessness, and nursing practice within the committee were as illuminating as the respondent's answers. Several themes have emerged that have struck familiar chords in the research committee. The themes identified thus far include "voice," describing the nurses' concerns with being heard. "Power as hierarchical" is a theme of the participants' experiences with the hierarchical nature of their work settings. An additional theme is the anger expressed

by the participants about the inequities they face on a daily basis. The most gratifying part of the study has been the emancipatory effect that participation had on some of the study participants. They expressed gratitude at being allowed to share their experiences. Some of them were surprised to find how much emotion the incident that they related still produced. Others approached the researchers after their interviews, to express how changed they felt because they had told their story. One nurse told a committee member that participating in the study had caused her to reflect on the meaning of power and powerlessness in her practice. She said that she would never think of these ideas in the same way again. This research again highlighted the existence of feelings of powerlessness in nursing. In addition, it reinforced the importance of voice and providing a forum for nurses to tell their stories and reflect on their meaning.

### Summary

In summary, the literature related to resistance has shown its connection with concepts of power and oppression, the need for a feminist or critical perspective in studying the concept, and the multifaceted ways in which resistance may present itself. The development of nursing can be closely linked with the status of women. Professional relationships between physicians and nurses reflect gender relationships throughout society. Research on the topic of power in nursing has generally taken the view of the dominant group, giving little consideration to the perspective of the subordinates. Finally, in the past 20 years, nurses have applied the lenses of critical and feminist theory to nursing and have reflected upon the power relations, which have



been largely in academia. Virtually no research has been done that looks at how nurses have resisted the oppressive conditions with which they live every day.

## CHAPTER III

### Methods

The purpose of this chapter is to present and discuss the epistemological assumptions and specific research strategies used in this study. This study proposed to relate and interpret female staff nurses' stories of their experiences in acts of resistance. A personal narrative approach was used.

#### Epistemological Assumptions

Qualitative research was described by Parse (1996) as the "less traveled path of formal inquiry in nursing." Qualitative research uses words and descriptions instead of numbers or statistics as data. Personal narrative is one of the qualitative approaches. It differs from other qualitative approaches in the importance that it places on the telling of the story from the narrator's perspective. While it is similar to phenomenology in that it seeks to ascertain meaning from actual experience, the methods have different philosophical bases and different purposes.

Polkinghorne (1983) describes narrative as a linguistic production providing insight into the whole of an event, object, idea, or lived experience. Josselson and Lieblich (1995) described narratives as stories that are tools to make a point or transmit a message. Narrative method is utilized as one of the most effective methods

to give "voice" to a silenced, ignored, abused, or invisible group (Reinharz, 1992).

While not all narrative methods are distinctly feminist, feminists identify the personal narrative or oral history as a particularly appropriate method for use in feminist research. Many research methods books do not even mention this method. Some of the purposes of the method, according to Reinhartz (1992), include "to develop feminist theory, contribute to social justice, explore the meaning of events through the eyes of women." She views the narrative as a feminist encounter because it creates new material about women, validates women's experiences, enhances communication among women, discovers women's roots and develops a previously denied sense of continuity (Reinharz, 1992).

The personal narrative method has been used in other fields, such as sociology, psychology, anthropology, and linguistics, and has recently found proponents in nursing. The aim of the narrative investigation of human life is the interpretation of experience (Josselson & Lieblich, 1995). "Narratives are a meaning-making system that makes sense out of the chaotic mass of perceptions and experiences of life" (Josselson & Lieblich, 1995, p.33). Personal narratives emphasize the multiple truths in life stories. Furthermore, narratives have been found to have emancipatory potential (Banks-Wallace, 1998), as well as the ability to support socialized movements and mobilize resistance (Couto, 1993). By its very nature, narrative is the preferred method to conduct a study of this type about acts of resistance by female nurses.

To my knowledge, only one other dissertation has been completed at the University of San Diego using the narrative approach, and that one was in the School

of Education. Therefore, no nursing faculty member has experience with this specific approach. However, this method is closely aligned with other qualitative approaches, most specifically phenomenology and ethnography. I have some limited experience as a qualitative researcher. I conducted a qualitative, grounded theory class project on the women playing soccer. Currently I am primary researcher for a phenomenological study, which is in the analysis stage, on nurses' experience of power and powerlessness in a veterans' medical center. Additionally, I have developed excellent interviewing and active listening skills in my years as a nurse and as a manager. Both of these skills are essential for a researcher in a qualitative study of this type.

### Methodology

#### Selection criteria

I had several concerns in selecting participants for this study. I was interested in the stories of a broad cross-sampling of nurses and did not want to limit the sample to individuals at one or two institutions. Next, because the topic was to be a sensitive one, I did not want to appear to be aligned with either the organization or the administration of the institutions in order to allow the participants to speak freely. Finally, I had concerns that the controversial nature of the question would prevent entrée to institutions. Therefore, I sought participants through personal contacts using a snowball approach. First, I sought out potential participants through personal and professional contacts in the healthcare field in San Diego. A number of nurses at my current workplace volunteered or recommended other nurse colleagues in the community. I talked about the study whenever I met colleagues or personal contacts

who knew nurses, and asked them to talk with their colleagues about participating. I had no problem finding participants at a variety of settings in this way. This is a study of female nurses' experiences, and only female nurses were interviewed.

A nonrandom sample of volunteer participants is appropriate in qualitative research. It is important to identify and seek out participants who have experienced the phenomenon in which the researcher is interested. This is called theoretical sampling. Recruitment and enlistment of participants continued until there was saturation. The content, amount, and richness of the interviews determined the number of participants included. In a narrative study of this type, 10 or fewer participants are appropriate. This study had 11 participants.

#### Data Collection

Data collection began after the study was approved by the Committee on the Protection of Human Subjects at the University of San Diego. Because the participants were self-referred or referred by a friend, I first contacted them by telephone and briefly explained the study. If they were interested in participating, I set up an appointment with them at time and place of their choosing. After reviewing and obtaining informed consent, I interviewed each participant using a semistructured interview.

Interviews took place in the setting preferred by the participants: some were in their homes, some in their work settings, and one was in a coffee shop. One interview was conducted on the telephone. The length of the interviews varied from about ten

minutes (for the phone interview) to an hour, with the average being around 30 minutes. The interviews were audiotaped.

I transcribed each interview myself, for expediency and to be able to develop the format for the transcriptions that worked best for analysis. After the interviews were transcribed, each was given an identification number. The brief demographic information obtained was also given a number, and filed separately from the interview transcriptions to avoid identification of the participants. The tapes, interviews, and demographic data were kept in a locked file until the research was completed. The tapes were destroyed at the conclusion of the research. All information, including quotations, will be reported in a manner that will protect the anonymity of the participant.

#### Interpretation of the narratives

Analysis of the narratives began at the time of the initial interview. As the participant told her story, I utilized an active listening technique, selecting the questions that would guide the storyteller. As the researcher, I paid attention to both what was said and what was not said. Then, in the analysis phase, it was the researcher's role to decode, recognize, recontextualize, or abstract the raw data in the interest of developing an interpretation or meaning.

There are several descriptions of the analysis process in the literature. The analysis processes described by Polkinghorne (1988) are detection, selection, and interpretation of data. The aim is to identify core plots that describe or explain human lives or events. The Personal Narratives Group (1989) stressed the importance of

context in interpreting women's life experience. They emphasized development of themes along the lines of historical context, frameworks of meaning, relationships, and memorable moments of life (experience) stages.

Riessman (1993) cautioned against reading the narrative simply for content. She recommended beginning with an analysis of the structure of the narrative. "How is it organized? Why does the informant develop her tale *this* way in conversation with *this* listener?" (Riessman, 1993, p. 61). She related that she starts from the meaning within the talk and also considers how the individual narratives are situated in the larger discourse. Additionally, issues of power and voice must be considered — whose interests are represented in the final product? Concurrently, she links the informant's narrative account with the evolving theoretical and philosophical perspectives of the research.

After reviewing available literature on narrative analysis, I proceeded to transcribe and analyze the interviews. After I completed each interview, I transcribed it using an electronic cassette transcribing system. This gave me the opportunity to listen to the interview again. I then reviewed each transcription when completed, jotting notes and comments, and highlighting important words and phrases. As recommended by Riessman (1993), I studied the narrative structure to establish the organization and purpose of the story. The first step was a reading of the narratives to gain a sense of the whole. Next, I read the material again, paying careful attention to the development of themes and the core narrative. As interviews were completed and transcribed, I repeated this process, comparing the narratives to one another for commonalities of

themes and core narratives. In order to bring the major themes of the participants together, I reviewed the transcriptions and interviews for quotes from each nurse that exemplifies each theme. As I proceeded, I found that I was able to identify common meanings amongst the participants, yet still preserve the uniqueness of their experiences and narratives.

#### Protection of Human Subjects

There were virtually no risks to the participants in this study. Because of the emancipatory nature of narrative, the benefits outweighed any perceived risks. The study was approved by the University of San Diego's Committee for the Protection of Human Subjects. I adhered strictly to their guidelines. I discussed the nature of the study with all participants, and had them sign an approved consent form. My name, address, and phone number were included, and the participants were informed that they could withdraw at any time without risk or penalty. There were no expenses to the participants.

All interviews were audiotaped, and each participant was asked to adopt a pseudonym to keep her identity confidential. No information or descriptions were used that could identify the individual participants. The audio tapes, diskettes and transcriptions were kept in a file cabinet in my home, or in a locked drawer in my workplace.

#### Summary of Research Methods

A qualitative feminist method, personal narratives, was used to elicit nurses' stories of acts of resistance. Informed consent was obtained according to the procedures



of the Committee for Protection of Human Subjects at the University of San Diego.

Data was obtained through interviews of female staff nurses. Data collection and analysis occurred simultaneously utilizing methods described by Josselson and Lieblich (1995), Riessman (1993) and Personal Narratives Group (1989).

## CHAPTER IV

### Content Analysis and Findings

#### Introduction

The framework for the analysis data for this study was developed from two methods from the literature that were blended into a format unique for this study. The contributing frameworks were from the work of Riessman (1993) and the Personal Narratives Group (1989). The Personal Narratives Group (PNG) stressed content of narratives, including such areas as social discourse, politics, and power relationships in their analytical structure. The PNG identified four areas for analysis: Historical context, frameworks of meaning, relationships, and memorable moments of the life story. Secrist (1996) used this framework in her study of midlife tomboys, and found the categories appropriate for her narratives, which included life stories. She found extensive data allowing for several subthemes under each of those four major areas. Riessman's (1993) framework for analysis delineates the structure of the narrative. As an essential first step to interpreting the narratives (Riessman, 1993), this framework requires retranscribing and coding them to see how they are organized, A. In this framework, texts are coded as: (A) providing an abstract for what follows, (O) orienting the listener, (CA) carry the complicating action, (E) evaluate its meaning and (R) resolve the action. After several initial readings of the interviews and coding for themes, I retranscribed the interviews, separating the narratives into connected phrases. I then coded all the interviews using Riessman's method. Over nine days in September

1998, I read and re-read the interviews and the methods. After first labeling parts of the narrative with Riessman's codes, I noted that some of the categories lacked depth, while others were rich in data. This led me to compare Riessman's method with that of the PNG (see Table 1).

Table 1.

Comparison of Narrative Analysis Methods

Riessman (1993) (structure)	PNG (1989) (content)	Garon (structure/content)
(A) Providing an abstract for what follows	(H) Historical context	(A) + (O) + (H) Setting the stage
(O) Orienting the listener	(M) Frameworks of meaning	(O) + (R) Systems of relationships
(CA) Carry the complicating action	(R) Relationships	(CA) + (LS) Turning points
(E) Evaluate its meaning	(LS) Memorable moments of the life story	(E) + (M) + (R) Creating meaning
(R) Resolve the action		

The conceptual basis for the framework for the PNG is consistent with this study. However, the four identified categories did not quite fit the data from these interviews. As a result, I developed a framework for analysis unique to this study. I developed categories based on the themes from the narratives. I gave each a name and assigned a color to each. Using colored pens, I went through each interview, one category at a time, marking them with the colored pens. Then, before writing the analysis, I wrote

the quotes for each theme on separate pieces of paper, and began the process of reintegrating the stories and constructing the chapter on findings. The four categories that emerged from the narratives were: setting the stage, systems of relationships, turning points, and creating meaning.

This chapter is organized into three main sections. In the first section, I introduce preliminary findings, the participants and their pseudonyms, and a brief synopsis of their stories. The next major section presents the four major categories described above, setting the stage, systems of relationships, turning points, and creating meaning. Each of them is divided into two to four subthemes. The final section concludes with discussion of the an overriding theme of discourse, and a summary of the findings.

### Preliminary Findings

Several preliminary findings emerged early in the research. First, the participants were highly enthusiastic about taking part in the study. They were willing to see me in their homes, meet me at coffee shops, and at their worksites. They recommended other friends and coworkers as participants. I could have doubled or tripled the number of narratives, if needed. The narratives were related with a variety of emotions. Some recounted the stories almost mechanically, with little emotion. One participant told her story in sad, muted tones, crying several times while relating her story. Most commonly, the narrators expressed relief at being able to tell their story. All participants were eager to hear about the stories of other nurses and asked to be given results of the study.

Another surprising finding was how easily they understood the concept. I had anticipated that an explanation and example might be necessary. The participants readily volunteered their stories, some of them almost impatient to begin as I went through the consent procedure and the explanations. I discovered after the first few interviews that telling the participants in advance the subject of the research and the first question ensured that they would have a story ready for me when we met. Some of them volunteered that they had thought of several stories and had to decide on which one to tell me. With others, several stories just tumbled out of them as they began to speak. Because I had completed several interviews before discovering this, the early participants had more difficulty thinking of a story.

#### Description of participants

The majority of the participants, nine of the eleven, reported their ages as between 41 and 50. Two participants are 31-40. (See Appendix B for demographics). However, many of their stories were from years past. Several participants emphasized that they were younger and less confident then. Only one participant had less than 10 years' experience as a nurse. Five of them had 20-29 years of nursing experience; four had 10-19 years' experience, and one had 30-39 years of experience. I decided to discuss the information about the work settings collectively rather than matching them with the participants and their stories. In this way, I could better disguise the identity of the participants and assure them of confidentiality. Therefore, the workplace demographics are presented collectively and only referred to when absolutely necessary for development of the narratives. Six of the participants reported stories that occurred

in government or military institutions, a naval hospital, USPHS Hospital, and Veterans Affairs hospitals. Of the remaining five, two were in independent hospitals - one in San Diego County and one in North Carolina. Three told stories that occurred in one multisystem healthcare setting in San Diego County. I had not deliberately set out to seek multiple participants from that one healthcare system, but these nurses were referred to me by different sources.

I did not ask ethnicity as part of the demographic data. However, since all but one interview were conducted in person, the participants were identified as: eight white, one African-American, one Hispanic, and one Filipina. Two of the minority participants expressed a belief that their race or ethnicity directly impacted the outcome of their stories.

#### Introducing the participants

I will introduce each participant by pseudonym, description and synopsis of their main story. Only one of the narrators selected a pseudonym for herself, so all but one were my creation. The pseudonyms were chosen somewhat randomly, based on names that I had recently heard or perhaps liked for years.

The first participant was Megan. She has a wholesome, natural appearance, chin length gray hair and a clear, direct way of communicating. Megan is one of the participants who did not seem to provide one distinct narrative. She related several brief anecdotes, with much humor, but little outward emotion or interpretation. Her main story was about a conflict with a physician who refused to respect her or the nurse's role.

Next came Melissa, a lively, fun-loving nurse who laughed often during her narration. She told, with much relish, of her efforts to help patients work around the system to get their needs met. Besides relating her tales with humor, she spent much time analyzing and evaluating the issue. Several days after the interview, she sent me a page of handwritten notes that included additional thoughts and evaluation.

I have called the third narrator Jeanine. Jeanine came to my office for the interview. She related her story about manipulating rooms and schedules in a Cath Lab in an attempt to keep two teams of nurses working, and her resultant conflict with the unit manager. Her narrative was related rapidly and dramatically, with little interpretation offered.

Flower was the fourth nurse interviewed. Flower is currently a nurse practitioner, but participated in a strike against a hospital in the South, when she was a staff nurse. Flower was thoughtful and reflective about the strike, and her role as a participant.

The fifth participant was Jackie. I interviewed in her own condominium in northern San Diego County. She is a slender, fit, athletic-looking nurse. After the interview, she related that she felt liberated by finally being able to share her story. Jackie shared an incredible tale of whistle blowing at her hospital, apparently retaliatory disciplinary actions against her, and the battle that she undertook to keep her job.

Trish met me at a coffee shop midway between our homes. She described herself as, "you know, I look like a nurse, brown hair, glasses." She brought her

grown daughter (who is considering studying nursing) to the interview. Trish's tale varied from the others, as she told of her attempts to make things more fair and equitable in her workplace, while she was in a Charge Nurse position. She offered two additional stories involving an unpopular anesthesiologist. Trish told of a time when she challenged this anesthesiologist about his attitude toward a prisoner-patient. She also related another incident when one of the nursing staff wrote something on their assignment board about the same anesthesiologist that was meant to embarrass him.

Angela was the seventh nurse interviewed. I wanted to include her in the study, because she founded and is the editor of a nursing magazine that publishes controversial articles about issues such as nurse abuse, power, and unionization. I contacted her by e-mail at the magazine. When she returned my phone call, I told her about the study and asked her to participate. She agreed to a phone interview. I have not revealed the actual name of her magazine, keeping with confidentiality requirements. Angela spoke rapidly and animatedly, with a distinct New York accent. She related one story of karate chopping a physician to protect a patient, and another of founding the nursing magazine.

Next is Twinkie, a petite, outspoken young nurse of Asian descent, with long dark hair and dark brown eyes. She is the only participant who chose her pseudonym, and her chosen pseudonym reflects her energy and playfulness. Twinkie had the least years of experience of any participant. She related several stories of how she has spoken up for herself from the time that she was a new graduate. Twinkie was one of two participants who returned their copy of the transcription to me covered with red-



inked corrections. She explained to me that she realized that she rambled during the interview, and she wanted to make sure that her points were understood.

The tenth participant is Diana. Diana is a thoughtful African-American nurse. I interviewed her in an unused examination room in a clinic at her current workplace. She told of a painful story of confronting her manager and eventually filing a grievance for the treatment she received. Diana also made numerous corrections to the printed transcription, at times crossing out and rewriting whole sections. She appears to have been very concerned with both the accuracy and clarity of her story.

The final participant was Rosa. Rosa is a small, wiry, energetic nurse, who invited me into her home for her interview. She told her story, curled up on one side of a comfortable couch, sipping tea. Rosa was animated as she told her story, her accented English revealing her Central American origins. She used her large expressive brown eyes, and frequent gestures to highlight dramatic portions of her story. She told about her actions with a doctor who "hates" her.

### Frameworks of Meaning

This section describes the frameworks of meaning for the study. Four main themes compose the framework. They are: setting the stage, systems of relationships, turning points, and creating meaning. Table 2 shows the four themes constituting the frameworks of meaning used in analysis. Setting the stage has two subthemes, context and definition. The theme, systems of relationships, has four subthemes. There were no subthemes for turning points. Creating meaning has two subthemes, self definition and coming to resolution. Each of those subthemes had an additional layer of findings.

The next column displays some of the patterns found in the interviews. These are presented in narrative form in the following text, as well as some of the unique threads from the stories of the participants.

Table 2

Frameworks of Meaning

<b>Theme</b>	<b>Subtheme</b>	<b>Patterns</b>	<b>Unique threads</b>
<b>1. Setting the stage</b>			
	Context	Little description of their settings	
	Definitions	Resistance as passive aggressive Recognize it, but didn't call it resistance before	It's difficult; We may do subtle resistances
<b>2. System of relations hips</b>			
	Management/ staff	Abusive Power Truth telling Non-participative decision making	Supportive
	Physician/ nurse	Abusive Difficult	
	Staff/staff	Backstabbing, bickering	Unity
	Patient/nurse	Patient advocates	
<b>3. Turning points</b>			Each story was unique
<b>4. Creating meaning</b>			

	<b>Self definition</b>		
	<b>*inhibiting factors</b>	<b>Fear, ambivalence</b>	
	<b>*reaching the limit</b>	<b>"Just had it," anger</b>	
	<b>*Looking within</b>	<b>Evaluated own personality traits</b>	<b>Racial prejudice contributed</b>
	<b>Coming to resolution</b>		
	<b>**"I made it!"</b>	<b>Pride Learned something Maturity</b>	
	<b>*Negative consequences</b>	<b>Can't change system Painful experience</b>	<b>Unable to trust</b>

### Setting the stage

Within the first theme, the narrators set the stage for their narratives by describing the context, and defining what it meant to resist or speak up. Unlike descriptions from other narrative studies, the participants in this study did not spend much of their story orienting the listener. Their descriptions of their workplaces were minimal; however, they were more descriptive about their roles and their workplace relationships.

### Context

All of the participants in this study related stories from hospital-based practices, and all the stories except Jeanine's were based in traditional inpatient settings. Two participants shared stories from inpatient psychiatric units, two from medical surgical units, two from maternal infant or obstetric (OB) units, two from adult critical care units, one from a neonatal intensive care unit (NICU), one from a post-anesthesia care unit (PACU), and one was from a Cardiac Catheterization Unit (Cath Lab). As

discussed with the demographics, the participants' workplaces were governmental, Veterans Administration and United States Public Health Service, military, a multisite private healthcare system, and independent hospitals. Flower situated her story in a small hospital in North Carolina. Angela's took place in New York. All the rest were located in southern California. All the participants described their role as clinical, except for Tamara, who did not mention her position. Jackie, Megan, Diana, and Trish all described themselves as having leadership roles in their units. The narrators tended to plunge into their stories of the actions that they took, with little description of their workplace and virtually no physical descriptions. They may have assumed that, since I am also a nurse, that description was not necessary.

### Definitions

I did not explicitly ask study participants for a definition of resistance, so the meanings that emerged came from their interpretations and insights into how their experiences fit into a definition of resistance. On introducing the topic for study, I told each participant that I was studying "acts of resistance." I then asked them the first question, "Tell me about a time that you spoke up or out against an injustice or an inequity in your workplace." A few participants returned to the concept of acts or resistance, while most just proceeded into their stories, which were their interpretations of acts of resistance. Each narrator chose a story that she felt was exemplary as an act of resistance. In retrospect, the stories have in common a problem in their work setting (usually related to an unequal power relationship), and the action they took.

Several of the respondents reflected on the meaning of acts of resistance. Melissa thought more about the concept after the interview, even sending me an additional page of written comments. She believes that nurses find numerous ways to resist, but don't always call it that. She mused:

I would think that it would be how "acts of resistance" would be interpreted, but I would think of "not going along with the mainstream", and being the patient advocate. I think that is probably the strongest act of resistance.

Later in the interview, Melissa reflected about her views of nursing and gave additional thought to how she uses acts of resistance in her practice. She admitted,

I think it is difficult to be resistive. Have I been resistive so I took a risk so that I would be in trouble? No. Because I am not that kind of person. I would be afraid to be in trouble, so my resistance would have to [pause]come in a more subtle way.

Two participants linked resistance with passive-aggressive behavior. Jeanine identified the staff's attempts to manipulate the Cath Lab schedule to stave off closing a room, "I guess passive aggressive behavior is what we were doing." Additionally, Megan pointed out the importance of language and the labels we use, stating:

I think that we do things that could be acts of resistance or could be passive aggressive, but I think it is important that we own them no matter which they are, because then, I think we won't be passive aggressive anymore. We'll label them as acts of resistance and be open about them!

Jeanine also offered examples of how she and other staff found ways to resist their manager. She describes the different ways they communicated:

Yeah, it was two different tiers of communication. Tom (the manager) would come in, and it was like, "Oh, O.K., yeah, we'll go home, no problem." And behind his back, it was like, "What is he trying to do? He doesn't support us. He doesn't do this, he is trying to close our program."

When I asked if the nurses in the unit had any underground jokes about the manager, she added, "We used to call him 'Forrest', you know, like 'Run, Forrest, run' [refers to the title character in Forrest Gump, a popular movie], because he would just run through the Cath Lab basically, and cause disruption."

Jackie's act of resistance, in her words, "came down to a legal issue. And, basically, I was a whistle blower." She spoke up to a licensing agency about what she saw as unsafe floating practices. Angela asserted that she had a career long history of acts of resistance. But she believes that her biggest act of resistance was starting \_\_\_\_\_ magazine. Other participants described being involved in a battle, whether it was over space, conflicts with managers or physicians, or legal issues. Jeanine described challenging the unit manager frequently. But she and the other unit staff recognized that he was representing a larger system that was trying to cut their hours.

The participants in this study recognized the concept of resistance, and were able to identify times in their careers when they had participated in acts of resistance. Their definitions derived from actions that they took when they or others were being

treated unfairly or inequitably. They knew oppression and resistance when they saw it, even if they did not use that language to describe it.

### Systems of Relationships

The Personal Narratives Group (1989) stressed the importance of paying attention to systems of relationships in which individuals are embedded in studying women's oppression. In addition, they maintained that "personal narratives are particularly rich sources because, attentively interpreted, they illuminate both the logic of individual courses of action and the effects of systems level constraints within which these courses evolved" (Personal Narratives Group, 1989, p.6).

Nurses have been shown to do the connecting work in healthcare institutions (Jacques, 1993). Therefore, it is not surprising that the systems of relationships of these participants emerged as a predominant theme. Relationships with their managers, administrators, the physicians, peers, and patients were central to the work of these narrators. Six of the respondents contributed stories that related an abusive power relationship with management or administration. Six stories concerned problematic relations with physicians (one participant had a story for each).

This section of the analytical framework deals with the systems of relationships in which the participants saw themselves embedded. In these narratives, themes emerged in four categories: management/administration and staff; physician and nurses, staff/staff; and nurse/patient. The first two categories detail abusive relationships. The other two highlight how other relationships are impacted in these conditions.

### Management/administration and staff

Jeanine, Flower, Trish, Jackie, Diana, and Twinkie related stories about conflict between themselves and management or administration. The themes that emerged from their narratives include abuse of power, truth telling, and nonparticipation in decision making. As the participants told their stories, they related their emotions and outrage over the issues of power relations, fairness, and truth. For many of these nurses, their nurse managers are portrayed as carrying out unjust policies of administrators who care only about the bottom line.

However, the individual personalities of the managers impacted how they carried out their role and their relationships with staff. Some of the nurse managers were depicted as using both verbal and physical abuse at times to maintain the power relationship. These participants did not report feeling valued by administration for their knowledge, expertise, or contributions to the mission of their institutions. Their managers and administrators seemed to view them as troublemakers, who needed to be silenced or removed.

Jeanine sat across from me in my office, dressed in her scrubs, and rapidly related her experiences at her last place of employment. As her story tumbled out, she mentioned that her manager had a bad temper and yelled at her in front of other people or talked behind her back. She told how she had finally confronted him about his behavior.

And I said, "you know, nobody wants to communicate with you because of your bad temper, and the way that you speak to us. And, because you use the f-



-- word at us. You've even called us f---ing babies at meetings and I wrote down the day that you did that, and I know that there area people in the lab that will validate this."

At this point, I expressed shock. This was beyond my experience; it seemed so incongruent with my beliefs about nursing. I stopped Jeanine's somewhat dry recounting of this, and asked her if this was really a nurse, a nurse manger. She assured me that he was indeed a nurse. I asked her what it was like dealing with managers like this. Jeanine answered, "Well, they are unfair and unethical. They are lying. They're calling us names, not just me, but other people. I heard him just a month or two before yelling at another employee, calling him a lazy f---ing a--hole."

In contrast to this open verbal abuse, Diana related how her nurse manager threatened her when the two were alone. Diana, the only African-American participant, told me it was difficult for her to revisit these incidents. Quietly, she told me of the inconsistency between her manager's public and private persona. In Diana's words, "She's the head nurse; she can put on this air. Behind closed doors, she's a witch!" Diana reported that her manager once said to her in private, "I am a very powerful person. I have a lot of power; I can hurt you! If you think that anyone is going to believe you over me, you're mistaken!" Using tissues to daub the tears welling in her eyes, Diana revealed that she felt that she "not only was emotionally raped, treated badly, and abused by the nurse manager, but by the system also."

While Rosa's conflict was with a physician, she also expressed concern about the behavior of her managers. She related that her manager was unsupportive during

her conflicts with the physician, and that the manager seemed to play favorites.

However, Rosa felt that she was never directly attacked, because she was popular

among the other nurses. One of her colleagues, an Indian nurse, was not as fortunate.

At one point, Rosa actually witnessed a physical encounter between the nurse manager

and the Indian nurse. With wide eyes, in a hushed, solemn tone, Rosa held out her left

forearm, grabbing it with her right hand, "I saw her grab her arm one day, go like this

[demonstrated], but, they never touched me!" She shook her head and leaned back on

the couch cushion, as if the memory itself tired her. The Indian nurse quit, and works

at another institution. Rosa told me that this nurse is still unhappy, and wishes she

could return to her old job.

Truth telling and fairness of the managers emerged from the narratives as an important theme. The nurses who were involved in disputes with managers, expressed outrage at the twisting of the truth in their cases, as well as the perceived inequity of staff treatment. Furthermore, the participants described their feelings of vindication, when the managers were caught in a lie. When Jeanine's manager made up things about her to Human Resources personnel in order to hasten her removal, she felt insulted. She recounted the event,

So, he was very angry. He was inappropriately angry. He was trying to get

me. So, when we got to Human Resources, and I told my side of the story, he

actually made up some things! He fabricated a phone call from a doctor and

said that this doctor was denied time on the schedule, and that wasn't true at all.

The doctor couldn't arrive . . . it was one of those things.

Later, Jeanine found herself in a dispute with a new unit manager about something that she had reported hearing from the medical director. Again, she asserted that the whole thing was a fabrication on the manager's part.

In Diana's story of conflict with her manager, truth telling was also an important issue. What the manager said to her in private differed greatly from what was said in public. Diana felt that her credibility was questioned both because of her position (less powerful) and her race. With resignation, she sighed, "after all, she's the head nurse, she's white, she can say whatever she wants." Diana confided that she believes that most white people characterize blacks as dishonest, liars, and thieves. With candor, she revealed her feelings at that time, that, "no matter what I said, no matter what I did, that I was a liar. Nobody believed me, because I'm a liar!"

Diana lived through months of this situation before two of the other nurses who worked with her came forward to nursing administration. They verified her story, and disclosed some of the tactics used by the manager. Diana reflected quietly, "If my co-workers hadn't had the courage to come forth and tell what they knew, I'd still be labeled as this awful, lying . . . "[doesn't complete sentence]. One disputed area was the claim by the manager that she had counseled Diana numerous times about her performance. To substantiate her claim, the manager produced documented counseling. Diana laughed softly, saying with resignation,

I don't know, she must have gone home, went to her computer and started writing, because, there were pages and pages and pages of stuff, with times and

dates, when she had supposedly called me into the office and counseled me about certain behaviors and things. I had never, ever seen these papers before! And, because Diana had not signed them to show that the counseling actually took place, the hospital director also concluded that they were untrue.

Jackie found numerous reasons to distrust management and administration at her workplace. She went to the Administration Office to find out if they had a copy of the California Nurse Practice Act. They didn't have one, and the secretary had never heard of it. Jackie described what happened next:

The Director happened to overhear me and came out of her office and started asking me why I wanted that. So, I went in and expressed my concerns and that I had talked with the BRN. She basically said, "Oh, they're just an agency for licensing, you know, for minimum competency of nurses. And really, we don't pay any attention to what they say. The only one that matters is the Department of Health Services." And then she said (Jackie changed the tone of her voice, mimicking haughtiness), "And, they are fine with our floating plan. There's no problem." And she just downplayed everything I had to say.

Jackie was unwilling to give up on the issue, and called the Department of Health Services (DHS). She discovered that her institution had already been investigated for these types of issues. Shortly after her phone call to DHS, the manager initiated a disciplinary process against her. Jackie reported that she was accused of vague charges and seemingly falsified dates. One accusation stated that the director "had come into the nursery on a day I was supposedly working (she listed the date),

and that I was having an argument with another nurse, talking about the floating plan." Jackie later checked the calendar, and found it to be a holiday, and that neither she nor the Director had worked! As a result, Jackie decided that her job was in jeopardy and she needed to defend herself against these charges.

Trish had a different perspective on the issue of truthfulness. Her first story was from her perspective as a charge nurse. She had designed changes to make a more equitable staffing plan. However, the staff nurses who lost the privilege of working a twelve-hour shift, never supported the change. They remained distrustful about the reasons behind it. According to Trish, they were convinced that management had skewed the numbers that she had used to support the need for the change, to their detriment.

Issues of both truthfulness and abuse contribute to the separation of staff nurses and managers, and highlight the predominance of power issues within healthcare institutions and nursing, in particular. The nurses who participated in this study, for the most part, did not see a work world in which any of the enlightened management styles existed. When I asked Jackie directly about staff participation in planning changes, she laughed derisively and stated:

We were basically just told that it was going to happen. We have rarely - and I've been there 17 years - had a staff meeting that is "participatory." It's kind of like one-way communication, "You will do this!". We have had so many managers who are very autocratic.

Even management models that are meant to increase staff participation are seen as imposed from above, with little attempt to gain support from staff or managers. For example, Diana described a meeting to introduce a new self-directed leadership model, "One day the manager and I, along with the other clinical coordinators, were called into a meeting with the director of nursing, and he announced at that time, that he was changing our role." This announcement was apparently made without input from the nurse manager or others involved. The lack of involvement or preparation may have accounted for the what Diana described as, "resistance and an unwillingness [on the manager's part] to give up even the smallest bit of authority."

Diana also related her observations about administration's view of staff and management. She expressed her disgust with the obvious hierarchy, the power differential saying, "To them, if you're in management, you're up here. And if you are not up there with them, you just don't count. You're a little peon down here. You don't count!" In the end, Diana summarized her view of administration, calling it "the Gestapo."

Jeanine expressed frustration at the lack of honesty and openness. In her view, if the staff had been told that keeping staff for two rooms in the Cath Lab was not economically viable, they would have been able to deal with the issue. She complained, "What they needed to do was just come forward and say, 'O.K. Our volumes are down, we are overstaffed, you're going to have to find another position.'" But, instead they dangled this carrot in front of us. I mean they should have been up

front and open, "Find work somewhere else, go back to critical care, go here, go to Endo."

Jeanine emphasized that the staff was "never asked. We were told; it was dictated." She observed that they were told that they could suggest how they wanted to lose their hours, "so it was almost like they gave us the illusion that we had some control, but we could see through that; we knew it was just an illusion, that they were giving us choices on things that didn't matter to them." As dissatisfied the staff was, Jeanine was could also see that the manager was himself in an untenable position:

If we had really believed that management above him would back up and listen to us, we would have gone to them and said, "this is what he does; this is how he acts. He is unreasonable; he does have his good points, but there is something wrong...you need to work with this manager." But, at ----- Healthcare System, that is not their style. Their style was to get you out. Instead of saying, he does have these good points, maybe with some proctoring. But, there was a lack of support for him at his level, and there's lack of support at our level.

When I asked Jeanine how people like her manager were promoted to management positions, she reflected that being willing to buy into the institutions' philosophy must be the main criterion. She noted, "It's cutthroat, and nothing matters but the bottomline. 'Keep your numbers up at any cost to your staff.' "

In contrast to most of the other narrators, Flower presented a highly positive view of her nurse managers, seeing them as allies in opposition to hospital

administration. She saw them as supportive of the strike efforts and the nurses' quest for higher pay, even though they could not say this officially, nor join in the strike. She even reported that the nurse executive was eventually fired, possibly over her supportive role during the strike.

### Summary

It is tempting to dismiss these narratives as being simply peculiar problems within a couple of healthcare systems in one part of the country. But the stories came from the narrator's experience in a variety of settings and from varied states. Angela, who is based on the East Coast, shared with me that she hears from nurses around the country who experience issues similar to the stories told here. This may be one of the most disturbing aspects of the findings. Nurses have sought for years to attain an idealized status, usually labeled as professionalism. Yet, a fundamental prerequisite for professionalism would involve autonomy and control over practice. Instead, nurses remain bound to institutional employment and to a system that condemns them to a factory-like supervisory model, in which the imbedded hierarchical power structure is unspoken. Nurse clinicians struggle to find their voice and speak up against the inequity of this system, and if they do, they are labeled as troublemakers, instead of risk takers or real leaders.

### Nurse - physician relationships

The dominant position of physicians in healthcare throughout history in this country is self-evident. The physician has been portrayed as "a man among men," able to command supremacy, power, control, and privilege (Lovell, 1981). Rafael (1996)



cited physicians' support for the use of unlicensed personnel to replace nurses, and opposition to the nurse practitioner movement as current examples of attempts to control nursing and nursing practice. It is not surprising therefore that themes of conflict with physicians came forth as an important theme.

Megan, Melissa, Angela, Tamara, Rosa, and Trish described incidents where physicians were central to their acts of resistance. Several participants explained their role as patient advocates, and articulated how they protected patients from physicians or encouraged their patients to manipulate the system to get their needs met. Melissa described how she taught patients in an inpatient psychiatric unit to "pass" their interviews with their physicians, so that they would be allowed increased privileges and day passes. She described this saying, "I'd kind of teach them what to say and how to respond to the doctor and how to talk to the doctor." She admits that this was just a little thing, and she felt sort of "impish" being successful at it. She may have been doing the patients a service, teaching them how to react appropriately in certain circumstances. Trish told of a more overt case of advocacy for her patient. She related a story in which one of the patients was under custody and chained to the siderails. The anesthesiologist walked into a roomful of people, physicians, surgeons, anesthesiologists, nurses and patients, and spoke out loudly, "Who's taking care of that thing over there in 12?" Trish continued with her story,

I'm thinking to myself, I must have heard that wrong! And, he said again, "who's taking care of that thing chained to the bed over in 12?' And I said, "this is really inappropriate. I am taking care of this patient; do you have an

issue?" You know, I just sort of dressed him down, right there, in front of everybody. And he was embarrassed, which was good. We don't get along to this day, because of that I'm sure, but it was just an inappropriate thing to say. He just treated the patient like garbage, and that is just not okay with me.

Trish related that this particular anesthesiologist was especially disliked by the nurses in her unit because of his obvious attention to the patients' payment plan or source of insurance, rather than to the medical needs of the patient. After silently putting up with his behavior, one of the nurses decided to call attention to it. In this unit, there was an assignment board, visible at the unit entrance that had messages for physicians, and information about patient assignment to nurses and physicians. One nurse wrote on the board next to this anesthesiologist's name, "No insurance - no narcotics." The nurse was making visible what they all knew about this doctor, and was holding him to public ridicule or censure. In Trish's mind, the nursing staff got "in trouble" for slandering him. However, in this instance, no one could be singled out for discipline because, even though the nurses all knew who wrote it, no one would reveal that person's identity. Trish reported that, "There was a big note in the communication book, 'We could potentially be indicted for slander.' " The physician was very angry about the incident, but seemed to improve for awhile, becoming more "covert" about his discrimination between patients depending on insurance.

Angela's story took patient advocacy to the extreme. I conducted the interview on the telephone, audiotaping it with her consent. In a matter-of-fact tone, she told me of working at a USPHS hospital in the early 1980s, where physicians were not

obtaining consent from patients for procedures or any kind of experimentation. The physician in charge of the intensive care unit (ICU) was experimenting with an injectable drug that was supposed to help wean patients from respirators. However, from Angela's report, all nine patients that she had seen receive it, died. She continued the story:

So, he went to give this medication I.V. [intravenously] to a 95-year-old woman, who was alert, oriented, and on a ventilator. Prior to him getting to her, I sat down and talked with her about what injection she was going to receive, and that I had seen nine people get it, and nine people died.

When the physician came to give the medication, the patient attempted to refuse, but the M.D. told her that she would get the medication anyway saying, "I'm the doctor!" Angela physically stopped the doctor from proceeding. Her ensuing actions led to her firing. But, Angela felt so strongly about protecting the patient that she had reacted automatically, without concern for the consequences.

Megan shared her story about conflicting with a physician about unit policy. Underlying that conflict was the physician's view of the nurse's role as his assistant. After a verbal confrontation about unit policy, Megan spoke up to the physician about his behavior. His view of nurses never changed, but he and Megan agreed not to work together, whenever possible.

Rosa recounted her story about a physician, who in her view, inexplicably "hates" her. Shrugging her small shoulders, Rosa related dramatically,

Then came this doctor, female doctor, who just hates me. And she still works there, until this day. I don't know why. She just doesn't like me. And, whenever I talk to her, the hair behind her neck just stands up, really bad!

This physician tried for three years to have Rosa removed from her position in the NICU. As Rosa told her story, "what really hurt me the most is that for many years, she tried to set me up to fail. But I never failed, because I was very careful." When asked how she was set up, she replied, "She would write STAT orders, hide them, and then say I wasn't fast enough to get the order, stuff like that." These continued encounters with the physician impacted Rosa's work life, causing her continued stress and pain. She finally left the neonatal intensive care unit to work in a less acute area.

Tamara recounted her story to me as we sat in her sun-drenched kitchen, her baby on her shoulder. Because the first interview had not audiotaped because of a battery problem, she related her story briefly, with limited detail. She told of a conflict between a group of physicians and the unit nursing staff over space. The OB (obstetric) physicians wanted more space for an additional sleeping room. The physicians were backed by their superiors, including the chairman of their department. Tamara reports the nursing side, "We had said 'no' that as nursing staff on a labor deck, we didn't have any more space to give them, that they should check with some of the other medical staff, such as pediatrics and even psychiatry." When other physicians would not give up any space, the OB doctors came back to the labor and delivery nursing staff and insisted that they needed to take over some of their space. The nursing staff had

more than adequate justification as to why they needed to keep their space, but the issue went up through the ranks for the commanders to make a final decision. The nurses were allowed to keep their space, but one of the physicians continued to complain about that and the nursing staff in front of staff and patients. It was that complaining and continued downgrading of nursing that led to Tamara's act of resistance.

In relating these stories of conflict with physicians, the nurses revealed much about the world of healthcare. The status and privilege of physicians permit behavior that would be unacceptable in most other situations. For a variety of reasons, the nurses felt it was often difficult to speak up or confront physicians.

In Tamara's case, physicians in other departments had the authority to say "no" to maintain control over their space, but the nurses had to enlist higher authority to prevent the physicians from taking over their much needed space. And, it seemed that the physicians could not understand why they could not have the nurses' space once they had asked for it. It was as if they believed that their needs or privilege superseded any others. Rosa felt unsupported by administration as she was hounded by a physician. Trish's and Angela's incidents demonstrate that unethical physician behavior can be largely ignored by administration, but nursing actions to make it visible are quickly punished. The nurses in these stories are obviously cognizant of the rules of power under which they operate. They learn over time and with experience how to handle them, when to speak up and when to remain silent. Trish commented on this,

describing how as she has gotten older and more experienced she has learned to handle the M.D.s:

Some of them, I don't even bother trying to diffuse the situation. It's easier to lay them out at the beginning, especially the ones that are going to stay. I like to make it really clear up front, that "I don't know what your expectations of nurses have been where you have come from, but this is how I am here, and I'd appreciate your collaboration and respect, because that is certainly what you will get from me." And it seems to work really well for me, to be really clear up front.

The nursing literature contains numerous articles about the nurse-physician relationship. This relationship represents the hierarchical and gendered nature of health care and physician nurse roles, and remains problematic. Individual nurses, such as Megan, Rosa, and Angela, learned individual ways to communicate or act assertively. But the systemic power issues that contribute to the inequity are not changed by these individual actions. This leads to further questions about the place of individualized resistance in this area.

#### Staff/staff relationships

An additional relationship category identified during analysis was staff-staff relationships. This was not an area identified by participants for their act of resistance. Instead, information about staff-staff relationships arose around aspects of other stories. Participants did not see these relationships as ones of inequity or power differences, but recognized how they could have powerful positive or negative influences.

Flower, Angela, and Trish noted accomplishments when nurses were cohesive. Flower's story of the strike at the southeastern hospital demonstrated the power the nurses and other hospital workers had from sticking together, "So, we got together a huge group, over 100 people just to decide what to do." Later, she described the massive support that the employees had on the day of the strike, "Everybody just poured out of this facility. There were so many employees out there!"

When Angela was fired for striking the physician, other nurses supported her. "The good thing about this was, thirty-two staff nurses refused to report to work. It was a case of nurses sticking together." Later, she described the positive energy that this group of nurses had, "We were all a bunch of big mouths. We were a thorn in administration's side. We were very close, we 'clicked.'" She agreed that this was an unusual occurrence and that the unity made the nurses more powerful as a group.

Trish told about a powerful group of staff nurses who could make both powerful and negative impacts. She described them, "They are a core group of very strong nurses, as most nurses in recovery rooms are. They actually have most of the power in the unit. These were people who were very politically active in the unit and in our national organization." However, Trish noted that when it came to deciding how to reorganize the unit, some of the senior nurses actually suggested laying off their colleagues, so that they (the more senior nurses) could continue to work 12-hour shifts. Trish related, "It is really disheartening [pause] some of those people were talking about laying off people that they have worked with 8 or 12 years!" She also recognized that moving into a charge nurse position made her an enemy to many of them. But now

that she is again a staff nurse, "We're all 'buds;' we're all friends, that's their perspective. That's not my perspective at all." On the positive side, Trish related how the staff's unity could also help them when dealing with physicians, "We are a pretty cohesive group that way. We don't cut 'em any slack, and then they get the idea and sort of straighten up."

Twinkie and Diana observed negative behaviors in staff relationships. When Twinkie entered her current workplace, it was to an area where two units were combining into one. "My perception was of - backstabbing. Staff were bickering. If they had a problem with staff, instead of confronting, they would rather talk behind their backs." Diana commented during her story, "You know how staff is. There's always some conflict. Somebody tells somebody else, etc."

The narratives highlight both the power of unity among nurses, as well as the impact of horizontal violence in their themes of staff-staff relationships. The nurses in Trish's story could not alter the administration's decisions about cost and shifts worked, so they turned against one another. Twinkie and Diana also gave examples of nurses fighting among themselves over policies or changes imposed from above. The sad conclusion is that these are mostly stories of solitary resistance - of one nurse getting the courage to speak up. Only Flower's story spoke to the positive change that can occur when nurses united in their resistance.

#### Nurse/patient relationship

The majority of these nurses were in clinical roles at the time of their stories. The nurse-patient relationship was an important aspect of their systems of relationships.



The predominant theme in this area was the responsibility the nurses felt as patient advocates. The nurses' view of their role with patients put them into conflict with physicians and managers. For most of these nurses, the driving desire to do right for their patients, to be a good nurse, was the major motivation in their resistance.

Jackie decided that she had to blow the whistle on the floating policy imposed by her organization, for the protection of her license, but mainly for the safety of her infant patients. She described her background experience as caring for healthy babies and mothers, with a little experience with high risk mothers and some transitional problems with newborns. But she had never cared for premature infants, nor given I.V.s or medications to them. She expressed her dismay with her assignment the first time she floated to the NICU,

So, I had three. I was assigned three infants, two of them were premature, weighing about two pounds each. And one of them was full-term, having withdrawal from drugs. I was familiar with that. They were all hooked up with monitors, with which I was unfamiliar. The preemie ones required medications, which I refused to give, because I didn't know what they were or, I knew nothing, or the isolettes. I wasn't familiar with any of the equipment at all!

Jackie's concern for the safety of the infants in the NICU prompted her to act. She was convinced that nurses should not be working in areas where they had few skills or little experience.

Both Angela and Trish took actions, because of their commitment to their patients. Angela wanted to protect her patient from the physician giving an untested

medication. Trish scolded a physician for demeaning a patient, because he was a prisoner. Melissa described her major acts of resistance, as acting as a patient advocate.

The nurses in this study have had to learn a variety of ways to cope with the system to help patients. Some have learned to be assertive, while others had to learn how to "dumb down." Twinkie told me how, when she was a new graduate, the nursing supervisor wanted to leave her alone on the second night shift that she worked. She spoke up to tell her that she wasn't comfortable with that, I was thinking, my license! I was afraid for the patients, because I was new!" For Rosa, she advocated for the infants in her care, trying to get the physicians to listen to her concerns. With one problem physician, she learned to be careful with how she approaches her, "She doesn't like people thinking. When I go to her and I know my baby's sick and there's a problem and I need an X-Ray, .oh! she can't stand that! So, I never ask. You have to act really stupid, you know."

Throughout the narratives is this underlying theme of nurses trying to do the important work of caring for patients while learning how to deal with the system. And, they are not seen as heroines, but as troublemakers. Managers and administrators focused their energy on punishing or silencing the nurses, rather than seeing them as experienced clinicians who called attention to areas for improvement.

### Turning Points

In the telling of stories, the narrator builds to a point where the plot reaches a climax or a turning point. This section involves the telling of what the participants

relayed as the turning point in their stories. The structure of the narrative is more evident at this point, as I tried to capture the sense of plot told by the narrators. Because this is a narrative study, the turning points or central parts of the narrative are important. These segments reflect how the participants recalled these incidents, what they recalled saying and how they remembered others reacting. Some of the participants were natural narrators, while others jumped between time periods and had to be brought back on track to get the whole story. Much of the content of the narratives were included in the previous section. In this section, I concentrate on the actions that the narrators considered their central acts of resistance. I did not include any of their attempt to find meaning, as that will constitute the final section.

The participants related their stories in different ways. Melissa related this part of the story with much relish and highlighted with laughter. She told about how she taught patients what to say when they would see the doctor for a pass out of the unit. She related:

I used to teach the patients [laughs loudly]. I used to teach the patients on the psych unit how to answer questions to the doctors. Because, their freedom or their ability to go on and off the unit was determined by their mental status exam, and how they behaved and what they would do. So, I would teach the patients what to say when they when they would see the doctor.

She knew that she was stretching the rules with this behavior, but her personal ethics told her it was the right thing to do. Her sense of humor about the actions doesn't minimize the strong connection that she had with her patients.

Jeanine and the nurses that she worked with were facing the prospect of having one of the two teams that worked in the Cath Lab eliminated, if one of their rooms was closed. For months, they were faced with one whole team being sent home each time that there wasn't enough work to keep two rooms operating. Jeanine related some of the ways that she and other staff managed to keep two rooms scheduled and running:

We would always encourage our doctors . . . . You know, they would call us for scheduling, so then we would say, 'well you know 7:30 is taken, 9:00 is taken, so you would have to follow at 11:30 or 12:00, unless you insist that you need 7:30 or 9:00, and then the other crew can come in!'"

After doing this for over a year, it finally caught up with her. One day, the manager came to her and told her that the two crews would split the day, and only one room would be opened. Her crew was to work 6:30 AM until 11:30 AM, and leave when the other crew came in at 11:30. So, even though the unit became busy, and there was enough work to support two teams, Jeanine and her team decided that they were going to finish up and leave, as they had been told. As she tells it:

So, I and three other people, who were assigned to leave at 11:30; and at 11:30, we just basically said, "Well, the other crew is here," and we left! And then, Dr. G. found out that he was going to be delayed [because they were leaving], which is almost routine. But, if you are going to send people home - the result is that people are going to go late. You can't have it both ways. You can't have us leaving all the time, and then, just saying, "Oh, yeah, you can stay now."

As a result of Jeanine and her crew's decision to leave, the manager took her to Human Resources to try to have her terminated. However, it was found that the manager didn't have grounds to dismiss her. He was told to apologize to her for some of the things that he had said. He eventually quit rather than apologize.

Flower told her story of striking against the hospital in North Carolina in a succinct way, adding little embellishment or description. She related that, after the staff walked out of the hospital en masse, "within 48 hours, we had a meeting with the Board of Directors as a group, the City Council, and the Hospital Administration. They agreed to a pay raise. They agreed to a dental plan; and they agreed to think about some kind of vision plan and retirement."

Jackie's story is longer and more complex. The turning point in the narrative could either be when she finally decided she had to call the Department of Health Services, or when she was finally acquitted by the institutional review board. Within days after she called the Department of Health Services, to inform them about her institution's policy of floating untrained nurses to the neo-natal intensive care unit (NICU), she was called into her manager's office and given two written warnings. One was for insubordination and failure to cooperate, and the other for her attendance. In addition, she was given a developmental plan, taken off her responsibilities as a Clinical Nurse III, and directed to go to the Employee Assistance Program to receive counseling. With the help of an attorney, she filed a grievance and followed it through the appeals process at her institution. After appealing through the administrative levels, she described what happened,

And finally, I got to the highest level, which is where we had the appeals committee. And, my attorney came with me, and we presented the whole thing, and by then, we knew that the Department of Health Services had come and found them in violation, and my manager came with the hospital attorney. And, in the end, the appeals committee dismissed everything and it was all taken out of my file.

Trish told several stories. Her first one was about how she devised a system to make flexing more fair for all staff. "We started collecting data to make things so fair. We made a system for flexing that took into account how many days or hours this pay period somebody flexed as opposed to last pay period, so that it could be equalized between shifts. And the floating thing was the same way." As it worked out, in order to equalize things, all staff would have to work eight hour shifts. Because this plan also worked better economically, management approved it, and all staff went to eight hour shifts. Trish found that her efforts to make things equitable were not popular, and many of the staff nurses that gave up twelve-hour shifts never forgave her.

Angela also had more than one story. In her first story, she spoke of preventing a doctor from giving an experimental drug to a 95-year-old woman, without her consent:

After he said, "Well, I'm giving it to you anyway; I'm the doctor," I physically stopped him. I just put my hand on top of his hand and said, "no."

He then elbowed me, which hit me in my stomach and knocked the wind out of

me. So, I wound up giving him a karate chop, because I'm a brown belt in taekwondo. And he went unconscious!

Angela was then fired and escorted off the property. She didn't give up though. When the patient, whose name was Mary, got off the ventilator, Angela took her on a Greyhound bus down to Washington D.C. to file formal papers against the physician. It was later found that he had forged his medical degree from Iran. Angela also told of founding a nursing magazine that was not supported by hospital or drug company advertising money to be able to print controversial topics, such as nurse abuse, paternalism, and unionizing.

Tamara came to the turning point in her narrative about the OB physicians who wanted the nurses' space. After months of listening to that one physician badmouthing the nursing staff in front of patients and other staff at the nurses' station, Tamara decided that she had to confront him:

Finally, one day, I had just had it! I said to him, "Look" and sort of went over the history, so that everyone else that was there, the other medical students, interns, nurses could know some of the background that I didn't think they did know. Such as, that nursing had compromised and given them some of our space in the past. That we didn't feel they were using some of the space that they had to the best of their abilities. That they could make more of it And, the reasons that we did need our space for storage and everything else, which is very important to it. And, while I didn't agree with doing it at the nurses' station, like I said, I had had my fill and I did it!

After that, the physician never spoke of the matter again. Of course, Tamara also noticed that she no longer had the same rapport with him after that, either.

Twinkie related several stories. One concerned being "counseled" for the use of sick leave by her nurse manager:

I was counseled for abuse sick leave back in 1995. I was upset because I felt I wasn't abusing my sick leave, but I didn't say anything to the head nurse during my counseling. I told her, "I haven't abused my sick leave, and I will check my records." When I checked my records I found that I had only used 16 hours of sick leave in three months. So the next day I told the head nurse of the error. I was upset. I am a responsible adult! So, I wrote the head nurse and said, "I don't appreciate this kind of counseling, when my records say that I have only used 16 hours of sick leave and I would like that removed from my record. That is what I did for myself.

Diana told her story of a nurse manager that she eventually confronted over the continued harassment and sabotaging. After months of confrontations, and arguments behind closed doors, the manager asked her to resign her position as clinical coordinator. Diana continued,

I refused. She just came to me and said, 'I'm taking it away from you. You're not in the position anymore.' Just like that. So, that is when I filed a grievance. And that's when things hit the fan.

Rosa told of the turning point in her story about the physician who hates her and tried to have her removed from the NICU. She had asked to be removed from the



NICU to a less intensive area, after an incident with this physician. However, as she tells it,

That didn't end it! She came after me again! She wrote an order and she hid it, again! Well, I went over and I grabbed her little b--- [slang for body part], and I said, "Now, that's it! This is the last time you ever do this to me. You are going to be written up! You're going to go right through the very last person in this whole hospital! And, I'm going to ride your little a-- ![slang term for anatomical part]"

Rosa wrote ten pages of documentation, recounting every incident with this physician and sent it to the Director of Nursing. As it turned out, the nurses in the delivery room also filed complaints against the M.D. for hitting at their hands and pushing them around. The physician was suspended from the hospital for a year.

In Megan's story about her conflict with a physician, the central part of her story was a conflict over policy. Even though Megan and this physician would never see eye-to-eye, they managed to negotiate a partial truce, by agreeing not to work together, because there was no compromise from her viewpoint.

### Summary

The turning point in a narrative is a plot device to complete and make sense of the story. Patterns or commonalities aren't apparent, because each individual nurse told her story in her own unique way. The overriding theme is that the narrators chose to relate these events in these ways and that the story unfolds as she intended. This is the story that the individual meant to be heard. And, most of these nurses have not been

asked to tell these stories before. Therefore, it is important to hear the individual voices, rather than collective themes, and to pay attention to their points as they related them.

### Creating Meaning

The fourth section of this framework for analysis focuses on the ways in which the participants drew the conclusions of their narratives and their actions. In doing so, they had to interpret their roles in the actions, and make sense of what happened to them. For many of them, this meant considering why they finally acted. And, for others, they had to consider if they would do the same thing again. The first part of this section covers the reflections and emotions involved in leading to their actions, and the final section explores how they came to resolution.

### Self-reflection

The Personal Narratives Group (1989) described the development of self-knowledge in feminist narrative research and included it in the context section. In this study, I found that these participants' reflections on their parts in these incidents came later in the narration and were entwined with their evaluation or creation of meaning. For each of these participants, an event happened in their worklife - and they had to decide how to respond. The participants were trying to answer the question, why did they take action or speak out, and why then?

### Inhibiting factors

These participants experienced diverse emotions as they considered whether or not they should resist. Several identified fear as one of the key factors in hesitating to

speak up. Their reticence to speak up or out can be related to the feelings of relative powerlessness they felt. Twinkie spoke about the fear, "I think the biggest thing when people hold back is fear. We all share the same thing. We want to be a good employee. And, they feel that if you speak too much or your mind, that you could be perceived that way." Jackie related, "I felt like I was being set up to be fired. I was getting nervous. I could be fired." Trish verified that staff does not bring complaints to management, "because they fear for their jobs, basically." Melissa confided that she has always been a nonconformist, but has found small underground ways to get around the system. She admitted that she has never had any conflict with administration at her facility, saying,

No, that wouldn't fit in with my personality. No, my goal was always to try and be as invisible as possible. I guess I would be like a Robin Hood. My goal was to try to stay out of administration's view.

Others participants didn't identify fear, but admitted that there was a sense of ambivalence, something that held them back before they could act. Jackie demonstrated this in her narrative. She was disturbed from the onset about the plan to float staff to the NICU. Other nurses, afraid to go to management, had expressed their concerns to her as a clinical leader. She confessed, "I am ashamed to say that at first, I really didn't do too much about it. I didn't get involved until November 1994, when it was my turn to float." Then, after she floated the initial time, she confronted her manager with the concerns. When nothing happened from that, she admitted, "I kind of let it go at that point. And then, in January, it looked like it was going to be my turn to float

again, and I started getting concerned again." Jackie questioned both the legality and safety of the plan to float generalist nurses to the NICU, but remained silent about it until it began to impact her directly. Later, when she was involved in the fight to keep her job, she recalls how difficult this time was and what it took to stay in it. She stated:

I did feel very much alone, when I was dealing with management. But, I knew in my heart that it is not right! I have never taken such a strong stance before in my life! I knew that the safety of those babies . . . I just know, it couldn't be legal. I mean, common sense, logically would tell you, this can't be right! But you begin to doubt yourself when these people in power tell you, 'no, you're not right, and you're going to do this!' "

Flower expressed her ambivalence at getting involved in a strike against a small independent hospital in North Carolina:

I don't think that I'm proud that we had to strike; it varied between ambivalence [doesn't complete sentence]. I wanted to do something positive for the people who were going to stay there. I knew that I would move on, because the military moves you, anyway, but the other people are there permanently, and they were really being taken advantage of.

She later stated that she and the rest of the staff realized that \$5.00 an hour was pitiful for a nurses' salary, and with the additional cuts in benefits that administration was proposing, "It was just time to take action." In the years since she participated in the strike, she has thought about it many times, reconsidering whether or not she took the right steps.

In this section, the participants identified a number of factors to be overcome before speaking up. Their feelings of fear and ambivalence were related to their positions of relative powerlessness. They had to decide how to confront someone with more power, and consider the consequences. However, they were able to overcome these factors and reach a point where they did speak up or act.

### Reaching the limit

For many of them, some emotional crest was reached. They described it as reaching a point where they just had to take action. Jeanine reported that she knew it was time to act, when her manager took her to the Human Resources office, "I was backed against the wall. He told me right there, when I was sitting in Human Resources, 'Well, you're in the hot seat', in those words! Those were kind of fighting words!" Tamara related her story to me calmly, but her voice told of strong emotions that led to finally speaking up. She described listening to one physician talking sarcastically about the nurses in front of patients, unit staff, other physicians and students, a number of times, "I was not happy when I heard it, and I never really said anything. And finally, one day I had just had it! I had had my fill and I did it!" Rosa relates enduring three years of abuse by a physician, who was trying to have her removed from her workplace. She finally realized, "I take a lot, but I can't take it anymore. She's abusing me!"

Diana also went through a long process before deciding that she needed to take action. She was mistreated by her nurse manager for months, then, "One day, I just was fed up! I called her a liar and that did it! The fight was on!" Later, she reflected on

her decision, "I probably brought it on myself, just by getting the courage to confront."

Angela overtly identified anger as the emotion that drove her: "Anger has been what has driven me to do what I do. There's always some anger. I find it is a good emotion, as good as love, the other side of the spectrum. And yes, I'm angry! I'm angry at what hospitals have done to nurses. I'm angry at what nurses have allowed hospitals to put them in a position where they can't give good care - I'm angry, without a doubt!"

### Looking within

Several participants discussed at length how and why they chose to speak up or speak out. For most, it took them time and reflection before they acted. They examined aspects of their own personalities and characteristics to explain their actions.

Diana thought that some of her own personality traits contributed to the development of the problem:

Being passive, that's one of the problems that I have in my personality. I will let things go one and on, and try to deal with them in a subtle way, but not really confront them. A flaw I have in my personality is that I will let things simmer and simmer and simmer, before I do something about it. I let this simmer for years. I don't like confrontation, I didn't want to have a confrontation.

Diana also believes that her race impacted the situation, "I feel because I'm black, she thought she could get away with things easier."

Twinkie was thoughtful about her actions in a number of cases, examining why she chose to speak up, and the process that she used to come to that decision. "I don't speak up immediately, I go through a thinking process overnight. Sometimes I talk to other people, 'was I right or was I wrong?'. I do go through some process." I asked her what she thought influenced her to speak up, she stated, "My values. In the past I would have kept quiet. I took the assertiveness training classes. And, when it is really important to me, I will speak up."

The nurses in this study were reflective about why this happened to them. They tried to evaluate their own personality characteristics for a source of blame or an explanation. They acknowledged that fear was one of the things that prevent nurses from taking action, but they each found something within themselves to overcome this fear. Whether it was anger, knowing they had been pushed to their limit, or identifying a value that they couldn't ignore, these nurses found there was something in themselves that led them to resist.

### Coming to resolution

Many of the acts of the resistance that were related to me had taken place in the past, from a few years ago to more than twenty. Yet, when most of the respondents told their stories, the emotions seemed as fresh as if they happened yesterday. All of these nurses were still practicing nurses (Angela, who is editor of a nursing magazine, is the exception), and had come to some sort of resolution. There were two dominant subthemes in the area of coming to resolution. The first subtheme was recognizing accomplishment, that I have called, "I made it!" Some of them were able to look back

with a sense of pride, as well as relief at their accomplishment. The second subtheme expressed by several participants was one of negative consequences. There is some overlap in these subthemes, as several respondents actually identified both positive and negative results from their actions.

"I made it!"

One of the questions that I asked the participants, was whether or not they would take their action again. In answering this question, many reflected on how they felt about what they did. Rosa told me proudly, "They tried to take my self-esteem down. But, I made it! I didn't quit!" Megan smiled, as she thought about her actions with the physicians, saying, "I'm kind of proud of them!" When I asked Jackie how she what kept on through the long legal process, she answered, "I just had a strong belief, I just couldn't do this [float]! It's good just to talk about it. It helps to go back. I really can effect a change! I did learn from it and I hung in there." She admitted that she would take the same course again. Flower agreed that, given similar circumstances, she would participate in a similar action again. Even Jeanine, who had little reflection included in her story, spoke with a bit of pride in her voice. She admitted that even though now she has a full-time position elsewhere, she continues to work per diem at the place in her story just to spite the nurse manager.

Looking back on the experiences now, the participants had a variety of reactions. Some of them related that they feel they have gained wisdom and experience with maturity. Rosa explained,



I think that, as you get older, you deal with things differently than when you were younger! When you are older, you are not afraid to speak up. The younger you are, the more frightened you are to say things. But, when you are older and more educated, you see things broader. And, you can act quicker. And now, I am not the same person.

Megan and Trish agreed that age and experience made them more able to speak up for themselves, especially when it came to dealing with physicians.

Jackie believes that learned a lot from her experiences, and expressed relief at finally being able to tell her story, "It's good to talk about it. I sort of shoved it away when it was all done and really didn't look at the end result and be happy about it." She was able to bring about real change in her work setting, because of her actions. As she thought back on them, she stated, "And I learned a lot. I learned what is legal, the Nurse Practice Act, and resources out there in the community, professional resources." Tamara also reported being glad that she spoke up, "It was good it was off my chest and the subject was closed!"

### Negative consequences

Not all conclusions were positive. Melissa came to realize that she couldn't change the system. "The bottom line is the system is very, very powerful" Trish still felt bad about the way that the other nurses in her unit had responded to the changes that she implemented. She also concluded that she cannot really change her relationship with the physicians, "I've given up thinking that I can change them, I just advocate for my patients." Megan also conceded, that she wasn't going to change the physician that

she had conflicted with, "It was fascinating to me that someone could understand my viewpoint as much as I thought he did and not respect it!"

Many of the respondents were still strongly affected by feelings about their experiences. Diana was the most notable in this category. During our interview, she cried several times, and she related the story in a quiet, sad voice. She reported that she still feels bad, still hurts about the incidents, and still feels castigated. She feels as if she is still labeled the troublemaker. It has impacted her ability to trust others. Diana finds it especially hurtful that while the accusations were public, when the truth came out, it was kept quiet. She also has no respect for nursing administration, because of their role in this. Flower reported that the strike episode was traumatic at the time, and it is still difficult to talk about, because "people treat you differently when you bring up these issues!"

Rosa also suffered a lot of pain throughout the ordeal that she experienced. She explained, "I felt that I was a very good nurse, and whatever they were saying about me was not true. And, I loved nursing so much!" Diana also wondered to herself, why she continued to work in the same institution, "I think probably the only reason that I work I this hospital, is, because, I love being a nurse, I like what I do. And, I can just take it a little bit longer."

The title of this section is creating meaning. Narratives are said to be attempts by the narrator to convey meaning. Reviewing these narratives and how the narrators talked about coming to resolution, I find the results mixed. Some of the participants, such as Jackie, Rosa, Flower, Megan and Angela, were able to find some meaning for

themselves in these experiences. A common pattern for these nurses was that they recognized that were able to face adversity and find something in themselves to overcome it. Later, they were able to look back and learn from what they had done. Diana seemed to find little meaning in her experience. Her words and demeanor conveyed feelings of defeat, even though she seemed satisfied that her actions were both proper and necessary. She still feels the pain and distrust of the incident. She looks within herself for a personality flaw that might have made a difference. She wonders if this happened to her because of racial prejudice.

Another common pattern was the satisfaction that a few of the participants saw because they could see real change from their actions. For Jackie, it meant getting the float policy changed and keeping her job. Angela was able to save her patient. Melissa saw her psychiatric patients get passes, and learn to communicate with their physicians. Flower was part of the hospital employees winning fair wages and benefits. Rosa felt vindicated when the physician was suspended, and she kept her position. The changes that occurred may be interpreted as small and localized, or they may be seen as small steps towards real change.

### Discourse

In addition to the narrative analysis of the four categories in the frameworks of meaning, an additional overriding theme emerged from the data during my numerous times coding and categorizing. The concept of discourse was pervasive throughout the narratives. In fact, I believe that this study could also be one of gendered discourse in healthcare. Nearly every respondent brought up issues of talk. Rubin and Zoloth-

Dorfman (1996) analyzed gendered discourse in healthcare related to ethics consultations, and discussed the following: Who can talk? Where can conversation take place? What can be said? How can things be said? And, how are individuals addressed? I would add questions derived from Scott's (1990) work, what are the official transcripts, and what are the hidden transcripts? Answers to each of these questions emerged from the stories of these nurses.

### Who can talk?

The question of who can talk appeared in many of the stories. In Melissa's story, the patients could talk to the doctors, under very controlled circumstances of time and place. And, the patients had to be very careful of what they said, as a mistake in the content of their talk could affect their actual freedom. Several of the participants noted that staff nurses did not complain directly to managers, instead they complained to some one they perceived as "safe," someone who still might transmit their message. Jackie reported:

And people, as they were floated, would come to me and express concern about safety and their license, and 'should we be doing this?' Because people sometimes have a resistance to going to management, if they feel like they're not going to be listened to — or they just don't have enough bravado to go.

Trish also noted that staff will "bitch and complain" to one another, but not to management. Diana concluded that persons in power, and white people are "heard" more often than those without positions of power and in minorities. Rosa felt that she was not as credible as other nurses with a physician, because she has an accent. Angela

has learned that this is not just an issue within institutions. When she started her magazine, she discovered that hospitals and others want to control what information nurses read. She came to the conclusion that she would forego advertising money from hospitals and drug companies, so that she could control her own editorial content.

Diana was made to sign a paper after her experience saying that she would not speak of the incident with her manager. This has been quite painful for her, and she believes has further damaged her credibility. Jackie also found that she could not talk about her incident. With her, it was not because of a formal agreement, but she feared that new charges could be brought up against her if she spoke up. Flower doesn't speak of her participation in the strike, because she thinks that people would view her negatively.

#### Where can people talk?

The topic of where people can talk also emerged from the narratives. Trish spoke of how the anesthesiologist was able to demean the relatively powerless patient who was a prisoner in front of scores of other professional staff and patients. Trish took a risk by speaking up herself and "dressing down" the physician in front of others. Tamara also reported the story of a physician making disparaging remarks in the nurses' station, in front of an audience. In this case, he was disparaging nurses, and Tamara also spoke up in the same setting. Tamara admitted that the nurses do occasionally talk about this incident - but in the nurses' locker room. For Diana, her conversations with her nurse manager were usually in the privacy of the manager's office.

### What can be said?

What can be said and how things can be said were interrelated in these transcripts. In some settings, managers actually used vulgarity to staff, called them names and even threatened them (Jeanine and Diana). A physicians called his patient a "thing" (Trish) and insulted nursing staff (Tamara). Physicians could go to nursing administration about nursing staff's competency (Rosa), but when the nurses in the ICU with Angela went to administration about an unsafe physician, they were told that they should be good team players.

The subject of address didn't arise in this study, except in the context of Rosa's outburst against the OB physician. At that point, she reportedly told the physician that she would "ride her little a--." This type of address is seldom accepted by M.D.s from nurses!

### Public and hidden transcripts

The stories of the participants revealed many examples of communication consistent with public and the hidden transcripts described by Scott (1990). First, the use of the written word seems to be one means to ensure that issues are made public. This was most evident in Trish's story, where one nurse wrote on the assignment board, what all the other nurses were saying about that one anesthesiologist in private. The response from administration was also written - in the communication book! It was the making public of the issue that was seen as a problem, not the attitude of the physician. Rosa was able to strike back against her tormentor by compiling pages of documentation about her, and Twinkie found that documenting her concerns were the

best action for being heard. Diana's manager produced reams of (unverified) documentation when accusing her, as did Jackie's. Angela founded a magazine to make public concerns of nurses about power issues in healthcare.

There are many examples of hidden transcripts. Melissa's examples of coaching psychiatric patients to "pass" their interviews with their physicians is one example of a hidden transcript. Jeanine found a way to persuade the physicians to schedule Cath Lab appointments that would necessitate keeping an additional room open, in direct conflict with the manager's official communications. She also had examples of staff talking behind the manager's back and having private jokes about him. Jackie discovered the gap between the public and hidden transcripts throughout her experiences. The communication pattern of the staff nurses were part of the hidden transcript, as the staff complained to one another, but not the managers. The public transcript about the Department of Health Services review did not match the reality that Jackie encountered. Additionally, after she took action, she found that other staff members never knew what had happened nor why floating plan had stopped.

#### What do words mean?

Since language is socially mediated, meanings of words can be changed depending on who is using them. Administrators may use euphemisms for unpopular policies to both hide the intent and divert blame. The use of the term flexing found in several transcripts is an example. Flexing has a somewhat positive connotation, sounding like it could be something pleasant. Does it come from another commonly used word in hospital workplaces, such as "flextime" or is it from the definition of

"flex"? A dictionary definition of flextime, describes it as "a system that allows employees to choose their own times for starting and finishing work within a broad range of available hours" (Webster's, 1993, p. 445). However, the definition of flex is, "1. To bend, esp. repeatedly, 2. To move muscles as to cause flexion of a joint; to move or tense by contraction" (Webster's, 1993, p. 445). The term flexing, as used in healthcare institutions, appears to be closer to the definition, "to bend repeatedly." In practice, it is used as a euphemism for sending employees home without pay. Flexing refers to a policy utilized by healthcare institutions to save money. The result is that fulltime nurses have to use their vacation time, or receive less than fulltime pay. This policy must be imposed upon nurses by their colleagues, their nurse managers. Some institutions, as described by both Trish and Jeanine, give the nurses some illusion of control by telling them to decide amongst themselves how to give up their hours.

### Summary

The challenge of a narrative study is finding commonalties in these stories while retaining each participant's individuality and unique voice. I analyzed these transcripts using a variety of methods, making sure that I was intimately familiar with the telling of these stories. At several junctions, I had an "aha" - a sudden insight into the patterns that I was seeing, that would then force me to go back and write out a new interpretation.

In the end, there were many commonalties and much individuality. The narrators chose their stories as exemplary in some way and shaped them to make their point. They had control over the story chosen and how it was said. Because this was a



feminist participatory study, I gave each participant a copy of the transcription and asked them to review it and give me feedback. At least two participants made multiple corrections. They wanted their story and their voice heard accurately. An important part of this study was to give "voice" to these nurses.

Looking for commonalities in the story, a problematic power issue can be found in each of them. For many it was with a manager or a physician. In some way, each participant had to decide what they would do. In some cases, it took a period of introspection and consideration. They may have experienced fear or ambivalence. They weighed the risks to their position, their career and their well-being. Others had little time to weigh consequences, as an event occurred that pushed them over the edge. For some of the participants their initial actions, such as Tamara's speaking up to the physician, resolved the problem immediately. For others, such as Diana, Jackie and Angela, their act of resistance set off retaliatory actions from management that they had to continue to fight.

For nearly all the stories presented, there was a clear end or resolution. However, the meanings that they have created from their experiences are quite varied. Some of the stories still elicit strong emotions from the participants, even when the experiences occurred decades ago. Many of them, such as Jackie, Angela, Megan and Rosa, felt some sense of pride that they had made changes, or just survived. In reviewing their experiences, they all agreed that they would take similar actions again.

In taking stock of these narratives, I went from being hopeful at times to being terribly depressed at others. I felt hope, listening to Jackie's courageous story and how

she was able to make a difference in her institution's floating policy. I felt depressed when I heard Diana and Jeanine talk about their treatment by their nursing colleagues, who were their managers. But, the outrage felt when I first heard some of the stories could actually fade after multiple readings. I wonder if too many in nursing and healthcare have lost their sense of shock and outrage at the stories of our first-line nurses. And, if we shrug our shoulders or minimize these stories, do we minimize these nurses themselves? Or, have we lost our ability to even hear them? And, if we are listening, if we are feeling outrage, and we do nothing ourselves to make real change, what is our role in helping to maintain the status quo, and perpetuate conditions such as these?

## CHAPTER V

### Discussion and Conclusion

This study related and interpreted female staff nurse's stories of their experiences with acts of resistance. I sought to better understand how nurses respond to oppression. These nurses, in relating their stories, told about some incredible experiences in the hierarchical world of healthcare. As the researcher and listener, I was at times shocked, saddened and angered by their stories. However there was also laughter at times, as well as shared satisfaction when they related positive outcomes or feeling vindicated.

In this chapter, I will compare findings from this study to relevant literature and discuss their significance for nursing.

### Implication of Study Findings

Narratives are admittedly subjective. They are one person's account of how an experience unfolded. Yet, narratives can be incredibly powerful. Narratives can humanize and personalize experience. The issues of power, oppression, and nurse abuse discussed in Chapter III become real when related by Jackie, Rosa, Diana, and Angela. We then realize that these are not just academic theories, but the real world as experienced by these nurses. Some readers may find themselves questioning the

"truth" of these participants' stories. Did the managers really say those things? Did that doctor really act like that? These are not the questions that really matter. "These truths don't reveal the past 'as it actually was' aspiring to a standard of objectivity. They give us instead the truths of our experiences" (Personal Narrative Group, 1989, p.261). The important aspect in this type of research is that these stories are ways in which the participants have come to understand the world of nursing and healthcare. It is their interpretations of what it is like to live in this world, and to find ways to act, when treated unfairly. These interpretations dictate the findings of this study.

These narratives tell of nurses' everyday experiences of oppression and their acts of resistance, not as theory, but as lived. In the healthcare organizations in which they work, they identified a clear hierarchy, with the staff nurses and patients at the lowest rung. Economics plays an important role, influencing staffing patterns, workload, and even physicians' treatment of patients. Nurse managers work for the hospital administration, not for the nurses. For many of these nurses, the relationships between them and those higher in the hierarchy are difficult at best, all-out war at worst.

The readers can understand, through these nurses' words, what it must be like to not have control over the pace, context, or amount of their own work. They can perhaps begin to feel what it is like to think that you don't matter, that you are must be like a "peon" to others. They may have an idea of the frustration of dealing with managers who are autocratic and vindictive, with the perception to know that the managers are also in a difficult position, with little support from above.

The importance of communication for these respondents was clear. They told of organizational communication that was not open, but controlled. In their experiences, nurses have to be careful about what they say, and to whom they say it. They listened to their colleagues, realizing that the safest talk was horizontal, staff nurse complaining to staff nurse. And, from their narratives, some understood that fear and ambivalence prevent many from speaking out. Twinkie's somewhat plaintive words recall that most nurses want to be good employees, and the consequences of speaking up and appearing to be the malcontent are too great for most. Melissa reminded us that it is often better to work underground and accomplish things for your patients than to take the risk of resisting openly and losing both your job and your ability to work for your patients. In their worlds, retribution was real, as Jackie and Jeanine found out.

In the end, maybe the most important thing from their narratives is that these nurses did speak up. Admittedly, it took a fair amount of abuse to force their hand. But in the end, they had to follow their consciences and act. The decision to act was difficult for most of them. After taking action, most felt more comfortable with themselves and their decision. And, they all would act the same way again.

### Contributions from the Literature

Even though this study revealed stories of courage from individuals, I don't think that the problems that these nurses faced have individualistic solutions. Turning to two main areas from the literature, additional perspectives can be found relevant to the findings. The first relevant area is the literature on resistance, most notably, Scott's

(1990) work on resistance. Then, because power and resistance are always linked, what follows is my returning to recent literature about power/oppression in nursing.

### Resistance

Scott (1990) described the public and hidden transcripts found in virtually all political systems and organizations. The public transcripts consist of the open interaction between the subordinates and those who dominate. They show things, as the dominants want them to appear. The public transcripts are self-portraits of the dominant elites as they would have themselves seen. These are the communications that appear at formal meetings and in publicity for healthcare systems. They are the onstage communications. It is a goal of the dominants to keep discord out of sight.

Offstage, the subordinates have vastly different communication. "By definition, the hidden transcript represents discourse - gestures, speech, practices - that is ordinarily excluded from the public transcripts of subordinates by the exercise of power" (Scott, 1990, p.27). Scott (1990) concluded that domination actually creates the hidden transcript. And, the more severe the domination, the more rich the accounts of hidden transcripts.

When the hidden transcript becomes public, it can be one of the most explosive of political events. Scott (1990) called this the "rupture of the cordon sanitaire between the hidden and public transcript" (p. 19). Many of the acts in this study were examples of making hidden transcripts public. Speaking up to physicians at nurses' stations, documenting injustices, and calling licensing bodies are all acts that challenged the official transcript of the more powerful.

The key point that Scott (1990) argues is that these hidden transcripts and disguised acts of resistance are means by which the subordinate group is conducting what he calls *infrapolitics*. These *infrapolitics* are as important, in his view, as actively seeking political change (and much safer for the subordinates). He asserted that formal political action can be built from the foundation of these hidden resistances. He also argued that "the appreciation of public and backstage transcripts of the dominant and the weak can illuminate power relations in a novel way" (Scott, 1990, p.202). In this group of eleven participants, nearly all gave examples of hidden transcripts. They mentioned jokes about their managers, nurse-to-nurse complaints, writing comments on assignment boards, and other covert actions. If the power structure in healthcare is as hierarchical as evidenced in this study, and communication as closed, it would seem obvious that healthcare institutions would be replete with hidden transcripts! This may be cause for optimism, as Cuoto (1993) believed that covert resistance may actually prepare people for more overt resistance.

O'Brien (1996) suggested "rightful" resistance as an effective form of resistance in democracies. He portrayed rightful resistance as using the actual rhetoric and values of the powerful against them. Because we have national ideals that are rooted in notions of equality, rights, and rules of law, nurses may be able to call attention to injustices against them by calling forth these very values. Individual nurses may use rightful resistance to resist unfair managers. Nursing as a profession could make stories such as these part of the "public transcript" to promote societal support for real change.

## Oppression

The nurses who related their stories were frustrated by the inequity and injustices in their workplaces. They recognized that the nurse managers were not on "their side." However, they didn't have the language to identify the underlying systemic issues. Turning to the literature, there continue to be articles on studies documenting the existence and the effects of oppressed group status on nurses and nursing (Bent, 1993; Rafael, 1996; Doering, 1992). This viewpoint does not seem to be openly discussed in popular clinical and administrative nursing journals. Instead, it appears in more academically oriented publications, such as Advances in Nursing Science and The Journal of Professional Nursing. One factor influencing this may be the influence of hospital advertisers in many popular journals. As Angela found out, the advertisers from major medical centers went to a "public transcript" that is favorable to them.

Because many staff nurses are not commonly exposed to this literature, the conditions that they must deal with in their day-to-day work life becomes "taken for granted." They recognize that things are not right but have not identified the problem as a systemic one. Popular views of power in nursing mirror Lukes' (1974) dimension one view. In this view, the nonparticipation in the power structure is seen to be the fault of the nonparticipant due to apathy, lack of experience, or skill (Varcoe, 1996). Nurses' inability to participate in decision making or to gain power, can be blamed on nurses themselves. Powerlessness is explained as a lack of knowledge, communication skills, or political expertise. Nurses have adopted theories and solutions that stress



changing individuals. Examples are theories of learned helplessness or classes on assertiveness. Twinkie provided us with an example when she told of seeking an assertiveness class to help her with these issues. The experienced nurses had also found individual ways over the years to communicate with physicians, as evidenced from the narratives of Trish and Megan.

Another common avenue utilized to attempt change has been to seek more power. Too often this means aligning with the more powerful groups, medicine, and administration. The traditional brokers of power in healthcare are largely male, or identify with what are traditionally identified as esteemed properties of masculinity: separation, strength, and control (Rafael, 1996). Therefore, to seek power, nurses must devalue traditional feminine characteristics and reject the caring, connected essence of nursing. Nurses are encouraged to become marginal in order to be accepted by the dominant culture. The dilemma has been that nurses who seek power through administrative advancement have had to separate themselves from other nurses (Bent, 1993). While many of these nurses enter this world with the hope of bringing both feminine and nursing issues into a more powerful position, these issues are not valued by the dominant groups, and the nurse leaders can lose their credibility if they do not adopt the dominant values. The findings from this study reinforce these notions about the marginality of nurse leaders and the oppressive power of the healthcare system.

#### Importance to Nursing

This study related the stories of women who have found the courage to resist in the face of domination, to speak up about an injustice or inequity in their workplace,

despite evidence of potential retribution. On the one hand, the findings can be discouraging. Hearing the firsthand stories of these nurses makes the oppression and power issues that we deal with more real. The optimistic view of these findings is that the hidden transcripts, that Scott (1990) found to be so fraught with possibilities, are evident throughout the narratives.

Rafael (1996) pointed out that patriarchy, as a system that justifies male dominance and the valuing of male characteristics and activities, permeates all human activity. Therefore, nursing's educational system, practice settings, and research grants are all influenced by the patriarchal view. It can be highly unpopular (and potentially career ending) to discuss or expose beliefs counter to the dominant view. However, as the nurses in this study found, resistance is possible and can bring about real change. Nurses need to find ways to recognize the impact of oppression and to promote effective resistance in their work world, in healthcare, and beyond.

### Education

I believe that alternative paradigms and approaches to knowledge must be incorporated in all areas of nursing education. Nursing educators such as Diekelman (1990) and Hedin (1989) have suggested incorporating educational methods that don't replicate the system of oppression. Nurses and nursing students need to learn to look critically at the ideology that have been perpetuated in our profession. Alternative ways of knowledge development, including critical theory, feminism, and postmodernism, need to be included at all levels of nursing education. Courses that espouse the teaching of nursing leadership must also present alternative views of power and critique the

numerous administrative nursing research studies that use biased tools to measure power. In addition to utilizing nursing's administrative and organization literature that incorporates critical, feminist, and postmodern views, nurses need also to be exposed to literature about organizational change and leadership from a variety of fields that incorporate those approaches (Hassard & Parker, 1993; Wilson, 1992, Lincoln, 1989).

#### Nursing practice and administration

Both feminism and critical theory promote consciousness raising as the first step in making change. Nurses must become more vocal about supporting one another and avoiding horizontal violence. Existing hierarchies that value nurse practitioners or ICU nurses more than home health or extended care nurses must be exposed for what they are — evidence of nurses' self-hatred. If nurses — managers in particular — could recognize that resistance is always present and can be a tool of change, it might be possible to make the staff nurse-manager relationship more open.

Habermas's critical theory of distorted communication seems to be one answer (Held, 1980). Openness in communication must prevail. Areas of distorted communication must be identified, opened to critique, and eliminated. We nurses must somehow break out of the silent, invisible arena to which we have been relegated and speak openly and collectively. We must strive to create conditions where communication is not inhibited by fears of retribution. We are all responsible for creating the social conditions that create autonomy and emancipation and that allow others to speak as freely as we do (Allen, Benner & Diekelmann, 1986).

## Research

The current emphasis for knowledge development and research in nursing and healthcare has been on empirical approaches that emphasize outcomes, quantitative methodologies and large-scale funding. Agencies that fund research, such as the National Institutes for Health, not only emphasize empiricism and quantification, but have increasingly called for clinical studies that demonstrate measurable outcomes.

Additionally, the very concept of utility of nursing research has favored the quantitative view (Sandelowski, 1997). Nurse researchers desiring to develop funded research programs and further their careers must of necessity follow these directives. However, I believe that it is imperative, for the very survival of the nursing profession to further develop the emancipatory approaches to knowledge development and research found in feminist, critical theory and postmodern methods.

There are many reasons to expand these approaches in nursing. In contrast to the traditional, objective views of positivistic ways of knowing, these alternative paradigms insist that knowledge is never really objective, but is subjective and socially constructed. For nursing to ascribe to the traditional views exclusively would mean recreating the current patriarchal structure and its concomitant world views of objectivity, dualism, and separateness. The alternative paradigms make it possible for people to see the world through an enlarged perspective. Therefore, I would make four arguments in favor of the expansion of critical theory, feminism and post-modernism in nursing research.

First, these methods can help to insure that divergent voices are heard in healthcare. Changes in healthcare towards an increased emphasis on economics has

spawned managed care, health maintenance organizations, and new payment methods. The effect on patients or healthcare workers in this era, has hardly been addressed.

Emancipatory methodology could emphasize the human factors in these directions.

Furthermore, alternative research paradigms could focus on those outside the managed care system, including uninsured groups such as the underemployed and migrant workers.

Next, there is a tremendous need to question how we can foster human caring in an increasingly technological healthcare system. A critical theoretical perspective would ask questions about ways in which technology has objectified the individual in health care. Feminist methods could raise issues involved in new reproductive technologies, including who controls these technologies and whose power interests are served.

The third argument in favor of expanding these methodologies is the need to identify power interests in healthcare organizations. Nurses involved in organizational research have typically replicated current power relations, rather than examining structures through a critical or postmodern view. In these perspectives, the influence of language and discourse, would be examined. For example, a critical organizational analysis could focus on how decisions about nurse staffing and nurse roles are made.

Finally, I think that the ultimate value of these paradigms is that they ask the alternative questions that don't emerge in empirical science. Instead of asking how healthcare providers can better influence patients' healthcare decisions, nurses would ask what are they trying to influence and why? What do patients hope to achieve in their encounters with the healthcare system? Instead of asking how nurses view power, as so many have, researchers will ask, who is benefitting from current power structures? The

questions that can be asked from this viewpoint are endless. Nursing just needs to continue to teach and utilize these research methods.

Furthermore, I believe that the concept of resistance as well as power in healthcare needs further study. However, problems remain in continuing in this area. One of the key problems is that these issues are not ones that the dominants or the elites want opened up. Additionally, research money in this area would be very difficult to obtain. However, I remain convinced that more research needs to be done in this area, if nurses are ever to bring about real change in their work world. If I continue research in the area of resistance, I would propose two divergent studies. First, I believe there would be value in conducting survey research to further document the scope of the problem. Additionally, even though I am not generally interested in quantitative research, I would like to pursue developing a tool to identify resistance, based on the concepts of Scott (1990) and O'Brien (1996). The tool might be used for survey research on a large basis, identifying issues of resistance in nursing across the country. An action research study involving staff nurses could provide insight into how real change might occur. The study participants could observe and discuss public and hidden transcripts in their unit, and then decide on how to make effective changes. However, it would take a highly enlightened administration to gain access for such a study.

My current plans for research are to continue in the area of feminism and critical theory, seeking further narratives from nurses on ways that they adjust to hegemonic oppression. I plan to develop a narrative study of nurses' friendships with

other nurses and the impact that these friendships have on the women and their work. Some prior work has been done in this area (Chinn, Wheeler, Roy, & Madsen, 1988), but none has focused on indepth narratives of nurses' experiences in this area.

However, my immediate, first step after completing this research is to make it public. I hope to publish the findings and present them at conferences. The underlying purpose of giving voice to these nurses and seeking to make real change cannot be realized if the information is not shared.

### Conclusion

In the end, what does this all mean? I would return to the words of the Personal Narratives Group. "No more elegant tool exists to describe the human condition than the personal narrative" (1989, p. 239). I would like to think that the women who participated in this study are hoping that their words might actually change the hearts of men and women who they have reached. Because, why, in the last year of the 20th Century, in a country that espouses ideals of equality, fairness, and democracy, do we allow so much inequity in a work world that is supposed to be about our most important human experiences — birth, death, caring, and health? Why is there not more outrage when a physician "hits at" the hand of a nurse, or when a manager calls his staff by using vulgarities? Why don't we all rise up in protest when unprepared nurses are floated to care for the most fragile of lives? Why have we remained silent for so long?

In an Ann Landers newspaper column on October 13, 1998, letters from nurses across the country were published. The letters were full of despair and disappointment

with nursing. Ann Landers made public, what so many nurses know to be the hidden transcripts of healthcare! Nurses deal daily with the effects of oppression and patriarchy. Could the narratives of these nurses make public some of the information that is kept hidden? Could they finally cause enough outrage, that nurses look at one another and ask, why do we continue to tolerate these conditions? Could they finally shatter the self-satisfied image we are projecting to the public and compel a revisionary reading of our collective experience as women and as nurses. I sincerely hope so. I hope that for the nurses who told these narratives, for all of us, and for our patients.



## REFERENCES

Allen, D. (1986). Using philosophical and historical methodologies to understand the concept of health. In Chinn, P., Ed., Nursing Research Methodology. Rockville, MD: Aspen Publishing.

Allen, D. (1996). Knowledge, politics, culture and gender: A discourse perspective. Canadian Journal of Nursing Research, 28 (1), 95-102.

Allen, D., Benner, P. & Diekelmann, N. (1986). Three paradigms for nursing research. In P. Chinn (Ed.), Nursing Research Methodology. Rockville, MD: Aspen Publishing.

Aptheker, B. (1989). Tapestries of Life: Women's Work, Women's Consciousness, and the Meaning of Daily Life. Amherst: University of Massachusetts Press.)

Ashley, J. (1973). This I believe: About power in nursing. American Journal of Nursing, 21(10), 637-641.

Ashley, J. (1976). Hospitals, Paternalism and the Role of the Nurse. New York: Teachers College Press.

Attridge, C. & Callahan, M. (1989). Women in women's work: Nurses, stress and power. Recent Advances in Nursing, 23, 41-69.

Banks-Wallace, J. (1998). Emancipatory potential of storytelling in a group. Image: Journal of Nursing Scholarship, 30(1), 17-21.

Bent, K. (1993). Perspectives on critical and feminist theory in developing Nursing praxis. Journal of Professional Nursing, 9, 296-303.

Branch, T. (1988). Parting the Waters: America in the King Years 1954-63. New York: Simon and Schuster.

Brown, B. (1996). Anger: Nurses Hidden Secrets. (Working paper presented at Seventh Annual International Critical and Feminist Perspectives in Nursing Conference).

Campbell, J. & Bunting, S. (1991). Vices and paradigms: Perspectives on critical and feminist theory in nursing. Advances in Nursing Science, 13(3), 1-15.

Chinn, P. (1989). Nursing patterns of knowing and feminist thought. Nursing and Health Care, 71-75.

Chinn, P., Wheeler, C., Roy, A. Berrey & Madsen, C. (1988). Friends on friendship. American Journal of Nursing, 88(8), 1094 -1096.

Chinn, P. & Wheeler, C. (1985). Feminism and nursing. Nursing Outlook, 33(2), 74-77.

Collins, P. (1990). Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment. New York: Routledge.

Couto, R. (1993). Narrative, free space and political leadership in social movements. The Journal of Politics, 55(1), 57-79.

Cox, H. (1991). Verbal abuse nationwide, Part I: Oppressed group behavior. Nursing Management, 22(2), 32-35.

Diaz, A.L. & McMillin, J.D. (1991). A definition and description of nurse abuse. Western Journal of Nursing Research, 13, (1), 97-109.

Dickson, G. (1994). Postmodernism: An Approach for Nursing Research? (Working paper presented at: Fifth Annual Critical and Feminist Perspectives in Nursing Conference., Bothell, Washington).

Diekelmann, N. (1990). The emancipatory power of narrative. In: Curriculum Revolution: Community Building and Activism. (No. 15-2398). New York: National League for Nursing Press.

Doering, L. (1992). Power and knowledge in nursing: A feminist poststructuralist view. Advances in Nursing Science, 14(4), 24-33.

Dykema, L. (1985). Gaventa's theory of power and powerlessness: Application to nursing. Occupational Health Nursing. September 1985, 443-446.

Eisler, R. (1987). The Chalice and the Blade. New York: HarperCollins.

Farley, M. (1987). Power orientations and communication style of managers and nonmanagers. Research in Nursing and Health, 10, 197-202.

Fonow, M. M. & Cook, J. A. (1991). Beyond Methodology: Feminist Scholarship as Lived Research. Bloomington and Indianapolis, IN: Indiana University Press.

Foucault, M. (1978). The History of Sexuality: Volume I: An Introduction. New York: Random House.

Freire, P. (1990). Pedagogy of the Oppressed. New York: Continuum.

French, M. (1985). Beyond Power: On Women, Men and Morals. New York: Ballantine Books.

Garon, M., Kodiath, M., Laverdiere, J., Magruder, K., Newell, M. & Joyce, M. (1998). An Exploratory Study of Nurses Experiences of Power and Powerlessness. (Unpublished paper).

Gaventa, J. (1980). Power and powerlessness: Quiescence and rebellion in an Appalachian Valley. Chicago: University of Illinois.

Giroux, H. (1983). Theory and Resistance in Education: A Pedagogy of the Opposition. South Hadley, Mass: Bergin & Garvey Publishers, Inc.

Gray, D. P. (1992). A feminist critique of Jean Watson's theory of caring. In Thompson, L., Allen, D. & Rodrigues-Fisher, L., Eds., Critique, Resistance and Action: Working Papers in the Politics of Nursing. New York: National League for Nursing Press, Pub. No. 14-2504.

Guba, E. G. (Ed.). (1990). The Paradigm Dialog. Thousand Oaks, CA: Sage Publications.

Gutmann, M. (1993). Rituals of resistance: A critique of the theory of everyday forms of resistance. Latin American Perspectives, 20, 74-92.

Habermas, J. (1979). Communication and the Evolution of Society. Translated by T. McCarthy. Boston: Beacon.

Hall, J. & Stevens, P. (1991). Rigor in feminist research. Advances in Nursing Science, 13(3), 16-29.

Hartsock, N. (1990). Foucault on power: A theory for women? In Linda J. Nicholson (Ed.), Feminism/Postmodernism. New York: Routledge, Chapman & Hall, Inc.

Hassard, J. & Parker, M. (1993). Postmodernism and Organizations. Newbury Park, CA: Sage Publications.

Hedin, B. A. & Donovan, J. (1989). A feminist perspective of nursing education. Nurse Educator, 14 (4), 8-13.

Heilbrun, C. (1988). Writing a Woman's Life. New York: Ballantine Books.

Heineken, J. (1985). Power: Conflicting views. Journal of Nursing Administration, 15(11), 36-39.

Heineken, J. & McCloskey, J. (1985). Teaching power concepts. Journal of Nursing Education, 24(1), 40-42.

Heineken, J. & Wozniak, D. (1988). Power perceptions of nurse managerial personnel. Western Journal of Nursing Research, 10(5), 591-599.

Held, D. (1980). Introduction to Critical Theory: Horkheimer to Habermas. Berkeley, CA: University of California Press.

Henderson, D. (1995). Consciousness raising in participatory research: Method and methodology for emancipatory nursing inquiry. Advances in Nursing Science, 17(3), 58-69.

Herngren, P. (1993). Path of Resistance: The Practice of Civil Disobedience. Philadelphia, PA: New Society Publishers.

Hiraki, A. (1992). Language and the reification of nursing care. In Thompson, L., Allen, D. & Rodrigues-Fisher, L., Eds., Critique, Resistance and Action: Working Papers in the Politics of Nursing. New York: National League for Nursing Press, Pub. No. 14-2504.

hooks, b. (1984). Feminist Theory: From margin to center. Boston: South End Press.

Ingraham, D. & Simon-Ingraham, J. (1992). Critical Theory: The Essential Readings. New York: Paragon House.

Jacques, R. (1993). Untheorized dimensions of caring: Caring as a structural practice and caring s a way of seeing. Nursing Administration Quarterly, 17 (2), 1-10.

Josselson, R. & Lieblich, A. (Eds.). (1995). Interpreting Experience: The Narrative Study of Lives. (Vol.3). Thousand Oaks, CA: Sage Publications,

Lerner, G. (1986). The Creation of Patriarchy. New York: Oxford University Press.

Lincoln, Y. (1989). Critical requisites for transformational leadership. Peabody Journal of Education, 66(3), 176-181.

Lukes, S. (1974). Power: A Radical View. London: The MacMillan Press Ltd.

McMahon, R. (1990). Power and collegial relations among nurses on wards adopting primary nursing and hierarchical ward management structures. Journal of Advanced Nursing, 15, 232-239.

McNay, L. (1992). Foucault and Feminism: Power, Gender and the Self. Boston: Northeastern University Press.

Melosh, B. (1982). The Physician's Hand: Work Culture and Conflict in American Nursing. Philadelphia: Temple University Press.

Merriam-Webster's Collegiate Dictionary (10th ed.). (1993). Springfield, MA: Merriam-Webster.

Miller, J. (1991a). The construction of anger in women. In Jordan, J., Kaplan, A., Miller, J.B., Stiver, I. & Surrey, J., Eds. Women's Growth in Connection: Writings from the Stone Center. (Pps 181-196) New York: The Guilford Press.

Miller, J. (1991b). Women and power. In Jordan, J., Kaplan, A., Miller, J.B., Stiver, I. & Surrey, J., Eds. Women's Growth in Connection: Writings from the Stone Center. (Pps 197-205) New York: The Guilford Press.

Nonini, D. (1988). Everyday forms of resistance. Monthly Review, 40 (6), 25-36.

Oakley, A. (1986). Telling the Truth about Jerusalem: A Collection of Essays and Poems. New York: Basil Blackwell.

O'Brien, K. (1996). Rightful resistance. World Politics, 49, pp. 31-55.

O'Neill, S. (1992). The drive for professionalism in nursing: A reflection of classism and racism. In Thompson, L., Allen, D. & Rodrigues-Fisher, L., Eds., Critique, Resistance and Action: Working Papers in the Politics of Nursing. New York: National League for Nursing Press, Pub. No. 14-2504.

Palmer, D.P. (1997). Structuralism and Poststructuralism for Beginners. New York: Writers and Readers Publishing, Inc.

Parse, R. R. (1996). Building knowledge through qualitative research: The road less traveled. Nursing Science Quarterly, 9 (1), 10-16.

Personal Narratives Group (1989). Interpreting Women's Lives: Feminist Theory and Personal Narratives. Bloomington and Indianapolis, IN: Indiana University Press.

Polkinghorne, D. (1988). Narrative Knowing and the Human Sciences. Albany, NY: State University of New York Press.

Prescott, P. & Dennis, K. (1985). Power and powerlessness in hospital nursing departments. Journal of Professional Nursing, November-December, 348-355.

Rafael, A. F. (1996). Power and Caring: A Dialectic in Nursing. Advances in Nursing Science, 19(1), 3-17.

Reed, P. G. (1995). A treatise on nursing knowledge development for the 21st century: Beyond postmodernism. Advances in Nursing Science, 17(3), 70-84.

Reimer, J., Morrissey, N., Mulcahy K. & Bernat, A. (1994). Power orientation: A study of female nurse and non-nurse managers. Nursing Management, 25(5), 55-58.

Reinharz, S. (1992). Feminist Methods in Social Research. New York: Oxford University Press.

Riessman, C. (1993). Narrative Analysis. Newbury Park, CA: Sage Publications.

Reverby, S. (1987). Ordered to Care: The dilemma of American nursing, 1850-1945. Cambridge, MA: Cambridge University Press.



Roberts, J. & Group (1995). Feminism and Nursing: An Historical Perspective on Power, Status, and Political Activism in the Nursing Profession. Westport, CT: Praeger.

Roberts, S. (1983). Oppressed group behavior: Implications for nursing. Advances in Nursing Science, 5(7), 21-30.

Rubin, S. & Zoloth-Dorman, L. (1996). She said/He said: Ethics consultation and the gendered discourse. The Journal of Clinical Ethics, 7(4), 321-332.

Sampselle, C. (1990). The influence of feminist philosophy on nursing practice. Image: The Journal of Nursing Scholarship, 22(4), 243-247.

Sandelowski, M. (1997). "To be of use": Enhancing the utility of qualitative research. Nursing Outlook, 45, 125-132.

Sands, D. & Ismeurt, R. (1986). Role alienation: Staff nurses and powerlessness. Nursing Management (Critical Care Edition), 17(5), 42J-42P.

Scott, J. (1990). Domination and the Arts of Resistance: Hidden Transcripts. New Haven, CT: Yale University Press.

Secrist, J. (1993). Voices of Midlife Tomboys: A Narrative Study. (Unpublished dissertation, University of San Diego).

Smith, M., Droppleman, P. & Thomas, S. (1996). Under assault: The experience of work-related anger in female registered nurses. Nursing Forum, 31(1), 22-33.

Sonnleitner, M. (1986). Gandhian Nonviolence: Levels of Satyagraha. New Delhi: Abhinav Publications.

Strauss, A. & Corbin, J. (1990). Basics of Qualitative Research. Newbury Park, CA: Sage Publications.

Street, A. (1992). Inside Nursing: A Critical Ethnography of Clinical Nursing Practice. Albany, NY: State University of New York Press.

Thomas, S. & Droppleman, P. (1997). Channeling nurses' anger into positive interventions. Nursing Forum, 32, (2), 13-21.

Thompson, J. (1987). Critical scholarship: The critique of domination in nursing. Advances in Nursing Science, 10 (1), 27-38.

Tisdell, E. (1993). Feminism and adult learning: Power pedagogy and praxis. New Directions for Adult and Continuing Education, 57, 91-103.

Turkoski, B. (1992). A critical analysis of professionalism in nursing. In Thompson, L., Allen, D. & Rodrigues-Fisher, L., Eds., Critique, Resistance and Action: Working Papers in the Politics of Nursing. New York: National League for Nursing Press, Pub. No. 14-2504.

Varcoe, C. (1996). Theorizing oppression: Implications for nursing research on violence against women. Canadian Journal of Nursing Research, 28(1), 61-78.

Webster's Third International Dictionary. (1986). Springfield, MA: G.& C. Merriam Co.

Wilson, F. (1992). Language, technology, gender and power. Human Relations, 45(9), 883-904.

## APPENDIX A

### INTERVIEW GUIDE

1. I am interested in your story about a time when you spoke up or did something about an injustice or inequity at your workplace.....

(For example, in a place that I worked a number of years ago....the staff nurses were very unhappy with some aspects of the Head Nurse's leadership and some of the unit policies. The morale on the unit was very low, the Head Nurse was very authoritarian in her approach, and there was not a feeling of collegiality. The staff nurses called a meeting outside the hospital and nearly all the staff that was off attended. We made a list of the problems and proposed solutions, and brought them back to present to her at a staff meeting. We felt very collegial in deciding to do this, and in being so supportive of one another. We also felt proud that we were not making this a personal issue, but doing some real problem solving for the good of the unit! I don't want to discuss the outcome of this venture, but want to offer it up as the kind of action that I am interested in! Can you think of any similar situation that you might have participated in?)

2. Who could you talk to about this? Have you spoken of it, since? To whom, and under what conditions?

3. What were the results of your actions?

4. What were your feelings about these experiences at the time?

5. What was it about that situation that led you to speak out (or act)? Would you do it again? Have you had other similar experiences? Did you take similar actions?

#### Demographics:

Age: 21-30 \_\_\_\_\_, 31-40 \_\_\_\_\_, 41-50 \_\_\_\_\_, 51-60 \_\_\_\_\_, over 60 \_\_\_\_\_

Years of Nursing Experience: 0-9 \_\_\_\_\_, 10-19 \_\_\_\_\_, 20-29 \_\_\_\_\_, 30-39 \_\_\_\_\_,  
over 40 \_\_\_\_\_

Health care setting: Independent hospital or medical center \_\_\_\_\_

HMO or group practice \_\_\_\_\_

Government/military hospital \_\_\_\_\_

University affiliated medical center \_\_\_\_\_

Large multi-site organization \_\_\_\_\_

Free standing clinic \_\_\_\_\_

Other \_\_\_\_\_

## APPENDIX B

Demographics

Pseudonym	Age Range	Years of Experience
Megan	41 - 50	20 - 29
Melissa	41 - 50	30 - 39
Jeanine	41 - 50	10 - 19
Flower	41 - 50	10 - 19
Jackie	41 - 50	20 - 29
Trish	41 - 50	20 - 29
Angela	41 - 50	20 - 29
Tamara	31 - 40	10 - 19
Diana	41 - 50	20 - 29
Twinkie	31 - 40	0 - 9
Rosa	41 - 50	10 - 19



## APPENDIX C

## University of San Diego

## Committee on the Protection of Human Subjects

**Project Action Summary****Action Date:** June 9, 1998*Note: Approval expires one year after this date.***Type:**      ☐ New Full Review    ☒ New Expedited Review    ☐ Continuation Review**Action:**      ☒ Approved    ☐ Approved Pending Modification    ☐ Not Approved

1998-06-068

Ms. Maryanne Garon SD-N

Acts of Resistance: Female Nurses Acts of Resistance

Dr. Jane M. Georges FA-N

*Note: We send CPHS correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.*

**Modifications Required or Reasons for Non-Approval**

None.

The next deadline for submitting project proposals to the Provost's Office for full review is \_\_\_\_\_.  
You may submit a project proposal for expedited review at any time.

\_\_\_\_\_  
Gary P. Schneider

Chair, Committee on the Protection of Human Subjects

## APPENDIX D

### CONSENT TO ACT AS A RESEARCH SUBJECT

Maryanne Garon R.N., M.S.N., a doctoral student at the University of San Diego, is conducting a study to find out more about nurses' acts of resistance. I understand that I have been asked to take part because I am a nurse who may have experienced these issues. Demographic information will be collected, as well as a taped interview.

I understand that if I choose to participate in this study:

1. No risks are anticipated.
2. Participation in this study is entirely voluntary and I may withdraw at any time.
3. I will have the opportunity to ask questions and seek clarification before I agree to participate.
4. I will be interviewed by the investigator, and my responses will be audiotaped.
5. Interviews will be approximately 30 - 60 minutes in length.
6. All comments and responses will be confidential. A pseudonym will be used in place of my name and any others involved in the dialog.
7. I will be asked to review the transcript of my interview to correct statements I believe are incorrect or to delete information I do not wish included in the study.

I will not receive payment for participation.

There will be no direct benefit to me from this study. The investigator may learn more about how nurses experience acts of resistance.

I, the undersigned, understand the above explanation, and on that basis, I give consent to my voluntary participation in this project.

\_\_\_\_\_  
Signature of study participant (subject)

\_\_\_\_\_  
date

\_\_\_\_\_  
Signature of researcher

\_\_\_\_\_  
date

\_\_\_\_\_  
Signature of witness

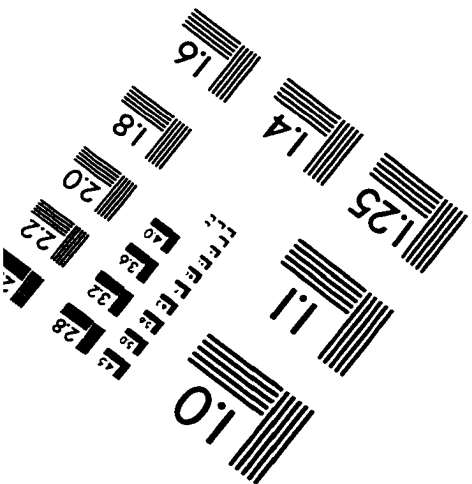
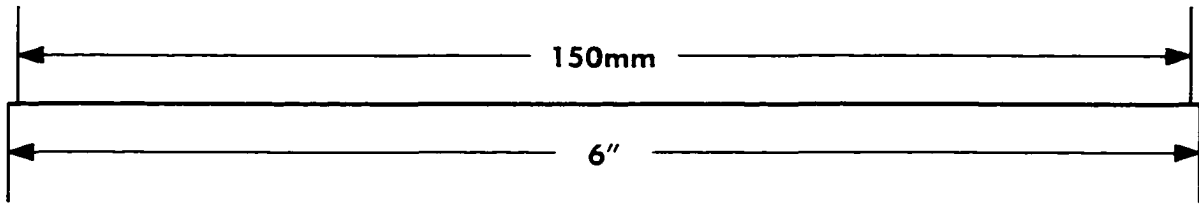
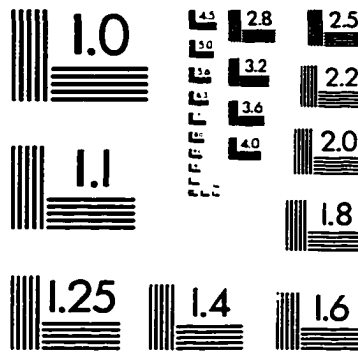
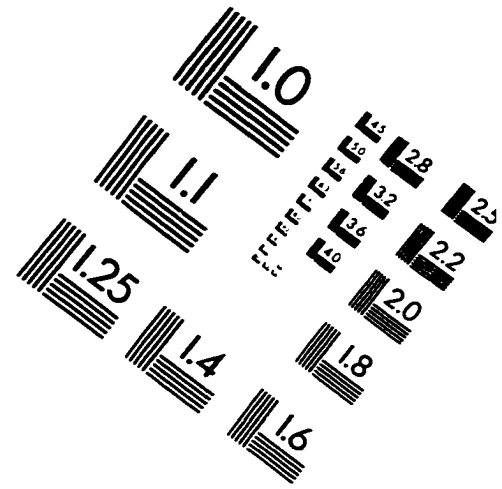
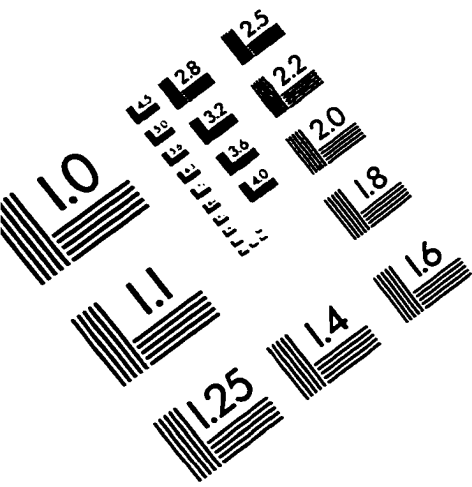
\_\_\_\_\_  
date

## APPENDIX E

### GLOSSARY OF HEALTHCARE TERMS OR ABBREVIATIONS USED IN THIS STUDY

B.R.N.	Board of Registered Nursing, the state licensing body for professional nurses.
Cath Lab	A specialized procedure unit, where procedures such as cardiac catheterizations are performed.
Charge Nurse	The nurse in charge of a unit, usually on a shift-by-shift basis.
Head Nurse	Traditional term for nurse manager of An organizational area in a hospital.
ICU	Intensive care unit.
I.V.	Intravenous. Usually refers to intravenous lines, or medication given directly into the veins.
M.D.	Medical Doctor.
NICU	Neo-natal intensive care unit.
NP	Nurse practitioner, a registered nurse with additional education who is prepared for advance practice with more independent decision making and accountability.
OB	Obstetrics, refers to the care of women during pregnancy and childbirth.
PACU	Post-anesthesia care unit. A patient care unit where patients are recovered following administration of anesthesia.
STAT	Abbreviation for <u>statim</u> , immediately.

# IMAGE EVALUATION TEST TARGET (QA-3)



APPLIED IMAGE, Inc.  
1653 East Main Street  
Rochester, NY 14609 USA  
Phone: 716/482-0300  
Fax: 716/288-5989

© 1993, Applied Image, Inc., All Rights Reserved

