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The tension between person centred and task focused care in an acute surgical setting: A critical ethnography

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ABSTRACT

Problem: Person centred care is a key indicator of quality care and a policy direction in many hospitals yet some patients experience care that falls short of this standard.
Background: Health services worldwide are prioritising the delivery of person centred in order to address historical concerns over patient safety and quality care and to improve workplace morale. Workplace culture is known to affect nurses' care giving.
Question: This research aimed to uncover the cultural factors that hindered or facilitated the delivery of person centred care in an acute setting and answer the question: How does workplace culture influence nurses' delivery of person centred care?
Methods: Critical ethnography provided the philosophical and methodological framework. Data were collected through participant observation, individual and focus group interviews, examination of care planning documents. Data were analysed hermeneutically and critically to make tacit cultural knowledge explicit and to suggest ways to reconstruct the culture of this specific nursing unit.
Findings: Nurses organised their work in response to the urgency of the task at hand and nursing routines. People who received that care were rarely included in planning care.
Discussion: Task focused ways of working can predominate in workplace cultures where an emphasis is placed on efficiency. Efficiency is part of the neoliberalist health care agenda and it stands in contrast to ideals of person-centred effectiveness because the latter may actually slow down procedures and require holistic approaches, rather than segmented care. Efficiency in this study appeared to be reinforced by an embedded and naturalised cultural practice amongst the nurses, which was to value fast-paced and completed tasks, because of the recognition it would receive from peers. Yet it also constituted a tension and bind for the nurses because the failure to be person-centred meant their professional values were unmet, and this led to moral distress and workplace dissatisfaction. If nurses were assisted to develop recognition of competing discourses in their work, and rationales to support a values-based practice, it is likely that they could be empowered to resist the status-quo and actually achieve the aspirations outlined in person-centred care rhetoric.
Conclusion: Organisations and individuals striving for person-centred care need to develop awareness of the social and political forces that shape and constrain practice, in order to approach their work more consciously and critically.

Summary of relevance

Issue

Person centred care is intrinsic to effective nursing practice and a key indicator of quality care.

What is Already Known

Nurses value person-centred care but are frustrated in their achievement of it. It remains unknown what specific factors occur in their working life and culture that act as barriers.

What this Paper Adds

Dominant, naturalised discourses that operate within health care, such as neoliberalism, value efficiency over effectiveness and are a potential barrier to the delivery of person centred care. Nurses unwittingly are co-opted into this discourse whenever they themselves reinforce a task-focus over person-centred effective-

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ness. Nurses lack the awareness and the language to articulate the sources of their distress in being unable to implement the values they aspire to.

1. Introduction

The nursing profession has a philosophical tradition where care and compassion are regarded as core. Indeed in Queensland, Australia, the Chief Nursing and Midwifery Officer, Dr Frances Hughes, stated in 2013 'Nurses in Queensland are renowned for their patient-centred care based on their intrinsic values' (Hughes, 2013). Equally, popular discourse depicts nurses as caring, altruistic and even angelic (Hallam, 2000; Summers & Summers, 2015). Yet not all patients experience this level of nursing care. A brief examination of some popular press reveals numerous reports where patients did not receive person centred care and even suffered neglect or abuse (Coward, 2013; Patterson, 2012; Smith, 2002). Commentators have since posed challenging questions to nursing, suggesting that the modern nurse is too soft, too posh, and not fit for the work required (Coward, 2013; Patterson, 2012; Smith, 2002). Some even accuse nurses of rejecting their professional and philosophical mandate to care (Coward, 2013; Patterson, 2012).

Although Hughes' comment is positive and motivating, her use of the word 'intrinsic' has an unfortunate implication that caring is natural or a simple matter for nurses, and, similarly that person centred care is dependent on personal values. Such a statement ignores the extra-personal factors that shape the context of care delivery; including organisational culture, a neoliberalist discourse that favours efficiency and outcomes, and rising patient acuity paired with short-staffed units (Goodman, 2014). Indeed, findings from several high profile health care scandals indicate that the manner in which nurses approach patient care is determined to a large extent by the shared philosophies and ways of doing things in the organisation and the particular setting in which they work (Davies, 2005; Garling, 2008; Francis, 2013; Walker, 2004). Furthermore workplace culture, rather than personal failings, profoundly impact on the quality of patient care (Francis, 2013). Thus, workplace culture can either facilitate or impede person centredness.

Cultural expectations and norms influence human behaviour without people being aware of this. Accordingly, as much as people believe they have the free will to behave as they choose, people's behaviour is usually predictable and conforms to societal or cultural expectations (Hardcastle, Usher, & Holmes, 2005). Similarly, culture not only directs people's behaviour but 'shapes and limits morality', indicating that what people value and place importance on is also culturally appropriated (Berghs, Dierckx de Casterlé, & Gastmans, 2006; p. 117.). As Nesbit (2012) reminds us our worldview derives from social interaction. In this regard social interaction and workplace culture appear to significantly affect nurses' individual and collective actions and beliefs. In turn culture itself is a product of social interactions and reinforced or reproduced in subtle ways (Forester, 1992). Thus, people are influenced by the culture they operate in and also perpetuate that culture, indicating why changing a culture is so difficult. It is therefore likely that a cultural inquiry, specifically critical ethnography, may illuminate and deepen understanding about this vexing problem.

1.1. Previous research

Previous research has noted an inconsistency between nurses' espoused values and practice and has highlighted that workplace culture can inhibit nurses from practicing in ways that are consistent with their value stance (Milton-Wildey & O'Brien, 2010; Dempsey, 2009). In these studies workload concerns and pressures led nurses to perceive that they had insufficient time to care for patients in the way they desired (Abdelhadi & Drach-Zahavy, 2012; Milton-Wildey & O'Brien, 2010; Dempsey, 2009). Furthermore nurses believed they were powerless to effect positive change in their workplace. It is known that feelings of powerlessness reduce the quality of patient care and can cause nurses to practice in ways to which they are opposed (Abdelhadi & Drach-Zahavy, 2011; Milton-Wildey & O'Brien, 2010; Dempsey, 2009). Examples might include taking risks with patient safety or failing to meet people's individual needs. However, what is not known about the dynamics that impact upon, and become barriers to care, are the specific mechanisms and structures inherent in workplace culture that influence nurses' beliefs, values and care giving behaviour. Therefore the research question underpinning this critical ethnography became: what assumptions and institutions of power impede autonomy and promote task focused ways of working?

2. Method

Carspecken's (1996) model of critical ethnography provided the framework for this research. Critical ethnographers emphasise the act of interpreting culture with the purpose of promoting cultural change (Greckhamer & Koro-Ljungberg, 2004). Examining a culture through the lens of power, privilege and authority uncovers unfair and unjust systems and reveals whose voice is heard and whose is silenced (Harrowing & Mill, 2010). The intent is to reveal the social and political forces that shape the culture and nurses' beliefs about themselves and their nursing practice (Batch & Windsor, 2015). In doing so critical research presents a broad understanding of what these nurses know, what they do and what they value.

Critical research acknowledges that power differentials and oppression operate at all levels of human interaction and that potentially oppressive organisational structures might hinder the delivery of person centred care (Hardcastle et al., 2005; Stewart, Holmes, & Usher, 2012). It may be that hierarchies of power in health care generally, and in this workplace specifically might constrain nurses' ability to plan and deliver nursing care according to their personal values and professional mandate and patient expectations.

A number of key concepts outline the ethnographic approach to social research. Firstly, the notion that all social life is meaningful and that social action can only make sense when contextualised; and secondly, that social actors know their own culture intimately and are therefore reliable informants (Goodson & Vassar, 2011). An understanding of these notions reveals why fieldwork is an important data collection tool. By engaging in fieldwork and becoming fully immersed in the culture being studied, the researcher gains access to privileged insider information (Sangasubana, 2011; Madison, 2012). Ordinary, everyday actions are more clearly understood within the cultural context. As a new insider, the researcher gains access to an intimate view of the society being studied that allows cultural phenomena to be understood from an insider's or emic perspective (Anderson, 1989).

In reporting ethnographically, the key is not merely to capture the voice of the informant but rather to illuminate for the reader the experience concerned (Denzin & Lincoln, 2011). However, critical ethnography differs from traditional ethnography in that it does not just speak *for* its participants, it speaks *on behalf of* its participants: the researcher thus becomes an advocate for participants (Thomas, 1993). The primary purpose of the researcher is to be sensitive to manifestations of power and to expose those tacit, unconscious elements that direct cultural thought and behaviour (Schein, 2004). This key differential describes how a critical approach 'aims to link social phenomena with wider socio-historical events to expose prevailing systems of power and dominion, hidden assumptions and ideologies' (Hardcastle et al., 2005, p.151).

Table 1
Carspecken's five stages of critical qualitative research (Carspecken, 1996).

Stage	Description	Data Collection	Analysis
1	Building a primary Etic record: What is going on?	Fieldwork: observer, monological unobtrusive, reflection	Cultural reconstruction (Etic)
2	Researcher interpretation: Etic perspective	Preliminary reconstructive analysis	Cultural reconstruction (etic)
3	Dialogical (emic) data generation; collaborative stage	Fieldwork: participant observation, interactive, interviews, reflection	Cultural reconstruction (emic)
4	Describing systems' relations to broader context	Conduct systems analysis between locales, sites, cultures (discovery)	System analysis (etic)
5	Explaining relational systems	Link findings to existing macro-level theories (explanation)	System analysis (etic)

Table 2
Study questions.

Potential interests to be investigated	Information that needs to be collected to address these issues
How is care delivery organised?	Care plans and tools used in unit
How is PCC understood and described by nurses?	Routines and rituals in unit Subjective views
How is care delivery individualised?	Communication and power networks
What factors constrain or enable individualised care delivery?	The organisation of care delivery
How do broader social structures influence care delivery?	Nursing communication structures Organisational priorities/influences
How do personal and group values, beliefs and norms influence care delivery?	Individual vs group dynamics
What relationship exists between care delivery in the unit and the hospital policies, procedures and strategic direction?	Policy documents and organisational strategic goals. Subjective perception of nurses of organisational goals and impact on care delivery.
How does economics and staffing policy influence care delivery?	Allocation of resources
How do nurses maintain autonomy in care planning decisions?	Subjective experience of nurses
How is care evaluated?	Audit process: consumer engagement—patient feedback, patient satisfaction surveys

PCC = patient centred care.

Carspecken (1996) framework comprises five stages (Table 1). The first three stages aim to reconstruct cultural themes and the final two describe systemic relations and articulate the findings in relation to the broader sociocultural factors and existing theories (Carspecken, 1996). Importantly, these stages are not linear; rather, they are cyclical and the researcher moves back and forth between the stages. Another key factor is the simultaneous data collection and analysis. These concurrent processes enable the researcher to remain sensitive to, and respond to new insights, and reveal culturally pragmatic material (Carspecken's, 1996; Hardcastle et al., 2005).

Prior to entering the field, a preliminary research plan is made in which the researcher develops a list of questions and potential aspects to be investigated (Carspecken, 1996). The first list identifies issues that can be investigated and the second outlines what information is required to address these questions. For this study the original list of questions is presented in Table 2.

2.1. Ethical issues

Ethics approval (HREC/14/QRBW/67) was obtained from the research site and the university ethics committees. Participants comprised (14) registered nurses and three (3) enrolled nurses out of thirty eight (38) permanently employed in the research area. This composition of participants is reflective of the workforce employed in this acute surgical area. Verbal and written information about the study and the requirements of participation were made available to the participants during several site visits prior to the research commencing. Those nurses who agreed to participate provided fully informed written consent and were able to withdraw from the study at any time until data collection. Key ethical principles of respect and confidentiality were maintained at all times.

2.2. Setting

As the researchers were interested in nurses working in an acute hospital setting, the fieldwork took place in an acute surgical setting in an Australian regional hospital. Participants were purposefully selected because they had specific knowledge about the research problem (Higginbottom, Pillay, & Boadu, 2013; Lambert, Glacken, & McCarron, 2011).

2.3. Data collection and analysis

In keeping with the format of ethnographic studies, the researcher was the primary instrument of data collection endeavouring to participate in the everyday lives of participants yet maintaining a professional distance that facilitated perception (Lambert et al., 2011; Sangasubana, 2011).

Participant observation was the primary method of data collection and conducted by author 1 (SS). Observations occurred primarily during day and afternoon shifts, and were typically 2–4 h in duration. Thick and thin descriptions of events characterise the field notes taken (Carspecken, 1996). 'Thick notes' are detailed and include verbatim speech, tone, body language and occasional bracketed observer comments or impressions; whereas 'thin notes' are compiled following an event and provide an overview of what transpired.

Observations were supplemented with interviews designed to illuminate the information gained through observation. Typically, the interviews were short and conducted in situ, shortly after a period of observation. Questions posed were open ended and used to clarify observed behaviours. An example was 'I noticed that. . .. can you tell me what was happening?' An additional four focus group interviews were held to discuss concepts that were of global concern to participants. Each focus group consisted of between four and eight nurses. The benefits of conducting focus groups were that they allowed a collective perspective on issues and provided further insight into the power dynamics operational in the team (Denzin & Lincoln, 2011; Minichiello, Greenwood, Axford, 2004). The focus groups were used to discuss particular issues that appeared to be of significance to all participants. An example was workload concerns. Interviews were digitally recorded and transcribed verbatim.

The documents that nurses used in their everyday practice were examined to explicate cultural understandings and priorities. These documents are pertinent to how nurses plan and deliver care and are worthy of examination. This was done with the understanding that the language used within these documents helped to shape

how nurses in this culture prioritised care planning and delivery within this acute surgical setting (Batch & Windsor, 2015).

Analysis was hermeneutic and reconstructive in order to make explicit the cultural and subjective factors that are tacit in nature (Carspecken, 1996; Hardcastle, Usher, Holmes, 2005). The reconstructive process unpacks the narrative and proceeds to articulate potential meanings that Carpsecken describes as 'meaning fields'. In articulating potential meaning fields, the researcher uses three ontological categories or claims through which analysis is made. These are objective, subjective and normative-evaluative claims.

Research rigour was achieved through the use of a robust methodological and analytical framework, and through the triangulation of data described above (Higginbottom et al., 2013).

2.4. Findings

Findings revealed a tension between the holistic, person centred care nurses wanted to provide, and the actual care provided, which was task focused. A range of factors contributed to the situation, notably, busy workloads with competing priorities and a focus on paperwork. This group of nurses keenly felt the impact of health care policies that mandated efficiency and responded accordingly. In this regard the collective perspective that valued efficiency overruled individual person centred values and reinforced the task focus. These aspects will be discussed further and supported with data.

2.5. Entering the field

Upon entering the ward I observed that nurses moved with purpose, eyes downward, walking briskly in a way that conveyed that they could not be interrupted. Consequently it was difficult to gain anyone's attention to introduce myself. I was later told

It's just head down, bottom up and get those things done. (EN1)

Once, when relationships had been established my observations began at clinical bedside handover, a process whereby the oncoming shift receives patient information from those nurses completing their shift. As the name implies this occurs at the bedside with the intention of promoting inclusivity and facilitating person centred care. However, inclusivity was rarely observed and the priority seemed to be on completing the handover in as swift manner as possible. During a morning observation, one of the participants, upon becoming aware that the handover group had moved on and that she was left behind, stated:

It's coming down to that when we hand over, they're checking the paperwork, they're not looking at the patient. It's check they've filled out this form, check they've filled out that form. . . (RN6)

On another occasion, one participant provided the following explanation as to why she could not immediately respond to a patient's request, She stated that handover needed to be conducted swiftly because '*these girls have been going all night and need to get home.*' (RN1)

Following handover, nurses set about their day's work and I observed there was very little opportunity for a pause. Nurses kept account of pending tasks using a shift planning sheet, meticulously kept by some, with brightly coloured highlighting when tasks were completed. On a somewhat humorous note, one nurse described how she got frustrated when a patient asked for the toilet because it wasn't on her plan.

I get frustrated 'cause people'd be calling for me and asking me to, like, take them to the toilet. I'd be like, "But I haven't [got] it in my plan." (RN4)

She laughed as she said this, perhaps recognising the irony of the situation and knowing that it was ridiculous to be so caught up with the task list that people's expressed needs were ignored. However, during the third focus group task focused working was justified because:

It's just so busy that if you, um, are not task orientated at times you will fall behind your workload. (CN1)

2.6. Competing priorities

In addition to a list of tasks, a number of other competing priorities demanded nursing attention. For example, nurses were observed to spend significant time completing a range of clinical documents. One such document was the 'Person Centred Care Plan' which included a range of tick boxes to record patient care and preferences. Interestingly these documents were often completed away from the bedside with no patient input observed. It seemed that despite the fact that these documents were designed to facilitate person centredness, nurses largely divorced them from individual patient care.

I think another thing that impacts on your time is the amount of paperwork that we are now are required to do to make sure that we tick the box, that we've [done] *the risk screen, that we've done falls assessment, you know, that we looked at pressure injuries, we've done skin inspections and that's just overwhelmingly – complicates the amount of time that you don't get to spend with the your patients because you're busy doing your paperwork. It's ridiculous.* (RN2)

This nurse's suggestion that she must choose between paperwork or time with patients is ironic because the very documentation designed to promote individualised care appeared to detract from it for these nurses. Perhaps a possible explanation for this is the apparent perception that the documentation had punitive component.

You're constantly worried about, have I filled the care plan out right. . .. If something goes wrong, and you haven't filled out the form properly . . .(RN5)

It's just us covering ourselves for what we've done in a day. (CN1)

Many of the competing priorities that nurses negotiated were not directly linked to patient care including: 'chasing doctors' to ensure prescriptions were current; seeking pertinent clinical information not readily available, and monitoring the work of junior doctors and other health care professionals. However, it is beyond the scope of this paper to explore all these aspects in depth. Regardless, they contributed to workload stress and detracted from nurses' ability to provide person centred care and favoured task focused work practices. As a result nurses described feeling overwhelmed with the workload.

Sometimes you can just feel like you're drowning. (RN1)

It appeared that nurses felt powerless to control and direct their workload and were conflicted between care they wanted to provide, and care they had to provide:

There's no going, well I'm not going to do that today because I feel like doing this with my patient. – it's dictated for us what we need to do, what's expected. (CN2)

2.7. A dichotomy between intentions and actions

Despite the observation that nurses were very task focused in this workplace they expressed a commitment to person centred care.

During the first focus group we discussed participants' perspective of ideal nursing care. Describing this one participant said:

Time to sit and do the psychological and social with them because I believe in nursing [laughs], that's where the healing takes place. (CN2)

Similar sentiments were expressed around the group, yet nurses frequently found themselves compromising their professional and ethical values and practising in ways to which they were philosophically opposed.

So when we talk about holistic care, our systems aren't set up for that. I think, we're doing obs – doing our work – doing dressings. . .. we're doing tasks. (RN5)

I was interested to know what aspects of the system were perceived as hindrances to person centred care and promoted this task focus. The major concerns of these participants were lack of staff, lack of time, increasing acuity and the increasing requirements of audit and accountability.

It's not like we don't want to provide that, it's just we don't have the resources or the time anymore. (RN2)

Another said:

It's absolutely impossible to give them the care that they actually need and we've got a growing population and the acuity is just so hard. (RN9)

The requirements of the system constrained nurses and left them feeling powerless. A realisation that was painful for some to contemplate.

W*ith that came the realisation that I can't change the system that I work in. I can only do the best I can do in that system.* (RN7)

But for me to actually stop beating myself and going, no, I've done okay. I've managed to do what I could do in the system that I work in. It's the only way I could—that's the only way I could get past my own feelings of not being a good nurse. (RN1)

2.8. Moral distress and workplace dissatisfaction

An inability to provide the level of care that participants aspired to resulted in workplace dissatisfaction and moral distress. The following quotes were provided during one focus group as nurses described how they felt about their work.

Just horrible, we don't go home with job satisfaction. (CN2)

Stressful thinking, did I do everything? Is everything covered? Did I say that? I forgot to tell them that. . .(RN6)

If the load was less, we would be able to put more time in and I think, like I find nursing very soul rewarding, sometimes I don't because you're just task orientated and you go home and you go oh my God I could of did that, I could have did that but there was no time. (RN3)

It is interesting to note that the apparent cause of nurses' stress was thinking of undone work, a factor that reinforced the importance of doing over being. Incomplete work was with associated negative emotions and feelings of failure that permeated nurses' personal lives and activities, as the following quotes illustrate:

You just stay back until it's under control. . . so that you can unburden yourself a bit more and make sure you go to sleep, or whatever you've got to do when you go home. (RN3)

2.9. The collective perspective

An interesting finding was the way in which the collective nursing team had a subversive impact on individual nurses and ensured they complied with task focused work practices. Contradictory to the espoused commitment to holistic care, the collective demanded that all tasks were completed before the end of the shift to benefit the oncoming staff.

It's just all about helping the team, I think. You don't want to be that one that lets people down—you want to be that one that walks out having everything done. (RN1)

Teamwork in this setting was tacitly understood to mean individual nurses working efficiently and getting through their own workload for the benefit of other team members. 'Good' team members were able to get through their workload and leave the shift without adding a burden to other staff.

You don't want to impact on another shift (workload) either, because each shift is busy. (RN3)

So you go home feeling dreadful because you've just added to their—burden. . .. to their workload. (RN5)

Clearly no-one wanted to let the team down; indeed, nurses who 'failed' engaged in negative internal dialogues. As one said:

I'm just internalising it and going, "You're a very bad nurse." (RN1)

In remaining loyal to the team, nurses retained their ability to function in this challenging health care system. At least in belonging to the team nurses felt that their worth was recognised and their contribution valued thereby meeting their self-esteem and self-respect needs socially, which were not being met professionally (Carspecken, 1996).

Doing makes me feel as though I'm contributing properly. (RN4)

Ironically, the very task focus that these nurses were opposed to became their *raison d'être*.

2.10. Collective expectations

Collective expectations were conveyed through the process of socialisation that occurred in this workplace.

I think you just sort of get a vibe with it, well, once you've started working here and—if you're not on top of things . . . (RN7)

This nurse's use of the word 'vibe' indicates how, through her early social interactions in this workplace, she was sensitive to the power dynamics operating, knew what knowledge was valued and had quickly learned the appropriate way to behave in this culture (Mahon & McPherson, 2014).

In any culture, understanding what constitutes right or wrong, good or bad is validated through consensus of the group (Harrowing & Mill, 2010). In this culture, people mostly learned the hard way through feedback *after* an action had taken place. This feedback included passive–aggressive behaviour or openly hostile responses. Foucoult (1995), describes this as normalising judgement whereby non-compliance with cultural expectations results in some form of sanction or punishment.

The following quote is just one example provided by participants.

There is like a few people that get really cranky if there's stuff that's not done. I think some people can be a bit scared or intimidated. (CN1)

Nurses avoided the risk of being shamed and viewed as a person unable to cope with the workload by actions such as moving at

great speed, exhibiting impatience and becoming distracted. The overwhelming need to get everything done was clear in the brisk way that nurses moved and executed their work.

> *I just move and I move fast and I mean, yeah, there's a lot of people who don't move and they don't move fast.* (RN1)

Clearly, distinctions were made between those who could and those who could not cope with this pace, with most nurses being eager to be in the former category. In doing so nurses demonstrated that the need to conform to cultural expectations was more powerful than the need to practice according to personal values.

2.11. Nurse leadership

It was the informal leaders within the collective who exercised authority that governed the limits of acceptable behaviour in this culture, whilst the formal nursing leadership had their time taken up by office work. At executive leadership level the apparent disconnect was even more pronounced. Nurses believed that their leaders had lost touch with the realities of contemporary nursing practice and were not advocating for nurses or patients.

> *I think executive have unrealistic expectations of staff now because they don't get on the floor and see what it's like, they expect the same care that they used to give 20, 30 years ago.* (RN8)

Furthermore, nurses believed the priority of their leaders was parsimony and complying with budgetary constraints over delivering person centred care.

> *It's all budget, it's all money and we just have to pull into line. That's the bottom line. It's out of our circle of control. We just have to suck it up and get in there and do what we can.* (CN2)

3. Discussion

This study supported previously reported arguments that nursing actions, and quality care, do not always arise because of individual activity, but from cultural pressures (Metlz & Hansen, 2014; Goodman, 2014; McAllister & Holmes, 2016).

The nurses in this research delivered care in ways that contravened their personal values, and this illustrated that nurses are not always free agents and nor do they always make carefully considered ethical decisions. Rather, their beliefs and attitudes were influenced by the system in which they live and work.

Nurses in this study felt constrained in the delivery of person centred care and behaved in ways that supported a task focus, even though they explicitly were critical of a task focus. A possible explanation for this is that the prevailing culture of neoliberalism, with its value placed on auditable, measurable activities has been naturalised and accepted (Churchill, 2007; Bergh, Friberg, Persson, & Dahlborg-Lyckhage, 2015). Consequently, aspects of healthcare perceived as having little economic value, such as relational aspects of care, risk being overlooked and considered unimportant (Churchill, 2007). Managerialism is another accepted and naturalised discourse in healthcare and thus nurses are aware that measures of care, such as nurse-patient dependency scales, are valued by their line-managers (Ballatt & Campling, 2011). As a result they too, become adept at measuring and monitoring, even though it may detract from ability to provide person centred care. In this way, the focus for nurses on the floor shifts from being (an ontological embodiment of care) to doing (actions of monitoring and dispensing).

Nurses in this study prioritised efficiency, and the swift completion of tasks despite voicing a philosophical commitment to the value in spending time with patients. Importantly, theirs was not a simple choice between tasks or relatedness; but rather, a response to multiple discourses shaping and constraining practice. In this regard, decisions made in the political sphere, although far removed from the day-to-day work of nurses, had a direct impact on the working conditions and practices of nurses (Taylor & Field, 2003). This finding is similar to what Boltz et al. (2008) argued when they said that decisions made at policy level either limit or support nursing practice. Unfortunately, many nurses accept increased reporting and monitoring practices as the way things are, and that they have no ability to influence change. This can cause them to experience feelings of powerlessness that leave them unable to practise to their ideals (DeForge, van Wyk, Hall, & Salmoni, 2011).

The nurses in this study were unable to see that their world could function in any other way; they felt a deep sense of powerlessness and resignation that the system – not they – controlled their practice. When nurses accept such hegemonic structures as inevitable and not amenable to change, their lifeworld has become colonised (Bedrous, 2009; Habermas, 1984; Stewart & Usher, 2012). Acceptance of hegemonic ideologies leads to actions, that then confer legitimacy to the ideology, and so the cycle continues.

In this study, it was frequently seen that nurses supported the task focus as a group. The group had its own rules and each nurse conformed to them or they risked ostracism and punishment. It was evident that in complying with group expectations individual nurses valued social identity more than personal ideals.

Willetts and Clarke (2014) explain that social identity theory operates when nurses meet their need for belonging through team acceptance. This theory helps us see that an individual's self-worth is aligned to the level of respect they acquire with their peer group, and that they are more likely to act in particular ways if there is a group expectation that they do so. For example, in this study, nurses prioritised the need to conduct an efficient clinical bedside handover in order to enable their colleagues leave on time. Patients were allowed little opportunity to participate in planning their own care, and even simple matters like showering were planned for nursing convenience and to ensure each individual nurse carried their fair share of the workload and did not add to the workload burden of their colleagues. In this way care was more team centred than person centred.

Goodman (2014) also explains that nurses are often unaware of discourses such as neo-liberalism and managerialism that impact on their everyday world. Therefore, perhaps a vital first step to empowering nurses is for them to understand how economics and politics operate in daily health-care practice (Mahon & McPherson, 2014). Through participation in critical reflection and research, such as critical ethnography, nurses may also develop a language to explain the tensions that they feel when ideals conflict with the realities of practice, and generate new ideas for practice (Sim & Van Loon, 2012).

4. Limitations

All studies have limitations and in this critical ethnography that was confined to one ward in a regional hospital, the findings may not be generalizable because the unit may have been unique and atypical. Also, observations were limited to nursing actions only and the contributions that the whole multi-disciplinary team had in influencing behaviour was not explored. That said the findings are consistent with those of similar studies that found tension between values and actions (Bolster & Manias, 2010; DeForge et al., 2011; Dempsey, 2009; Haigh & Ormandy, 2011; Milton-Wildey, 2010).

5. Conclusion

The key finding of this research is that despite an espoused commitment to person centred care based within a therapeutic

relationship, this group of nurses practiced in ways where efficiency and the swift completion of tasks took priority and created dissatisfaction and stress for them. Thus a dichotomy is revealed between nurses' values and their practice. It is important to recognise that nurses did not deliberately choose this behaviour; rather they were constrained by cultural expectations and competing priorities that left them without agency. Nurses experienced moral distress and work dissatisfaction.

Through awareness and engagement in critical reflections, nurses such as these may be able to reclaim agentic practice if they develop a language to explain the influence that prevailing discourses have on them. They may also discuss ways to gently resist being colonised, and articulate alternative ways to work so that person-centredness can take priority over profits.

References

Abdelhadi, N., & Drach-Zahavy, A. (2012). Promoting patient care: work engagement as a mediator between ward service climate and patient-centred care. *Journal of Advanced Nursing*, *68*(6), 1276–1287. http://dx.doi.org/10.1111/j.1365-2648.2011.05834.x

Anderson, G. L. (1989). *Critical ethnography in education: Origins, current status, and new directions*. Retrieved from. http://ezproxy.cqu.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=eric&AN=ED307285&site=eds-live&scope=site

Ballatt, J., & Campling, P. (2011). *Intelligent kindness: reforming the culture of healthcare*. Glasgow, UK: RC Psych.

Batch, M., & Windsor, C. (2015). Nursing casualization and communication: a critical ethnography. *Journal of Advanced Nursing*, *71*(4), 870–880. http://dx.doi.org/10.1111/jan.12557

Bedrous, A. (2009). The environment as lifeworld: using habermas' theory of communicative action in the environmental discourse. *Conference Papers—American Sociological Association*, 1.

Bergh, A.-L., Friberg, F., Persson, E., & Dahlborg-Lyckhage, E. (2015). Perpetuating 'New Public Management' at the expense of nurses' patient education: a discourse analysis. *Nursing Inquiry*, *22*(3) http://dx.doi.org/10.1111/nin.12085 [190–201 112p.

Berghs, M., Dierckx de Casterlé, B., & Gastmans, C. (2006). Nursing, obedience, and complicity with eugenics: A contextual interpretation of nursing morality at the turn of the twentieth century. *Journal of Medical Ethics*, *32*(2), 117–122.

Bolster, D., & Manias, E. (2010). Person-centred interactions between nurses and patients during medication activities in an acute hospital setting: qualitative observation and interview study. *International Journal of Nursing Studies*, *47*(2), 154–165.

Boltz, M., Capezuti, E., Bowar-Ferres, S., Norman, R., Secic, M., & Kim, H. (2008). Hospital nurses' perception of the geriatric nurse practice environment. *Journal of Nursing Scholarship*, *40*(3), 282–289. http://dx.doi.org/10.1111/j.1547-5069.2008.00239.x

Carspecken, P. (1996). *Critical ethnography in educational research: A theoretical and practical guide*. New York: Routledge. http://dx.doi.org/10.1016/j.ijnurstu.2009.05.021

Churchill, L. R. (2007). The hegemony of money: commercialism and professionalism in American medicine. *Cambridge Quarterly of Healthcare Ethics*, *16*(4), 407–414.

Coward, R. (2013). Why have so many nurses stopped CARING? An investigation into the crisis-hit NHS. *Mail Online*,. Retrieved from. http://www.dailymail.co.uk/health/article-2275943/NHS-Why-nurses-stopped-CARING.html#ixzz45havUM9s

Davies, G. (2005). *Queensland public hospitals commission of inquiry report*. Brisbane]: Queensland Public Hospitals Commission of Inquiry.

DeForge, R., Van wyk, P., Hall, J., & Salmoni, A. (2011). Afraid to care; unable to care: A critical ethnography within a long term care home. *Journal of Aging Studies*, *25*, 415–426.

Dempsey, J. (2009). Nurses' values, attitudes and behaviour related to falls prevention. *Journal of Clinical Nursing*, *18*, 10.

Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage handbook of qualitative research* (4th ed., pp. c2011). Thousand Oaks: Sage.

Forester, J. (1992). Critical ethnography: on fieldwork in a Habermasian way. In M. W. Alvesson, & H. Wilmott (Eds.), *Critical management studies* (pp. 46–65). London, UK: Sage.

Foucoult, M. (1995). *Discipline & punish: The birth of the prison* (2nd ed.). New York: Vintage Books.

Francis, R. Q. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary*. Retrieved from. www.midstaffspublicinquiry.com

Garling, P. F. C. (2008). *Final report of the special commission of inquiry: acute care in NSW public hospitals*. State of NSW.

Goodman, B. (2014). Risk, rationality and learning for compassionate care: the link between management practices and the 'lifeworld' of nursing. *Nurse Education Today*, *34*(9), 1265–1268. http://dx.doi.org/10.1016/j.nedt.2014.04.009

Goodson, L., & Vassar, M. (2011). An overview of ethnography in healthcare and medical education research. *Journal of Educational Evaluation for Health Professions*, *8*(4), 4. http://dx.doi.org/10.3352/jeehp.2011.8.4

Greckhamer T., Koro-Ljungberg M. (2004). 2004/08/14/2004 Annual Meeting, San Francisco). *Ethnographies and epistemologies on the continuum: From traditional to strategic uses of cultural theories*.

Habermas, J. (1984). *The theory of communicative action. Reason and the rationalisation of society* (Vol. 1) Boston, MA: Beacon Press.

Haigh, C., & Ormandy, P. (2011). Evaluation of the organisation and delivery of patient-centred acute nursing care. *Contemporary Nurse*, *37*(2), 253–264.

Hallam, J. (2000). *Nursing the image: media, image, and professional identity*. pp. 2000. London: Routledge.

Hardcastle, M.-A., Usher, K., & Holmes, C. (2005). Carspecken's five-stage critical qualitative research method: an application to nursing research. *Qualitative Health Research*, *16*, 151–161.

Harrowing, J. N., & Mill, J. (2010). Moral distress among Ugandan nurses providing HIV care: a critical ethnography. *International Journal of Nursing Studies*, *47*, 723–731. http://dx.doi.org/10.1016/j.ijnurstu.2009.11.010

Higginbottom, G. M. A., Pillay, J. J., & Boadu, N. Y. (2013). Guidance on performing focused ethnographies with an emphasis on healthcare research. In *Qualitative report*. pp. 18.

Hughes, F. (2013). *Strenghtening health services through optimising nursing*. Brisbane: State of Queensland.

Lambert, V., Glacken, M., & McCarron, M. (2011). Employing an ethnographic approach: key characteristics. (Cover story). *Nurse Researcher*, *19*(1), 17–24.

Madison, D. (2012). *Critical ethnography: method, ethics and performance*. Thousand Oaks, CA: Sage.

Mahon, P., & McPherson, G. (2014). Explaining why nurses remain in or leave bedside nursing: A critical ethnography. *Nurse Researcher*, *22*(1), 8–13. http://dx.doi.org/10.7748/nr.22.1.8.e1271

Metlz, J., & Hansen, H. (2014). Structural competency: theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, *103*(92014), 126–133.

Milton-Wildey, K., & O'Brien, L. (2010). Nursing care of older patients in hospital: implications for clincial leadership. *Australian Journal of Advanced Nursing*, *28*(2), 6–16.

Minichiello, V. S. G., Greenwood, K., & Axford, R. (Eds.). (2004). *Handbook of research methods for nursing and health science*. Australia: Pearson Education.

Nesbit, P. L. (2012). The role of self-reflection, emotional management of feedback, and self-regulation processes in self-directed leadership development. *Human Resource Development Review*, *11*(2), 203.

Patterson, C. (2012). A crisis in nursing. *The Independent*,. Retrieved from. http://www.independent.co.uk/voices/commentators/christina-patterson/a-crisis-in-nursing-six-operations-six-stays-in-hospital-and-six-firsthand-experiences-of-the-care-that-doesnt-care-enough-7628092.html

Sangasubana, N. (2011). How to conduct ethnographic research. *Qualitative Report*, *16*(2), 567–573.

Schein, E. H. (2004). *Organizational culture and leadership* (3rd ed.). San Francisco, CA: Jossey-Bass.

Sim, S., & Van Loon, B. (2012). *Introducing critical theory*. London: Icon Books Ltd.

Smith, R. (2002, 27th august, 2002). 'Cruel and neglectful' care of one million NHS patients exposed. *The Telegraph*. Retrieved from http://www.telegraph.co.uk/news/health/news/6092658/Cruel-and-neglectful-care-of-one-million-NHS-patients-exposed.html.

Stewart, L., Holmes, C., & Usher, K. (2012). *Reclaiming caring in nursing leadership: A Habermasian lens*.

Summers, S., & Summers, H. (2015). *Saving Lives: Why the Media's Portrayal of Nursing Puts Us All at Risk* (Vol. Updated second edition). Oxford.

Taylor, S., & Field, D. (2003). *Sociology, social research and health sociology of health and health care*. pp. 3–20. Oxford: Blackwell.

Thomas, J. (1993). *Doing critical ethnography*. Newbury Park, CA: Sage Publications.

Walker, B. (2004). *Final report of the special commission of inquiry into Campbelltown and Camden hospitals*. Sydney, N.S.W: NSW Government, Special Commission of Inquiry.

Willetts, G., & Clarke, D. (2014). Constructing nurses' professional idenitity through social identity theory. *International Journal of Nursing Practice*, *20*, 164–169.