

When Paradoxes Hamper The Search For Meaning: The Psychodynamics of Work of Nurses in a Residential and Long-Term Care Facility

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Abstract

This article seeks to analyze the effects of changes in the organization of work performed by nurses on long-term care wards in a residential and long-term care facility (centre d'hébergement et de soins de longue durée, CHSLD) in Quebec. The changes involved are 1) the introduction of a modular care system, a "living environment" approach and a computerized client-information system specifically for residential and long-term care centres (SICHELD).

Problem: The changes have been implemented in most of Quebec's CHSLDs but have not been evaluated.

Theoretical Framework: The theoretical approach used here is that of the psychodynamics of work, which was developed in France by C. Dejours and adopted in Quebec by M-C. Carpentier-Roy and others.

Method: The investigative methodology of the psychodynamics of work is fundamental to the examination. Study groups formed of nurses who volunteered to participate comprised 26 (out of a possible 76) nurses representing all the wards and all the shifts in the CHSLD.

Results: Major sources of suffering take the form of paradoxes and undermine the meaning of work. The suffering the participants experience is evidenced by their resorting to a wide range of defensive strategies.

Implications: Various considerations related to the structure and organization of work raise important questions about the nurses' role. The discussion expands on the issues of role conflict, the ambiguous exercise of power and a broad search for identity; the situation is marked by an identity crisis and an impasse in action

Introduction

This article reports on a study funded by the Canadian Institutes of Health Research (CIHR) that seeks to better understand the links between nurses' work, as structured and organized at the time of the study in the long-term care wards of a residential and long-term care facility in Montreal (in French, Centre d'hébergement et de soins de longue durée, CHSLD), and the nurses' subjective experience of their work in these wards. The examination focuses on their experience or lived experience of three organizational changes: the introduction of a substitute-living-environment approach; the implementation of a computerized client-information system specifically for residential and long-term-care centres (SICHELD); and the establishment of a modular care system. CHSLDs are residential and long term care facilities for people requiring more than 3.5 hours of care per day. The aim of such establishments is to provide a warm, intimate and safe environment where residents can maintain meaningful relations with their family and the staff caring for them and continue to realize their potential while receiving the care and services necessitated by their state of health.

The psychodynamics of work, an approach developed by Christophe Dejours in the 1970s [1-5], provided the framework for this participatory, interpretative and comprehensive inquiry. The approach was deemed appropriate specifically because it allows for a comprehensive analysis of the relationship between the organization of work and the mental health of workers. The core concepts of the approach are pleasure and suffering at work and defensive strategies that workers apply to alleviate the perception of the suffering they experience and so be able to keep on working. The interviews were conducted in groups and on a voluntary basis. The nursing administration, the nurses' union, and the people in charge of introducing the changes made up the advisory committee, whose role it was to facilitate implementation of the study.

We conducted this qualitative study because, to our knowledge, up to now no research has been carried out on the effects these three organizational changes have had on work as experienced by the nurses. In the current situation of a nursing shortage, every nurse kept on the

job counts. It is therefore important to find out if the new organizational methods have a negative or positive effect on nurses' experience of their work.

The sections below provide a statement of the goal of the study, followed by presentations of the psychodynamics of work; the organization of the study; a general description of the work environment; the principal changes in the way work was organized; the sources of pleasure and suffering in work; and the defensive strategies applied by the participants.

The psychodynamics of work, its objective and the method for studying it

The psychodynamics of work was developed in France in the 1970s by Christophe Dejours, a psychiatrist and specialist in workers' health. It has been adopted in Quebec by such researchers as Marie-Claire Carpentier-Roy, Michel Vézina, Jacques Rhéaume, Micheline Saint-Jean, Marie-France Maranda, Louise Saint-Arnaud, Louis Trudel, Marc-André Gilbert, Marie Alderson, and others. Its objective is to analyze matters that pose problems at work by collectively involving the workers in an effort to elicit an understanding of the issues that would be shared by the investigators and the workers. The psychodynamics of

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work refers to the organization of work as a source not only of pleasure and suffering but also of defensive strategies, as workers attempt to cope with the demands of their employment situation. The approach brings out the psychic charge of a nurse's work, a charge that is naturally subjective, qualitative, and essentially defined by the significance that the work has for her. The subjective experience of work cannot be grasped without listening to what the people actually doing the work have to say [6]. The role of researchers into the psychodynamics of work is to help workers better understand the elements at play in or affecting the difficulties they encounter on the job.

According to the psychodynamic approach to work, pleasure is a state of psychic well-being experienced when a person's work fulfils his or her desire for recognition, power, autonomy, achievement, and identity. Pleasure in one's work includes the experience of confidence, cooperation, solidarity, and sociability. The concept of psychic suffering at work relates to a state of boredom, monotony, fear, anxiety, anguish, disappointment, dissatisfaction, anger, and the absence of pleasure, cooperation, or solidarity [7].

The psychodynamics of work provides a framework for action research. The goal is the appropriation of the study's conclusions by the participants themselves in order to transform their work situation [8]. This method fits in with the overall approach of the subjectivist paradigm. In order to analyze complex work relationships, the method calls for the participation of researchers from different disciplines [1]. It thus provides for a convergence of ideas and the complementarity of different disciplinary viewpoints, which is the basis of much of the heuristic power of the approach. For the present study, the researcher was joined by a health sociologist and a psychoanalyst.

With this method, data collection invariably comprises two steps. The first is the pre-inquiry. In this case, it included meetings with institutional administrators, explanations to the head nurses and staff nurses on the units chosen for the study, and non-participatory observation by the researcher. Such observation is not intended to provide a detailed description of the observed dimensions but to give the observer an understanding of the situation so that he or she can fully grasp what the participants are talking about during the interviews. An observation guide indicated what the main dimensions to be observed were: the characteristics, environment, organization, constraints, context, and climate of the work; horizontal and vertical social relationships; physical, psychological, and socio-organizational risks; and the nurses' behaviour with regard to the risks. The second step is the actual data collection, encompassing everything from the group interviews to the final research report. The interview method is based on a process of taping the conversation, interpreting the content, and, finally, discerning the meaning by comparing the interpretations of the interdisciplinary researchers with those of the participants. The purpose is to develop a common and shared understanding of the collective experience of work. An interview guide suggested by the frame of reference reminds the researcher of the topics to be discussed with the participants so that a comprehensive understanding of the work experience might emerge. The topics were as follows: the nature and specifics of the work; the sources of suffering at work; the risks, fears, and anxieties at work; defensive strategies; enjoyment of work; and support at work. The guide and the interview process were flexible so that the discussions might elicit spontaneous comments from the nurses that would reveal the meaning they attribute to their work experience.

Organization of the study

Study groups (the term used for interview groups in studies in

work psychodynamics) were set up with nurses who volunteered to take part. Since results are not meant to be generalized, there is no need for a representative sample. The nurses' voluntary participation in the group interviews ensured the authenticity of their testimony. In order to participate, the nurses had to meet the following inclusion criteria: be a nurse working days or evenings on a long-term-care unit; understand and speak French; agree to take part in a group interview; and agree to forego any financial remuneration for participating. Since employment implied a willingness to participate in research and the study concerned collective experience, the inclusion criterion did not specify part-time or full-time employment, on-call or regular staff, or degree of seniority.

Before the interview groups were formed, the investigators held several information sessions for all the nurses at the institution. All the establishment's long-term-care wards were represented in the study. There were two groups for day-shift nurses, a third for nurses who work evenings; and a fourth for night nurses. Each group comprised 4 to 7 nurses; the membership of each group was the same for all interviews. A total of 26 out of a possible 76 nurses took part; 22 were women, and 4 were men. Their ages ranged from 22 to 65. Most were posted to a ward, two were in the float team, and one was on the recall list.

An informed consent form was signed, and approval was obtained from the institutional review board (IRB) to conduct the study.

Each study group took part in four meetings at the institution. Each meeting lasted from 120 to 180 minutes. The first two meetings were held in November and December 2005; the goal was to have the nurses share their experience of their work. The data gathered at the meetings were then analyzed by the investigators.

The interviews were taped, video recorded and transcribed. No transcription software was used. Analysis of the interviews was carried out by all three investigators in order to avoid any risk of bias in interpretation.

The analysis was presented (returned) to the participants at a third meeting (in February 2006) so that they could validate the investigators' interpretations. The participants' comments were noted. At the fourth meeting (in February 2007), the investigators presented the participants with a report based on the interpretations they had validated. A final copy of the report incorporating the latest comments collected during the fourth meeting were given to each of the participants and presented to the advisory committee.

The work context

General context

The institution is a residential and long-term care centre that, in the main, provides care and services to the elderly. At the time of the study the philosophy of care and service advanced by the institution centred on offering the frail elderly the best quality of life possible by intervening holistically to stabilize their health and maintain their skills and abilities. The institution operationalized this philosophy through interdisciplinarity; that is, the involvement of representatives of a large number of health-science disciplines: nurses, occupational therapists, respiratory therapists, physiotherapists, social workers, nutritionists, recreation therapists, physicians, and others.

At the time of the study, the way work was organized varied somewhat from one shift to another. On the day shift, each ward was divided into modules of ten to fifteen residents depending on the number of care hours required by each of them over a 24-hour period.

Every module included one nurse and one nursing attendant and/or one nursing assistant, as necessary. Depending on ward needs, the attendant and the nursing assistant could cover or partially cover more than one module. For the evening shift, care was not delivered on a modular basis. While there were variations in terms of ward size (as defined by number of beds), the ward was run by an assistant head nurse with or without the help of a nurse and by one or two nursing attendants. The modular system was not used on the night shift either. Here too, ward size might vary, but in most cases, the ward was managed by one nurse and one attendant.

In terms of supervision, each long-term care ward was run by a head nurse during the day. In the evening, she was represented by an assistant head nurse, who fulfilled the management functions for the ward while assuming or covering the clinical needs of some of the residents. In the evening, at night and on weekends, nursing care managers supervised proper operation of the entire establishment. The nursing administration was responsible for the overall management of nursing care and services.

Over the five years from 2001 to 2006, several organizational changes took place in the long-term care program in terms of organization of work, philosophy of care, and operating procedures. Of particular interest in terms of nursing are the introduction of the "living environment" approach, which had gradually been implemented over the preceding years; the introduction of SICHELD, a computerized client-information system for residential and long-term-care centres; and the shift from the primary-nursing to the modular-care delivery model. We shall now examine these changes in greater detail.

Principal organizational changes

As noted above, three main organizational changes occurred in the facility between 2001 and 2006. The first was the ongoing integration of the "living environment" approach, which was begun some time earlier. This change took place in all Quebec's CHSLDs and was a response to an initiative of the provincial health and social services ministry. The aim was to establish a "home-like" atmosphere in the residential and long-term care wards: a welcoming, intimate and safe environment, in which residents would be able to interact meaningfully with their relatives and the healthcare personnel and continue to realize their potential. Given this aim, the residents' care and day-to-day living must be organized as a continuum of activities spread over a twelve-hour period rather than on the basis of the three shifts worked by the nursing staff, as was previously the case. At the time of the study (2006), however, the organization of care and of residents' day-to-day living was still largely carried out on the basis of the three shifts.

The second organizational change was the introduction into the facility (and most CHSLDs) of another health ministry initiative, SICHELD, a computerized, modular, open-ended, integrated tool. According to the designers, it was developed to provide caregivers and management in CHSLDs with help to support their operations and enhance the efficiency of client care and services [9,10]. The tool comprises three modules. Module 1 involves clinical administration (admission, departure, transfer). Module 2 draws the biopsychosocial profile of the patient on the basis of a particular conceptual nursing model; it leads to the setting of objectives, which are to be attained through certain interventions. Module 3 manages the planning (but not the execution) of the clinical interventions and care required by each resident. This computer-based support is expected to give healthcare professionals greater autonomy; facilitate the planning of care and services and clinical decision making; and allow for the assessment of the quality of care and services provided [10]. The system is intended to

enable more efficient use of resources by freeing some administrative hours and reallocating them to direct service to clients [10]. It should be noted that, in the institution where the study was conducted, only the nurses use SICHELD.

The third organizational change involved the care-delivery system. In 2001, the institution's nursing administration opted to introduce a modular approach. In theory, the organizational structure associated with modular nursing allows for decentralized decision making and gives the nurse decision-making power with regard to care. Modular care is a hybrid of primary nursing and team nursing and seeks to provide personalized continuing care administered by a nursing staff usually composed of one nurse, a nursing assistant and two or three attendants; the nurse, however, remains accountable for the care [11,12]. A nurse in charge of a module has more patients under her care than she would in the primary-nursing system (6 patients or fewer) but fewer than in the team-nursing system (15 to 30 patients). A module generally includes 6 to 12 patients or even fewer if warranted by the level of acuity [13]. In the facility's long-term care program, a nurse in charge of a module is responsible for 10 to 12 residents, though the number may go as high as 15.

As the following paragraphs illustrate, the changes clearly affected the nurses' subjective experience of work. The analysis centred on the three core concepts of the psychodynamics of work: the sources of pleasure and suffering at work and the defensive strategies used to counter such suffering.

Pleasure and suffering at work

Diminishing sources of pleasure

The investigation highlights the fact that the nurses who attended the meetings had decided to devote their career to long-term care because, at least in theory, the field is known for setting a premium on an aspect of the profession to which they are strongly attached and which gives meaning to their work: relational nursing in its broadest sense, and, more particularly, relationships characterized by helping and companionship. The participants' statements illustrate unambiguously that the relationship aspect of nursing constitutes the core of meaning and pleasure in their work:

Relationships are the heart of our practice.

What I like in the care we give the resident is the helping relationship.

When I go into a room, I'm glad, I'm happy.

The marked prevalence of fairly significant cognitive disabilities among the clients in long-term care wards gives the nurse-resident relationship a singular quality that is generally beyond words, beyond the rational and cerebral. This very special relationship is what really "carries" and "nourishes" the nurses in their daily practice. Furthermore, they know how important they are to the residents and what a difference they make in their daily life. Over time, their adaptation to and knowledge of each other had given rise to a familial sort of shared affection and attachment:

I even say "Hello, Mrs So-and-so. It's me!" To the residents with dementia. When she smiles at me, she makes my day. We're attached to them. We know them. We're like a family.

Unfortunately, according to the participants, they experience these relational pleasures less and less in their daily work. The heavy workload that comes with lack of staff and the assignment of new roles (factors related to the organization of work) considerably reduces their access to this major source of pleasure and meaning in their work:

We don't have a lot of time to give them anymore. We don't have the time anymore.

This lack of time hinders the delivery of quality relational nursing care and prevents the meaningful practice of their profession:

When I pass with the cart and a resident grabs my coat to make me stay with him for a little while, it gets to me. We know what we should do to make him feel better, to make him feel less anxious. We could help him, comfort him, but we don't have the time.

Seeing a resident in psychological distress and knowing I could help and give her some relief, but that I don't have the time because it's 4:30, the suppers arrive at a quarter to five, and I still have to give out the medications first... it's hard to take.

We shall examine this subject further in the next section, which deals with sources of suffering and broaches, among other things, the question of a workload which deprives nurses of the constructive (positive) feeling that a job well done can contribute to identity and mental health.

Sources of suffering that undermine the meaning of work and identity confirmation

While the sources of pleasure cited by the participants appear to be directly linked to the very nature of the nursing profession and, more particularly, in the case under study, to the development of lasting relationships with the principal actors at work (the residents and some families), the sources of suffering tend to derive more from aspects of the organization and management of their work. The sources of suffering reported below are felt by the great majority of participants, albeit to varying degrees depending on the ward and work shift. Our experience in investigating the psychodynamics of work has also enabled us to see that, though the nurses can more easily verbalize some of these types of suffering, it is harder for them to verbalize others, whether because the emotional loading is very high or because potent defensive strategies may actually attenuate or lessen their perception of suffering. We shall return to the question of defensive strategies, but first we shall present the principal sources of suffering cited by the participants. One might say these sources are closely linked to the experience of a painful discrepancy between the vision promoted or touted by the institution's management and the daily reality that the participants experience: an excessive workload that keeps them from accomplishing high-quality work; an increasingly instrumental practice of nursing; and work relations that are difficult at every level. We shall now examine these sources of suffering in greater detail.

The discrepancy between institutional vision and nurses' everyday experience

The participants cite a discrepancy between the vision projected by the management which centres on the excellence of care and stirs high hopes of improved health for the residents and the reality in the wards. They note that the discrepancy issue stems from the first contacts families have with management representatives during preadmission meetings and visits. According to the nurses, at these meetings management presents families with an offer of care and services that holds out the possibility or likelihood of improvement in the prospective resident's health rather than of the maintenance of their condition and support for those who have lost autonomy. Raising or holding out this prospect appeals to the families and inclines them to place their relation in the institution. What family would not be delighted to be told their loved one's health may improve? However, holding out such a promise has the effect (corollary) of raising families'

expectations and putting the nurses in a position where they must produce results that are very difficult if not impossible to attain for most of the residents (because of irreversible losses or harm) or in their actual day-to-day working conditions (lack of staff, lack of time, work overload). The prospect raised by the management thus places the nurses in an awkward position because it simply is not possible to carry out the interventions discussed during the preadmission visits. The account of one participant provides a good illustration of the uncomfortable situation the nurses are in:

Here's an example: I recently admitted someone. The resident in question hadn't been walking at home for three months. The family had to pick her up, put her in her chair... do everything. She'd fallen several times trying to get up by herself at night. So her family doctor advised them to place her. She got here, and the family wants me to send her to exercise class, to get her walking, to do this, do that ... a full program! The resident is 92 years old. She hurts so much everywhere; it's hard just getting her to sit on the edge of the bed: "Ow, my back! Ow, my leg, ow!" How am I supposed to get her to walk? Two weeks after admission, the family comes to the nursing station and writes me to say their mother isn't making progress as promised, that she isn't walking, she isn't getting exercise.... The families expect us to save them, repair them, restore them...

The results of the investigation reveal how the discrepancy between management's assertions to families and the reality the nurses confront every day provide fertile ground for difficult and conflictual relations between families and nurses.

Advertised excellence and insufficient care

It should also be noted that the vision of excellence articulated by management in the preadmission meetings is not reflected in the lived experience of work as reported by the participants. They speak particularly of the difficulty in providing residents with care appropriate to their condition. Indeed, there is a parallel system of care provided by a private agency, a sign to the nurses that care and services are systematically and regularly deficient. The 1:00 pm to 9:00 pm work shift of some of the attendants also raises many questions among the participants. They have a great deal of trouble accepting the idea that residents in a "living environment" should have to wait (some of them in soiled incontinence briefs) until early afternoon to be changed, washed, helped out of bed, and dressed because the attendant assigned to them does not start work until 1:00 pm, and the morning team is so busy with its own workload that it does not have the time to deal with them:

They don't get these residents up before 1:00 pm, even 3:00 pm for the last ones. The morning attendants don't have the time to see if they're comfortable.

The participants also point out that the management asks that personal care be administered at the end of the night to lighten the workload for the day shift. According to the nurses, this measure affects the quality of rest for the residents, who, because of their health problems (cognitive disabilities), are subject to displaying hostile reactions to intrusive interventions. Being awakened or disturbed at the end of the night to be washed may rightly be perceived as an intrusive intervention. We shall return to this point when we deal with the question of the living environment.

A vision that places major emphasis on specialized interventions while basic needs go unmet

Citing, for example, the increased number of curative interventions

at the end of life, the participants say that over the previous five years, despite official promotion of the “living-environment” approach, they had observed that the institution was becoming more like a healthcare facility. They feel torn between the intense interventionism prescribed for many residents and the “living-environment” philosophy, which favours support, supervision, helping, and companionship:

I find it seems more like a general hospital than a residential and care facility for the elderly.

The doctors’ mental outlook should be different from the prevailing one. Some of them are extremely interventionist. For example, when a patient stops drinking or eating, he gets an IV or a feeding tube right away.

The participants also say that the residents’ pain and anxiety are not relieved as they should be in a long-term-care setting. They deplore their lack of autonomy in alleviating pain and anxiety:

They don’t relieve pain. We have one resident who moans 24 hours a day but has nothing prescribed for pain.

Some residents are so agitated they can’t sleep for two, three, four, or five nights in a row. When we suggest prescribing a sedative, we don’t get it. Unfortunately, these things are beyond our control.

In the eyes of the participants, the absence of a true palliative-care practice is a reflection of the “curative” or “specialized care” approach favoured by the institution. This situation is a source of suffering for the nurses insofar as it places them at the centre of ethical conflicts: they are led to do things that run counter to their conception of what care and services in a CHSLD should be. They perceive many interventions as aggressive therapy:

When I have to take a blood sample from a dying woman, the memory stays with me for a week. The resident said to me: “I don’t want any blood taken.” But I had to do it. It was hard! I can’t watch that happening anymore.

We’re hurt when they persist in treating a patient at the end of life.

They prolong residents’ life unduly and persist in treating them so that they survive, even though it’s detrimental to their comfort and well-being.

They’re in awful condition, and their life is being prolonged. That’s not a life anymore; it’s survival.

The participants say how difficult it is for them to square two such contrary and irreconcilable visions as the “living environment” and the “high level of intervention at the end of life”:

A living environment with so many blood samples, even on weekends, is no living environment to me.

The interventionist vision of care is so powerful that the question of death becomes almost taboo; according to the participants, death is not discussed or dealt with much in their everyday work. When a resident dies, the fact is almost not even brought up or alluded to in the ward. It is not mentioned; no one speaks about it. The nurses have the feeling that it is “inappropriate” to speak about death, and that strikes them as incongruous in a long-term-care environment:

Why is death such a taboo? We are in a geriatric setting, after all!

According to the participants, death is perceived as a failure: a failure of medical expertise, of care, of excellence, of the institution, and of management. They think that the management is afraid the family will blame them for the death of their relation:

They’re afraid of being blamed.

The nurses also express a fear of being blamed for the death of a resident. Indeed, many participants say they are afraid of a resident dying on their shift; they fear the families will attribute the death to incompetence on their part:

I’m afraid of the family’s reaction. If a resident dies on my shift, it’s as if I’d been incompetent.

The participants maintain that strong support from the nursing administration in their relations with the families would make all the difference in the way a resident’s death is experienced.

A “living environment” approach that is, in fact, almost totally nonexistent

As noted earlier, despite the official discourse promoting the advent of a true living environment, the nurses see themselves working in an intensive-treatment environment. According to them, the “living environment” so highly touted by the management is reflected mainly in physical amenities, which are meant to tone down the institutional character of the facility and create a homelike atmosphere. The participants say they deplore the fact that the residents’ (and families’) social, affective and relational needs have still not been substantively addressed:

In a living environment, they need personalized attention. Pictures on the walls, nice curtains, easy chairs with fabulous upholstery—that’s not what they need most in a living environment. They need company. They need to be touched. They need someone to talk to them.

We see beautiful paintings, sofas and drapes appear. But what’s being done in terms of care for the patients? The attendants don’t even have time anymore to cut their nails, shave their beards or take them to the toilet.

Since management advocates the “living environment” approach, the participants expect it to work actively to see this vision reflected in everyday operations. However, the participants claim, that’s hardly the case. They say the residents’ should spend their days in ways that resemble as closely as possible how they spent their days at home; they should have control on how their activities are organized and the latitude to do what they wish:

A living environment means being able to play cards or read a paper when you feel like it.

Unfortunately, rather than respect the residents’ lifestyles, the actual planning of activities is still largely a function of organizational convenience (presence of personnel, time):

A living environment with baths or showers that absolutely must be given at 8 o’clock in the morning is no living environment.

Work, as structured and organized at the time of the study, created situations that the participants describe as disrespectful of the residents:

Residents are woken up at 5 o’clock in the morning to be washed! Is that a living environment? I don’t think it makes sense.

The participants add that in accordance with the “living environment” approach, which sets great store by social life in the establishment, the institution has organized a number of recreational activities. Unfortunately, they say, given their physical and cognitive disabilities, only a minority of residents actually have access to them. The nurses judge the appropriateness and suitability of the organized activities rather severely:

Management organized an event. Very few of the clients were up

to taking part. It was all for show. That's not what we'd call a living environment.

An excessive workload prevents good work

All the participants point up their increased workload, described as "overload," which has developed because of the new residents' more complex clinical profile, the resultant intensification of work, and insufficient nursing staff, among other factors:

They admit very difficult cases, but resources are at a minimum. We'll receive an obese resident who's had a tracheotomy and is under a respirator.

The number of neurovegetative residents under a respirator is constantly growing.

I have dressings to apply, IVs to insert, antibiotics to administer every two hours. I can't manage it anymore.

For the daytime nursing staff, the shift from primary nursing to modular care was another factor that increased their workload. With the change from six nurses to four or even three per 49-bed ward, each nurse was responsible for more residents, and the time available for each resident was significantly reduced:

I have a team of 15 residents and I'm also often responsible for the ward. I'm burnt out, and I don't have contact with the residents any more. I don't see them anymore.

On the evening shift, the special 1:00 pm to 9:00 pm schedule had the effect of reducing the number of attendants on duty after 9:00 pm. Since the families usually visit in the evening and it is not permitted to put a resident to bed while visitors are there, the staff remaining after 9:00 o'clock is responsible for putting a large number of patients to bed. When something unexpected arises, the staff still on duty cannot cope with everything that has to be done:

The way they organize the work doesn't work well because as soon as something unexpected comes up, we're overwhelmed.

For their part, the nurses working nights see duties normally conducted during the day backing up or spilling over into their shift:

The number of day nurses went from seven to six, then to five, then four and finally to three. This has an impact on the preceding shift; the work gets fed back. For example, they want us to give them partial baths at the end of the night, around 5 in the morning: face, underarms....

The participants stress that the management thinks wrongly that all the residents sleep at night. This false impression considerably skews the way work is organized:

Night work is organized with the notion that the residents sleep, that they've switched "off." But it's often at night that major problem occur. Residents collapse. Others die.

To sum up, all the nurses, whatever their shift, point up the lack of staff and the nervousness of their duties:

There is not enough staff. The work is exhausting.

Apart from tiring them out, the increased workload has an impact on how they perceive the work that they do accomplish. They have the feeling they are not doing high-quality work:

I have huge frustrations; I tell myself I could have done such and such a thing for the resident. But I didn't have the time, so I didn't do anything, and I feel sorry.

We don't have time to massage the residents or settle them in comfortably! We do the best we can, but we don't manage to do things as carefully or gently as we'd like because we're rushed.

You've given him his pills, but a nurse's work isn't just giving pills. There's everything else! We have to ignore a lot of things, a lot of needs. That's what's hard. How can you be satisfied in such conditions?! You saw the distress in the resident's eyes. You saw the attention she wanted and that you weren't able to give her. That's what I can't stand.

What makes you suffer is not being able to do a good job.

The participants point out that, unlike themselves, the nursing trainees have better conditions that allow them to accommodate the residents' or families' requests, to enhance the residents' quality of life and, consequently, to feel the pleasure that comes from accomplishing high-quality work:

The trainees have the time to respond to the residents' requests, but we, unfortunately, can't do things as we'd like to. If we had a little more time, we could improve the residents' quality of life.

An increasingly instrumentalized practice

The participants underscore the increasingly marked presence of evaluation grids and information-management tools (such as SICHELD). Although the nurses consider the grids valuable and useful in some respects, they also have the feeling that nurses are being relegated to the status of mere "information coders." With respect to SICHELD, the nurses are deeply concerned about the lack of flexibility in the system and feel that using it entails a loss of autonomy; they feel that they are serving the system more than the system is serving them:

This system tells you everything you have to do. It even tells you when you have to print out your own and the others' work plan.

It's as though we were there to serve the tools instead of the other way around.

It should also be noted that the nurses perceive SICHELD as a method for management to check, supervise, and evaluate their work. Their sense of autonomy in their work is affected:

It lets them see whether or not you're doing your job. It almost becomes a tool for surveillance.

In general, the nurses do not perceive SICHELD as an instrument that helps them carry out their work; on the contrary, they see it adding to their burden. Apart from occasional nurses from the float team or the recall list, whom SICHELD provides with a certain amount of information about the residents, the participants find it of little use:

Before, we had a Cardex. It was more effective; it was a real job aid. SICHELD isn't a job aid; it's a burden.

It's useful for the nurses from the float team, who don't know the residents, but not for a regular nurse. It doesn't do anything for a regular nurse. But it does take up a lot of her time.

Difficult work relations at every level

While relations with other care providers on the nursing and interdisciplinary team are important factors in constructing the meaning of work and, consequently, mental health at work, the participants say they are deeply concerned about the difficult or fragile work climate that generally prevails in the long-term care wards. This section will examine more closely the relations between nurses and other workers in the institution, such as the nursing attendants, nursing

assistants, clinical nurses, and management. The section will close with a look at significant aspects of relations between nurses and families.

Relations with attendants and nursing assistants: Relations between nurses, nursing attendants and nursing assistants are generally good. Still, to a considerable degree, they are influenced or marked by the constraints of the organization of work, which sometimes set them against each other. The participants do not have the slightest doubt that the attendants' and nursing assistants' work is onerous and demanding. However, they note that relations become strained or harden when a nurse asks them to perform interventions that depart ever so slightly from the planned routine. Although they are held accountable for the overall quality of the care administered, the nurses point up how little official authority they have over the attendants and the nursing assistants (and on the organization and management of their work). The spectre of accountability means the nurses ultimately carry out or complete the work that was not or could not be done by the attendants and nursing assistants. They thus risk overwork and exhaustion:

If they don't have the time to take the residents to the toilet, we have to take them. If they don't have the time to turn the patients after breakfast, we have to turn them.

The participants point out the attendants' greater cohesion and the real union support they enjoy, which enhance their ability to defend themselves:

When the attendants aren't happy about something, they complain to their union. The head nurse sides with them, and we have to accept it.

According to the participants, many attendants do not always seem to understand that the nurses may be busy and cannot accompany them on their rounds:

The attendants expect to be helped a lot. They have a hard time understanding that we'd like to help and accompany them, but that we're not always able to.

They don't always understand the reality of our work. For them, the real work is the rounds.

As for the nursing assistants, the participants consider that management gives them preferential treatment in the new organization:

The nursing assistant is entitled to breaks in the afternoon. She's entitled not to do any clinical work. The nurse who supervises her will do it for her! It's always the nurse who takes up the slack. I find the nursing assistants are treated like gods in the new organization.

With three staff for 49 residents, work relations between nurses and attendants on the night shift are marked by greater autonomy and informal group practices that allow them to respond to the major demands of the job. The particular way work is organized overnight seems to foster good relations:

The night teams are like old couples.

We become like brothers. Let's just say we have no choice.

We share the attendant's work. We accompany him on his rounds. It's something that practically never happens on the other shifts.

Relations with clinical nurses: The participants note that relations with some clinical nurses are marked by tension and a lack of recognition for the work they perform and the expertise they possess. This situation causes them particular suffering, the participants say, because the clinical nurses are nurses just as they are and should therefore understand the beauty of the demanding job they do. The

nurses feel they are simply used by some clinical nurses to execute programs they have developed, sometimes without even consulting the ward nurses about the selection of residents for the programs. The participants feel they are treated like "information gatherers" or "note takers" rather than real experts in nursing. The suffering associated with this lack of consultation and recognition is great; they feel all their professional expertise is being questioned:

I'd had this team for three years. I knew everything about the residents by heart. The clinical nurse came to select patients from my team without even consulting me. She made up intervention programs without even talking to me about them.

The clinical nurse came to select residents who had aggressive or disruptive behaviour without even consulting me.

The nurses do not criticize the programs and evaluation grids in themselves but question mainly the way they are implemented and used: the tools that are supposed to make their work easier are widely perceived as making it more onerous.

Relations with managers: The relations that appear to be most difficult and problematic are the relations participants have with certain head nurses, whom the participants see more as extensions of management—that is, as budget managers—rather than as real leaders focussed on providing support and guidance for their team. Although the participants acknowledge the complexity of the head nurses' job, they lament the fact that the head nurses do not show more consideration or understanding for the difficulty of their job. They remark on the head nurses' highly critical, guilt-inducing attitude:

The role of head nurse is a hard one. A lot is asked of them but, sometimes, all I'd like would be for them to say we're doing a good job. That's what's missing. We get a lot of criticism.

If you make a mistake, you'll be criticized, and you'll meet your superiors a thousand times during the day. They'll make you feel guilty. They won't give you credit for the thousand things you do well.

You never get a pat on the back to tell you, "Go on. Keep it up. You're doing fine."

They're all right for telling you what your weak points are, but they never say much about your strong points. We don't get much recognition.

The participants deplore the fact that the head nurses do not support their requests. They feel the head nurses give top priority to the demands of the families, followed by those of the residents, the physicians, and only lastly the nurses:

The families come first, then the residents, the doctors, and the kitchen, and the nursing staff comes after them.

In the day-to-day provision of care and services, the nurses deplore that the nursing administration gives precedence to the requests and viewpoints of the families without even taking circumstances in the ward into account. This state of affairs is a major source of suffering since the nurses think that by giving priority to the families' views, the nursing administration does not give due consideration to their professional expertise. The situation is especially hard to bear because they see that the families' viewpoints and demands sometimes undermine the quality of care and quality of life of the residents, for which they as nurses are, in the final analysis, held accountable:

As a nurse, you make what you think are the best decisions for the patient. If the family disagrees, they'll complain to the head nurse, who will then challenge the nurse's decision. Isn't the head nurse supposed to support and defend us? The very opposite happens.

The participants note that they are left little autonomy to organize the work for their team despite the accountability that goes with their job:

They watch us closely to make sure we follow routine. Things have to be done as they want them. That's how they take away what little autonomy we have.

Some participants go so far as to think that management somehow exploits the nurses' suffering. Indeed, in order not to be held responsible for a lack of care or an adversarial working climate, the nurses ultimately bow to everyone's demands at the expense of their own professional opinion and quality of life at work. The managers know this but willingly ignore this reality:

At some point, they know, we're compelled to fulfil our obligations. We can't just do what we want. We're nurses. We work with people who have needs, and they're the ones who'll be penalized if we don't behave ethically.

The employer knows we're obliged to complete the medical records. A nurse can't leave without doing the medical records. She knows her responsibilities.

The participants who work at night have the feeling that the nursing administration gives priority to the way the day shift is organized because it is highly visible. It is the institution's "showcase," as it were. The evening shift and, especially, the night shift operate at hours when there is less traffic, and so they are less visible. According to the nurses, the nursing administration therefore gives precedence to the organization of the day shift; the "showcase" has to be perfect to display the most brilliant image possible:

That way, day work that is, the work people see is okay. The spillover into the evening shift is not too visible, and the backup into the night shift isn't visible at all. There it is again: the need to look good!

So everything is great during the day! The spillover into the night shift isn't seen. No one's there to see it! It doesn't bother anyone.

Appearances, looking good, are very important for them.

The participants describe their relations with the nursing administration as distant. They speak about "the ones on the second floor," as if to note that management keeps behind closed doors with no contact with the wards. According to them, the nursing administration does not realize the real difficulties and constraints their work entails. For management "everything is all right" or everything has to seem to be all right, and it is inappropriate to say anything to the contrary:

Things have to look good here. You don't talk here. You don't talk about problems. You mustn't ask troubling questions. You don't settle problems here. You apply adhesive tape.

They fear being singled out, so it is hard for them to go against the tide.

From what the participants say, it emerges that consultation is more illusory and apparent than real. This situation, they say, reflects the lack of recognition for their professional expertise. For example, when new admissions are selected, the nurses feel that budgetary considerations carry more weight than the analysis of the applicants' clinical profile:

My greatest frustration is that no one asks our opinion. For example, we had to choose from three new residents. We'd agreed among ourselves to choose one. The head nurse came back over and over again to encourage us to choose the resident she wanted. In the end, it was the resident she wanted who was admitted.

Some participants point up that there are head nurses who try to show themselves to best advantage by admitting residents exhibiting a severe clinical profile to their ward.

To sum up, the participants say they do not feel they receive support from any level of the hierarchy. They say they are grappling with major operational problems that will not be resolved so long as they are not discussed. They say they make considerable efforts to make up for the lack of resources and guidance but think they get very little recognition in return.

Relations among nurses: While not openly adversarial, the climate between nurses is far from being as good as it could be. The participants describe their relations as functional, insofar as the heavy workload leads—or compels—they to help one another. However, this mutual assistance seems to have more to do with a strategy of survival, defence or protection than with the operation of a true working group:

We've learned how to manage the work overload. We help each other. We've got to protect ourselves.

Some participants paint a rather bleak picture of relations between nurses, saying they are marked by a lack of respect or support between peers:

Even before the head nurse arrives, some of them will go see if we've done everything we're supposed to. It shows a flagrant lack of respect. Their attitude discourages and undermines us.

The participants who work in the evening and at night express an acute sense of a lack of respect and consideration from their colleagues on the dayshift:

We get no respect.

For us, it's more a matter of indifference. There are mornings when they don't even listen to me. It makes me furious when some of them begin to talk about what they did over the weekend while I'm giving them the night report. When that happens, I get up, put down the papers and say: "Good-bye. Have a good day." Sometimes, they don't even notice I've gone.

We sometimes have the feeling we don't count, that we're nothing.

In some long-term care wards, the relations between nurses are reportedly marked by pettiness and spying. Some participants note a lack of solidarity and the existence of cliques:

There's not a lot of solidarity among nurses. I'd go so far as to say there's a lot of pettiness. They'll look for something another nurse is doing wrong, and they'll find it, you can be sure of that. All that, to have something to beat a colleague over the head with. That's kind of violent, wouldn't you say?

The deterioration in social relations between nurses can in part be explained by the very heavy workload, which reduces opportunities for interaction. Many participants lament the fact they have practically no more time to take breaks together. The night nurses denounce the absence of meetings between assistant head nurses "like before." These meetings fostered interaction and discussion. The organizational changes introduced over the past few years do not seem to be unrelated to the deterioration in relations between nurses:

The new organization separated and divided the nurses. It contributed to the development of cliques. Before, we could interact. We nurses would discuss among ourselves problems we were having in the teams or in nursing. We'd ask for advice about a dressing or a wound. Now we don't have time anymore.

Some participants even mention managerial attitudes that do little to “bring people together.”

Some head nurses divide in order to rule better.

There’s favouritism. Some nurses get preferential treatment.

Relations with families: From the outset, when the participants speak about the families, it is with a complaining tone. In their eyes, the families make too many (and, what is more, sometimes inappropriate) demands and adopt aggressive attitudes towards them. Though relations with some families give them pleasure, the situation is very different with most families.

As mentioned earlier, the participants complain bitterly that management sides with the families when they complain. The nurses have the feeling that the management is afraid the families may file complaints, and it therefore favours their requests:

The families complain, and, to stop things from going farther, the administration forwards their requests. I’d like it sometimes if the management told them: “Listen sir or madam, the staff are doing what they can. There are limits to what we can do.” But no, they get all the requests from the families and ask us to do more and more.

The people here grovel to the families.

We shall see below that the relations with the families also assume a defensive aspect.

Defensive strategies

As we mentioned earlier, no true working groups were observed in the wards. Nor, therefore, do we find any group defence strategies that would enable nurses together to counter the various sources of suffering they confront. An analysis of the views expressed by the participants reveals, instead, various individual defence strategies, which many of the nurses share. These strategies are presented below.

The choice of silence

The situations reported by the participants confront them with a contradiction so hard to accept that it causes them pain and is a source of suffering. On the one hand, there is a “showcase” and a discourse promoting a “living environment” and excellence. On the other, there is a reality marked by a range of shortcomings. This context gives rise to a conflict of loyalties. The nurses have to choose between remaining loyal to the image and views promoted by management and dissociating themselves from the “showcase” and the management line by denouncing the deficiencies they observe every day. They face a major dilemma:

The 1:00 pm to 9:00 pm schedule makes us want to condemn the situation, but ... we can’t condemn it. We have to keep quiet about it.

It is important to see and to understand that if they denounced the situation, the participants would also be underscoring the deficiencies in the quality of nursing care. This consideration may well be a factor in their silence:

There’s no point talking. We’d just be shooting ourselves in the foot by talking.

It’s better not to talk, because it could backfire on us.

That said, the participants note that nurses who do voice such remarks or comments find themselves labelled whiners, moaners, or spoilsports by the nursing administration. This fact also encourages them to keep silent, but their silence troubles their conscience and is a silence of suffering:

It’s not worth talking. If we talk, we end up paying. So we keep quiet.

I don’t talk anymore. I do what I have to.

We prefer to keep quiet, because talking exposes you to criticism

When someone makes comments, it’s like they’ve ruined the party.

Many participants emphasize that at one time they did speak out, try to intervene, take action, and change things, but these attempts were never fruitful or helpful:

Before, there were attempts to change things.

When I got here, I used to talk, but now ... we’ve got no more taste for asserting ourselves.

They wonder whether by keeping quiet about what frustrates them they are not doing what the management wants them to do; namely, keep quiet about their dissatisfactions:

I think we’re kept from talking about what makes us mad.

Disinvestment and disengagement

Whether because they have no more energy or because they fear the consequences, many participants say they choose to avoid confrontation and conflict. They have already been hurt or got their fingers burnt. They therefore try to protect themselves by moderating or reducing their psychological investment:

I’m not giving anymore.

They say they no longer have a taste for getting involved in the fight:

I’m buying peace.

Some reduce their involvement in different committees, participate less in activities initiated by the clinical nurses, or neglect on-the-job professional development. If they can afford to, they deliberately cut back on the time they are exposed to suffering by working part time or refusing overtime:

There’s a reason I don’t work full time.

Retreat, withdrawal, and defensive individualism

Confronted with a management style that offers them little support and generates more division than collegiality among co-workers, the nurses try to protect themselves by seeking refuge in a defensive individualism:

We surround ourselves with a shell. We retire to our den. That’s how we protect ourselves. We’re trying to save our skin.

In the short term, this individualism enables them to protect themselves and carry on. In the long term, though, it penalizes them, since it does nothing to improve the climate or environment at work.

Lowering expectations, the disempowering adaptation

Many participants say that they prefer to lower their expectations and adapt to the situation while they await the deliverance that retirement will bring:

Coming to work to get paid on Thursday and for your pension fund.

This adaptation seems to be more common among the older nurses, who have paid into the pension fund for years and do not want to lose this benefit:

What’s kept me here is my pension fund.

If I were in my twenties, my pension fund would be small, and I don't know if I'd stay. Maybe I'd get myself a laser hair-removal clinic like the girl I saw on [TV] the other day. After working in a hospital for two years, she said: "No. I'm not going to do this for 35 years."

Unfortunately, this adaptation puts a stop to any search for solutions that might diminish the sources of suffering at work.

Negation, denial

The analysis reveals that many participants negate or deny the lack of care that some residents must endure. The negation and denial are generally unconscious. The participants become aware of them only when confronted with their own contradictory statements, on the one hand, touting the "high quality" of care and, on the other, denouncing situations that unambiguously illustrate the deficiencies in care, such as the treatment reserved for residents whose attendants work the 1:00-pm-to-9:00-pm shift and the lack of time to provide comfort care and have meaningful human relations with the residents.

Aggressiveness, anger and hostility towards families

Some participants express aggressiveness, anger or even hostility towards the families who remind them of or hold them responsible for the deterioration in the quality of care:

We've got aggressiveness to spare.

The painful reminder by families of the deficiencies in their relation's care leads the participants to try to discredit the families because the confrontation with or reminder of the lack of care causes them suffering as professionals. In other words, the families who tell the nurses that the day-to-day situation is far from being as lovely as promised before admission and who challenge the nurses on this point trigger an unconscious defensive reaction aimed at suppressing the suffering associated with this reminder. Metaphorically speaking, the nurses are shooting the messenger who is reminding them how unacceptable the situation is:

Yes. It's as if we were shooting the messenger.

The hostility, anger and aggressiveness displayed towards certain families must thus be interpreted as a defence.

Avoiding families

Participants also note that they sometimes try to avoid meeting families who want to complain about the lack of care they see their loved one receiving. The nurses are thus trying to avoid confrontations that serve as painful reminders of what they know but no longer want or are no longer able to see or hear:

We hide from some families.

Acting out frustrations, whining

Some participants report that colleagues say they have changed, that they are not as cheerful as they used to be, that they have become moaners:

There are people who tell me, "We've never seen you like this. What's going on? You've become a whiner. Before, you used to sing. Now you gripe!"

Venting their frustrations, albeit by complaining, allows them, as they say, to "lower the pressure that's building in [their] head." Verbalization is thus a way of avoiding the build up of painful psychic tension:

If I have something to say, I say it, like it or not! It's true that afterwards I sometimes take the consequences, but at least I have the pleasure of having said it.

Boycotting activities

In reaction to their difficult relations with colleagues, head nurses, clinical nurses, and members of the nursing administration, nurses ignore or even boycott some recreational initiatives or activities. Christmas dinners are thus no longer well attended; in some wards they are simply cancelled.

Cynicism

The participants' statements reflect a great deal of cynicism, which enables them to turn around the representation they have made of their situation. The "It's better to laugh than cry" attitude alters their perception of the situation and thus changes their relationship to the source of suffering.

Rationalization as a shared strategy

The participants' talk is replete with rationalizations for the difficult work conditions they endure. Rationalization is a defensive strategy that lessens the perception of suffering. For example, after voicing a litany of their frustrations at work, they go on to minimize the problems by saying that the situation is even worse in other CHSLDs:

Since the last reorganization, everyone's dissatisfied. But compared to other centres, we're in great shape. Things aren't as bad here as they are elsewhere.

When confronted with their rationalizations, the participants say they are only repeating what the administration tells them:

We're told it's worse elsewhere and that we're living off the fat of the land.

According to them, they hear management and senior staff members saying similar things, which they ultimately internalize, and they come to think that they may be complaining or protesting too much:

We end up thinking that maybe we're the ones with the problem. Maybe we're the ones who are too whiney.

Many say, however, that they have never checked whether management's assertions are true and so do not know how well founded they are:

The fact is I don't know if it is worse elsewhere. I've never gone anywhere else.

I've been told by the administration that it's worse elsewhere. But I've never gone to see if it's true.

Discussion and Conclusion

Role, role ambiguity, and role conflict

A comprehensive analysis of the participants' (rather rare) sources of pleasure and (rather numerous) sources of suffering in the light of the various defensive strategies that emerge from their stated views reveals a professional identity whose suffering is associated with major difficulties in the proper definition and fulfilment of the role of nurse. For the sake of fuller understanding, it is useful to briefly recall the concepts of role, role ambiguity, and role conflict.

The concept of role refers to the entire set of expectations and

attributions attached to a worker in terms of what he or she has to do (prescribed conduct and interventions), of bases for action, values, and standards of conduct associated with the status of the person (in this case, the status of the “healthcare professional”). These expectations and attributions may be made explicit (for example, in a job description) or remain informal and implicit, emerging, for instance, from the interactions of daily life at work: assumptions, workers’ perceptions, workers’ judgments of each other. A role thus implies the judgement of recognition pronounced by other people—recognition of skills and of work accomplished. A person with a given role may or may not subscribe to a professional “identity,” to the rules of the profession, or to an ideal of performance.

Role ambiguity occurs when several meanings, expectations, and attributions are attached to the same role without the worker being able to decide which one takes precedence in a given situation. It may also mean that several roles are expected from the same person without one or another of the roles explicitly holding priority. This blurring in the definition of what must be done and of what is an expected lead to much confusion in assessing what has actually been accomplished. Benchmarks are thus lost, as is any meaning given to the work.

Ambiguity may also emerge when a specific role is played by different actors (for example, nurses and attendants).

If the prescribed or informal expectations attached to roles diverge or contradict one another, role conflict develops: fulfilling (complying with) one role puts a worker in contradiction with another role. Such a state of affairs results in significant psychic tension, which may sometimes leave a worker in an impasse. Role ambiguity and role conflict thus directly threaten the bases of professional-identity building and induce confusion and a feeling of loss of recognition.

It seems to us that this is the situation that emerges from the statements of the participants: a number of factors are contributing to role ambiguity and even role conflict.

A major source of ambiguity, which the participants brought up a number of times, is related to the inconsistencies between three aspects of their work situation: the overall institutional framework, the prescribed organization of work, and their actual day-to-day work. First there are the expectations (or demands) associated with the status of a geriatrics facility. To live up to this status, the institution must be a locus of research, teaching and innovative practices in geriatrics, and the status is reflected in a discourse and image that tell of excellence in care and services. All these aspects of the setting clearly take in the practice of nursing. For the nurses, practising in such an establishment is a source of pride.

That said, according to the participants, this “showcase of excellence” is not clearly reflected in the prescribed organization of work. Recent organizational changes, such as the shift from primary nursing to modular care and the introduction of the SICHELD computerized support tool, seem to call for increased professionalism, involving as they do authority over the entire module and more sophisticated work aids. However, these changes are accompanied by conflicting measures and new constraints: fewer nursing positions; more responsibilities; a heavier workload; more intense work; maintenance of a markedly hierarchical structure in which the nurse has no more authority than before; and more technical administrative work. It is mainly in their day-to-day work life that they feel the ambiguity that stems from the discrepancy between the excellences promoted and expected by the institution and the way work is organized. Indeed, in their day-to-day work, role ambiguity has been amplified by the changes that have been

introduced: The new duties of the person in charge of the module do not come with any additional authority; the use of SICHELD makes work more onerous, not easier; the hierarchical nursing structure remains intact; and the residents constantly present more serious clinical signs requiring not only more care but also more complex care, and by that fact alone make creating a true “living environment” more problematic.

The participants’ statements give expression to real role conflicts that stem from the way work is organized. For example, in the modular approach, because each nurse is responsible for a greater number of residents, the participants feel or see that they have been compelled to abandon certain roles, such as the “helping” or companionship relationship. Moreover, the increase in technical management chores (completing forms, entering data into SICHELD) compels them to reduce the time they allot to nursing practices. The nurses also seem to suffer from a conflict about the clinical approach: between the ever-growing delivery of specialized curative care on the one hand and a more *caring* approach to nursing (listening, being present, supporting, supervising, comforting) on the other. It sometimes seems to them that the touted “living environment” approach does not accord with the concrete reality of increasingly dependent and ill residents. A role conflict also emerges when the nurses see themselves compelled to deliver care they consider invasive to dying residents.

The organization of work is thus a source of role conflict and ambiguity due to the observed discrepancy between the institution’s mission of excellence, the conflicting effects of the prescribed form of organization and actual organizational changes, and the lived experience of everyday professional work with a highly dependent clientele.

Some of the statements provide evidence of the nurses’ situation of ambiguity and role conflict. The nurses are supposed to be in charge of or head modules, but in fact they cannot say anything to the attendants or nursing assistants because they lack legitimate or official authority:

We just have responsibilities, not rights.

There’s a lot of ambiguity in our role. There was less twenty years ago. It’s changed a lot.

We’ve lost our identity.

The attendants put you in your place if you say anything to them.

The workload is too heavy and may conflict with prescribed professional responsibilities; the nurses may resolve this conflict by taking on too much:

I can’t leave my medical records even though it’s already 8:30 and I’m already 30 minutes late. I know I won’t be paid for this overtime. I’m working for nothing. I should have the right to say: “That’s enough. Either you pay me or I leave the charts here.”

If you act that way, you’ll be blamed.

Over the past five years, the changes in nurses’ work and the way it is organized have done away with a component that the participants consider to be at the heart of the role of nurse: relational support. Other components, such as management, hold sway in their day-to-day reality:

Our role as nurses has changed a lot. I feel more and more distant from the residents.

Before, we were very close to the patients. We delivered care for their greater welfare. A little while ago we moved into a management role. We

manage the module (residents and families). We take part in managing the ward. We manage the paperwork.

In primary nursing they said they had a “comprehensive” practice that allowed them to deliver complete (holistic) care. With the introduction of modular care, they feel they have “lost” the companionship relationship with the residents and families and instead engage in more intense technical and clerical work, which brings with it a fair measure of suffering.

An ambiguous, even conflictual, exercise of power

According to the participants, one factor that does not help support professional identity is the loss of control and decision-making power over their work. Although they say and are told that they are healthcare professionals and that they have to take their place in the interdisciplinary team, they regularly have to fight for and justify the requests they make with the aim of enhancing the well-being of the patients they are responsible for. They point out that their responsibilities have increased, but they have received no real power over the way their work is organized:

I have to go through the head nurse to ask, “Would you agree if I... because such and such. What do think?”

Nurses should play the key role in solving problems. Often, though, we're powerless. We can't do anything.

We have no power.

The nurses see themselves confronted with conflicting responsibilities, sources of paradox, as the following example shows:

Here's a good example of a paradox. They say no caregiver is supposed to work alone, especially when you're mobilizing a resident. The problem comes up at night, when the nurse is busy with IVs or other urgent care and isn't free to accompany the attendant on her rounds. So, last weekend, the attendant I was working with decided to follow instructions to the letter. She told me, “Since you're busy, I'll wait for you to do my rounds. You know I'm not authorized to do it by myself.” Well, since I couldn't get away from what I was doing, the attendant sat there, and her rounds didn't get done. That triggered a whole war with the daytime staff.

The management doesn't know that the attendants have been making the last night rounds alone while the nurse is busy with other duties. They do it themselves. If they didn't, it wouldn't get done. They do it themselves so as not to get criticized by the day staff.

Organization of work, identity crisis and an impasse in action

The main issue that emerges from the analysis is that of the negative effects of a way of organizing work that was experienced as inappropriate to the development of a strong professional identity by nurses. Role ambiguity and role conflict are sources of suffering. Many features of the institution's “showcase of excellence” are highly regarded but at the same time criticized by the participants because they bear little or no relation to the real work of the nurse as it relates to the residents. As for the organizational changes, they bring with them new demands (computerized management, a hoped-for decentralization, concern for the residents' quality of life). However, the actual organization very often conflicts with the necessities of or impulses for change.

The participants do not really ask to be managers of modules or super specialists of sophisticated care delivered from a curative approach. They wish to receive enough authority and enjoy the support of their superiors to restore and maintain the balance between relational

care (caring) and invasive care and to be recognized for their expertise and experiential knowledge with long-term-care residents. There is room as they might want to proclaim following [13] for “ordinary” nurses who focus on the well-being and comfort of patients at the end of life. The current expectations of the institution represent a strong challenge to such professional ordinariness. The nurses are afraid to assert this vision of their role because they do not want to receive a negative evaluation or a discriminatory judgement that they are not the professionals the institution wants.

The various defensive strategies applied by the nurses lead us to the hypothesis that they are in an impasse with regard to the changes that would have to be made to restore full recognition to the role of the nurse, a clearer role free of the ambiguities and conflicts we have identified and better adapted to the care and services required by the residents and their families. In fact, however, the defensive strategies are characterized by ambivalence, individual solutions, the fragmentation of the nurses as a group, and silence. They are reflected in the nurses' feeling that they are unable to intervene collectively and change the way their work is organized; hence the impasse regarding action.

In conclusion, one may say that the main sources of suffering that emerge from our findings are role ambiguity, role conflict, non-recognition of the real work accomplished, and the lack of consideration for the work the nurses would like to accomplish. The discrepancy between the institution's expressed views (promoting the living environment and excellence and the development of new professional roles) and the way nursing work is actually organized (which bears little relation to the much-vaunted approaches and sometimes even undermines the conditions needed to accomplish or fulfil them) appears to be a major factor behind most of the sources of suffering. The large number of defensive strategies that emerge from the participants' statements illustrates the great difficulty they feel in raising the issue of the organization of their work with the authorities concerned. In fact, these strategies represent a common position of withdrawal, which results in their not taking action about the situation.

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