

## **Towards Ethical Inquiry in the Economic Evaluation of Nursing Practice**

**Patricia Rodney and Colleen Varcoe**

L'évaluation de la pratique infirmière selon des critères économiques constitue un outil essentiel dans le domaine des soins infirmiers et des soins de santé. Les auteurs affirment que la cueillette de données économiques doit être faite en tenant compte des données éthiques, et que la profession infirmière se doit d'examiner les valeurs en même temps que l'aspect économique. En s'appuyant sur deux études ethnographiques portant sur la pratique infirmière, les auteurs mettent en lumière le travail invisible des infirmières, la tâche invisible que constitue le triage de clients ainsi que les coûts invisibles que doivent payer les infirmières et les clients. Selon eux, le travail, la tâche de triage et les coûts invisibles relèvent profondément de certaines valeurs, et si la profession infirmière est tenue de réagir aux conséquences de la réforme de santé, celle-ci doit se pencher sur les valeurs inhérentes au mesurage économique et sur les décisions qui en découlent sur le plan des politiques de santé. Ce qui est invisible peut échapper à la « comptabilisation », à moins que l'évaluation économique ne soit fondée sur une cueillette de données éthiques. En conclusion, les auteurs suggèrent d'intégrer la cueillette de données économiques et éthiques dans le but de favoriser la mise en place d'un système plus humain, qui dessert, de façon plus efficace, tous les intervenants œuvrant dans le domaine de la santé.

Economic evaluation is a critical tool for nursing and health care. The authors claim that economic inquiry needs to be supported by expertise in ethical inquiry, that the nursing profession needs to examine values concurrently with economics. Drawing on 2 ethnographic studies of nursing practice, the authors illustrate nurses' invisible work, their invisible triaging of clients, and the invisible costs to nurses and clients. They argue that invisible work, triage, and costs are embedded in a number of values, and that if nursing is to respond to the consequences of health reform, it must examine the values inherent in economic measurement and subsequent health-policy decisions; what is invisible may go "unaccounted" unless economic evaluation is informed by ethical inquiry. The authors conclude by suggesting that economic and ethical inquiry be integrated in order to foster a system that is more humane as well as more effective and efficient for all those involved in health-care delivery.

Nurses in all arenas of practice across Canada, as well as in other Western industrialized countries, are facing excessive workloads, a shortage of skilled colleagues, a decimated cadre of nurse leaders, and increasing acuity/distress among patients/clients, families, and com-

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munities (Acorn, Baxter, & Walker, 1999; Adams & Bond, 2000; Aiken, Clarke, & Sloane, 2000; Canadian Nurses Association, 1998; Nagle, 1999; Redman & Fry, 2000; Rodney & Starzomski, 1993; Sochalski et al., 1998; Varcoe & Rodney, in press; Woodward et al., 1998). At the same time, nurses are being challenged to examine — indeed, defend — the economic aspects of nursing practice. This issue of the Journal is testament to the importance of nursing expertise in measuring the cost implications of nursing services. In this paper, we will argue that economic inquiry needs to be supported by expertise in ethical inquiry; that is, we believe that our profession needs to examine *values* concurrently with economics. A new but growing body of research is warning that the past decade of health-care reform has been one of profound deterioration in the conditions of nurses' work, with increasingly deleterious effects on health-care delivery (Adams & Bond; Aiken et al.; Barry-Walker, 2000; Mohr, 1997; Mohr & Mahon, 1996; Redman & Fry; Reinhardt, 1997; Reynolds, Scott, & Austin, 2000; Shindul-Rothschild, Berry, & Long-Middleton, 1996; Sochalski et al.; Varcoe & Rodney; Woodward et al.). If we are to respond to and reverse the consequences of health reform, it is crucial that we examine the values that are inherent in economic measurement and subsequent health-policy decisions.

In order to support our methodological reflections, we will draw on results from our own qualitative studies describing nursing practice and the cultural context of health-care delivery, as well as other relevant empirical data. Rodney's (1997) feminist ethnographic account of nurses' enactment of their moral agency included over 200 hours of participant observation on two acute-care medical units, with 22 interviews with 11 nurses from acute care and three from home care. Varcoe's (1997) critical ethnographic account of nurses' practice in relation to violence against women was conducted in the emergency units of two hospitals and their communities. The latter study involved over 200 hours of participant observation and interviews with 45 participants, including nurses, social workers, physicians, clerks, and patients (see also Varcoe, 2001; Varcoe & Rodney, in press).

In this paper, we intend to shed light on some of the values inherent in health care that, if not critically examined, may distort the economic evaluation of costs. We will explicate the often invisible, and frequently paradoxical, processes involved in day-to-day rationing of nursing and other resources. We will conclude by suggesting how we might integrate economic and ethical inquiry to foster a system that is more humane as well as more effective and efficient for all those involved in health-care delivery — patients/clients, families, communities, providers, and practice leaders.

### Unseen Nursing

As the health system changes and continues to become more complex, there is increasing emphasis on the need for greater co-ordination and integration. There is a challenge to find new ways of conceptualizing health, and new ways of organizing, delivering, financing, and evaluating health services. (Giovannetti, Smith, & Broad, 1999, p. 298)

Despite the mandate to evaluate services, *nursing* services remain largely invisible to other providers, to administrators and policy-makers, and to theorists in fields such as bioethics and health economics (Campbell, 1987, 1994; David, 2000; Giovannetti et al.; Liaschenko, 1993a, 1993b; Stelling, 1994a, 1994b; Street, 1992; Varcoe & Rodney, in press). As Giovannetti et al. explain, "data that reflects the demand for nursing care, the response of nurses to that demand, and the contribution of nurses to the public's health, is generally not available for use in planning, managing, and evaluating the effectiveness of the health system" (p. 306). Clearly, this is of concern. What remains invisible is all too easy to dismiss, and what *does* get measured does not necessarily reflect the full worth of nursing services (Giovannetti, 1994; Mitchell, 1993).

Meanwhile, federal, provincial, and regional health-policy changes in Canada, while occurring at an unprecedented rate and while unparalleled in scope (Brown, 1996; Storch & Meilicke, 1994, 1999), are largely uninformed by a comprehensive analysis of nursing and nursing practice. This has potentially disastrous consequences for nursing practice and health-care delivery (Armstrong & Armstrong, 1996; Canadian Nurses Association, 1998). To illustrate, let us turn to the province of Alberta. Brown (1996) writes that in 1993 Alberta "initiated a set of financial reforms for its health care sector, modeled in general terms after reforms already implemented in New Zealand and Britain" (p. 137). The key feature of the reforms was the creation of 17 Regional Health Authorities (RHAs), thus replacing the single provincial budget authority with 17 budget authorities and charging them with responsibility for funding health-care activities. This reform effectively created a split between the demanders (RHAs) and suppliers (health-care providers) by expecting potential suppliers to bid for business. Brown explains that these moves were based on the ideology of economic rationalism, in which public-sector intervention to create managed markets is seen to be feasible and efficient where competitive markets do not naturally evolve. Among the effects of these changes were a distancing of health-care providers from health policy-makers, an emphasis on health-care processes rather than on health outcomes, and equity being given short shrift relative to efficiency (Brown, p. 139).

Such changes might be expected to distance nurses from health policy and support nursing "efficiency" over care aimed at health outcomes or equity.<sup>1</sup> Indeed, in 1994 the Alberta Association of Registered Nurses released the results of a survey it had undertaken to assess the impact of the reforms on patients/clients, families, and communities (Oberle & Grant, 1994). Responses from nurses across the province concerning staff cutbacks were frightening. For instance, elderly residents were reported as being inadequately fed in nursing homes and seriously ill children were reported as being discharged prematurely from emergency departments (Oberle & Grant). It is our experience, and the experience of nursing colleagues across the country from whom we have heard, that the situation in Alberta was not unique.

However, much of the impact of health-care "reform" on nursing is invisible and therefore overlooked. In fact, there is a startling lack of evaluative data on the impact of health-care reform measures in Canada, the United States, and elsewhere on outcomes for clients<sup>2</sup> as well as providers (Aiken et al., 2000; Sochalski et al., 1998). Below, we draw on our own research to shed light on aspects of nurses' work that are likely to be invisible and/or underestimated in economic evaluations of nursing care. Our data were collected between 1995 and 1997 in a Canadian province that was undergoing regionalization and rationalization of health-care delivery. We argue that under the economically driven changes that characterize recent health-care reforms, only certain processes are costed. Thus only certain aspects of care are accounted for and funded, while significant aspects of nursing care are not. Our research has led us to be particularly concerned about nurses' invisible work, the invisible triaging of clients, and the invisible costs to nurses and clients. We will suggest that different values underlie what gets accounted for and what is overlooked in economic evaluation and subsequent health-policy decisions.

### *Invisible Work*

An important aspect of invisible nursing work identified from our studies was *nurses' emotional labour* — that is, fulfilling patients' needs

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<sup>1</sup>Equity is not the same as equality. The word equality, though often misused or misinterpreted, means the state of *being* equal. Equity, on the other hand, means fairness or equality of *treatment*. Thus inequity (or unequal treatment) can result in unfair allocation decisions.

<sup>2</sup>Hereinafter, when we use the term "client" we are referring to all those who are the target of nursing practice — patients/clients, families, and communities.

for emotional support (Yyelland, 1994; see also Varcoe & Rodney, in press). According to the nurses in our two studies, one of the greatest impacts of limited resources was that the nurses did not have time to "talk" to patients. Everything within the context of practice — from the allocation of the workload, to the geography of units (maximum surveillance, minimum privacy), to the design of charts — fostered the devaluing of non-physical concerns. Nurses' emotional labour was therefore found to be particularly undervalued in both studies. Under the increasing pressure of high acuity combined with cost-saving measures, such work was the lowest priority. Most nurses at all study sites worried about their inability to attend to these patient needs. One nurse said:

*Sometimes due to the busyness of the department you don't really have a chance to get into the emotional aspect of it...you don't really have the time...to sit down and say "really, what really happened?" (Varcoe, 1997, p. 251)*

Even when patient needs for emotional support were particularly high, as in the case of a death, terminal diagnosis, or severe trauma, nurses were unable to make such work a priority. Many nurses told of such situations. Their inability to provide support caused them distress that lingered long after the incident. For example:

*I get really angry when I don't have the time to spend with the patients and yet...there are lots of times that I'm thinking "thank God they don't want it." I remember asking somebody, he had just been diagnosed with lung cancer, and saying "do you want to talk about it" and he said "no, I'm not quite ready to talk about it" and honest to God I just said [to myself] "thank God" because I had a gazillion other things to do. (Varcoe, 1997, p. 128)*

Emotional labour was not only devalued but actively discouraged. Nurses spoke not only about lacking the time for what they referred to as "the psychosocial," but also about how colleagues who *took* the time to talk to patients were criticized because they interrupted the work flow. Many nurses expressed derision for "bleeding hearts" or for those who were "slow," spent "too much time talking," and so on. As one nurse explained:

*[We] don't support each other...one of the nursing staff...has a very strong psych background and she wants to do that, and so her colleagues get frustrated because she's behind in this, that and the other thing. And I said "Well, what was she doing to get behind?" "She's talking to patients!" [laughs] All right, I forgot we don't do that here [laughs] you know, and I mean it's a dilemma because...you've got to get your ten*



*o'clock meds out sometime around ten o'clock, you know, at least before the two o'clock ones are due. (Rodney, 1997, pp. 145–146)*

A second important — and related — invisible aspect of nurses' work was their *systems work*. This involved dealing with issues that have no "place" in the organization, such as social problems beyond the official mandate of the hospital, in ways that were unlikely to be noticed. In the emergency setting, for instance, nurses were required on a daily basis to deal with people who were brought to the hospital because no one knew what else to do with them. One nurse described this kind of situation:

*People don't have the support of their families or the church or whatever and a lot of the time they end up in Emergency because nobody knows what else to do with them. The police bring them in because they don't know what to do with them, or the ambulance goes to the situation and they don't really think this is a physical problem but they bring them in because they don't know what else to do with them and therefore, it is becoming more and more frequent that we are the catchment area for people who are slipping through the hole some way or other. (Varcoe, 1997, p. 121)*

People with mental illness, drug or alcohol problems, or social problems secondary to poverty were seen by nurses as ending up in hospital whether or not they had an immediate health issue requiring hospital services. Moreover, systems work included nurses' support of vulnerable families coping with the discharge home of fragile (often elderly) patients. An experienced nurse recounted a situation on a medical unit:

*This little lady who had bad rheumatoid arthritis...she was requiring two people to get her up and to get her into the commode and she didn't want to sit up and she was...having major trouble...yet she was going to go...home, which is with her daughter and son-in-law. The daughter is taking chemo and is really quite sick with her chemo, and there's a son-in-law who's in his sixties trying to...look after the two of them and I think he probably had an awful lot on his plate. [The patient was] just a sweetheart but she required a lot of care so I said to her doctor, "Well, what are the plans for this lady?"...you've got to find out these things. (Rodney, 1997, p. 177)*

Without the nurse's actions in notifying the physician and initiating assessment and follow-up, the consequences for this client and her family might have been serious. Yet the nurse's actions would not have shown up readily on a workload measurement index, and may have been overlooked — along with the client's problems — by her nursing and medical colleagues.

### *Invisible Triage*

Our research also provides evidence of economic allocation decisions at a micro level — or triage decisions — that are obscured by established costing mechanisms in health care and are thus not likely to be taken into account in economic evaluation. Two complex and interrelated processes that we observed were *emotional distancing* from patients in order to preserve work time for other priorities and *rationing of care based on judgements about deservedness* (see also Varcoe & Rodney, in press).

Nurses routinely distanced themselves emotionally from patients in order to preserve time for the nursing work that “counts.” Since emotional labour is often invisible, many nurses used this strategy. In the study with emergency nurses, for example, nurses complied with the demands of the organization by becoming more “efficient”<sup>3</sup> and emotionally “strong,” which meant focusing on physical care and not engaging with patients. Nurses felt they could not afford to engage with patients, partly because of time constraints and partly because of the need to be ready for the unknown. Repeatedly, nurses described the ways in which time constraints affected their interactions with patients:

*When you are looking at your seven patients and you've got IV antibiotics to start here, you've NG's [nasogastric tubes] to put down there...and you've got this to do, that, and the next thing you know you get a new patient and there is just too much to do. So you are running around as fast as you can go, doing as much as you can but you are not talking to the patient. As a matter of fact you are almost a little bit relieved if the patient isn't talking because then you don't have to slow down. (Varcoe, 1997, p. 180)*

One nurse explained that nurses developed ways of curtailing conversations with patients to keep them “on track” — in line with the needs of the organization. In addition to making the nurse more “efficient,” this emotional distancing helped her to cope with the distress of witnessing human misery and being unable to deal with it effectively:

*Open ended questions...that we don't have to do now because we can manipulate answers out of patients. One word answers like you've never seen. But feelings, senses, that's another story, 'cause that involves time and it involves an investment on your part...and I think that as an Emergency nurse I have learned...I am protective now of myself. I am not prepared to give as much as I used to, and I'm certainly not proud of it,*

<sup>3</sup>The terms “efficient” and “efficiency” are used as intended by the nurses in the study — to mean the rapid processing of patients under particular economic conditions.

*but it is safer...I'm not prepared to be bitten, for a little while. I may never be prepared.* (Varcoe, 1997, p. 151)

Under the conditions of practice in the units studied, there was simply not enough of each nurse to meet the requirements of care. Despite emotionally distancing themselves and remaining as efficient as possible, nurses often could not keep up with the tasks dictated by policy and minimum safety requirements. For example, nurses were often caring for so many patients in such spatially separate areas that they were unable to properly monitor patients or provide adequate pain management (Rodney, 1997; Varcoe, 1997). Because nurses lacked the time to provide the care they saw as necessary, their standards of care were affected:

*Even for those nurses who really do value them [the elderly] and want to do good...they go into the work situation with escalating work loads to the point where...one of the nurse managers on another medical unit said to me the other day, "You know" she said, "We're just back into restraints again" ...I haven't seen [restraints] for so long, we've been working so hard at it [getting rid of restraints], but it's like all of that goes out the window...when the pressure of work load is in place and I should think that goes back into the guilt [nurses feel] because the more knowledge you have the more guilty you're going to feel.* (Rodney, 1997, pp. 234-235)

In such situations, nurses must decide "what care can be hurried over, skimped on, or deleted completely" (Campbell, 1994, p. 602). Thus decisions had to be made about which patients would receive less care. Most decisions on the rationing of care were based on physiological acuity, but a disturbing number were based on covert social criteria regarding "who deserves what care."

In both studies, the patients routinely seen as less deserving were those who had substance-use problems, were demanding or abusive, used health-care services frequently, or were perceived to be using health-care services inappropriately and making little effort to take responsibility for their health and their lives. These judgements apparently arose partly from the way in which some patients treat nurses and other health-care providers. Nurses are regularly verbally abused and often physically assaulted (Armstrong & Armstrong, 1996; Croker & Cummings, 1995; Mahoney, 1991; Schnieden & Marren-Bell, 1995). In addition, nurses in both studies often spoke of those who over-use the system as contributing unreasonably to their workload. One nurse said:

*I've lost it. There are some repeaters that we have, frequent flyers we call them, that on a good day, if you haven't been busy you can deal with them, but on other days you need to say "listen I can't deal with this*



*particular patient right now, it is not to the patient's advantage."*  
(Varcoe, 1997, p. 177)

However, underlying these and other judgements regarding deservedness were the ideas, images, and assumptions of nurses and other health-care providers, particularly about class. For example, it was not merely alcohol abuse that made a person less deserving; it was being poor and abusing alcohol — for poverty made individuals more open to the scrutiny of health-care providers and poverty made alcoholism more visible. "Frequent flyers," the people who use emergency and other acute-care services repeatedly, generally have multiple health and social issues, most commonly poverty, chronic illness, mental illness, and drug or alcohol abuse. For some nurses, such judgements about deservedness by their colleagues were a significant source of moral distress. One participant said:

*My discomfort comes when I am given this kind of patient [a patient with a history of intravenous drug use and who is in severe pain] and I am given [an order for] Tylenol Three, you know...and then I have to ask [for a stronger analgesic] and then I have to sort of explain and it's almost like explaining away to a wall, and it's very difficult for me because the others are thinking, "What is she doing?"* (Rodney, 1997, p. 162)

The insight that nurses make social judgements about patients is beginning to emerge in the literature. Studies have been done of nurses' construction of patients as good or bad, popular or unpopular — and the role of social judgement in power relations, clinical decision-making, and pressure to get patients to acquiesce to nursing and medical goals (Carveth, 1995; Corley & Goren, 1998; Greif & Elliot, 1994; Johnson & Webb, 1995a, 1995b; Kelly & May, 1982; Liaschenko, 1995; McCormick, 1997). We suggest that in the current climate of fiscal constraint, however, nurses are more predisposed to allocate their services based on covert and ethically questionable judgements about deservedness<sup>4</sup> (see also Corley & Goren; Stevens, 1998).

### ***Invisible Costs***

What are the consequences of invisible work and invisible triage? Let us start by discussing the costs for *nurses*. In both of our studies,

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<sup>4</sup>We would like to make it clear that we do not see nurses' allocation of their services based on covert and ethically questionable judgements about deservedness as a *new* phenomenon. Nor are nurses the only providers who engage in this kind of covert triage. Our concern is that it has *worsened* in the current era of fiscal constraint. We see nurses as having to operate within a pervasive and disempowering *ideology of scarcity* (Varcoe, 1997, 2001; Varcoe & Rodney, in press).

nurses all too often had to either donate their own time to fulfil even minimal care requirements, or provide less care and suffer moral distress,<sup>5</sup> or provide less care and consider it adequate (see also Varcoe & Rodney, in press). Because there was insufficient time to do the work that was "expected" (as evidenced by charting requirements, policies, and practice norms), and because they saw both emotional labour and systems work as important, nurses routinely worked through their allotted breaks and beyond their assigned work hours. Donations of time were a constant feature of nurses' work in the units we studied. At one emergency site (Varcoe, 1997) and in one medical unit (Rodney, 1997) nurses were routinely observed staying from 15 to 30 minutes after their 8- or 12-hour shift was over, to complete their charting, deal with an unexpected crisis with a patient, assist with an admission, or provide basic care for a patient that had not been provided during the shift. When asked about this, the nurses said they needed the extra time to finish their work and did not like to leave things undone. Interestingly, they did not claim overtime for the extra work unless they felt it was an unusual situation. They apparently made these donations for their own peace of mind. Many described going home distressed over unfinished work. In fact, some nurses associated losing the willingness to donate time with becoming "burned out." One nurse said that as part of her burnout she had become complacent:

*She said "I used to go home and think 'I didn't do this, I didn't do that,' but now I just..." She shrugs. She says that she doesn't worry about obvious things, like did she take that patient off the bedpan but less obvious things that might be missed. (Varcoe, 1997, p. 123)*

In all of the units, the nurses appeared to be continuously engaged in a race against the clock to complete their required tasks. Any extra or unexpected events (such as the admission of a new patient or the dying and death of a patient) strained their workload to the point that they frequently shortened or skipped a meal break or stayed overtime. On one unit, the workload measurement system indicated that nurses were routinely working at 110% of their capacity. One of the practice leaders

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<sup>5</sup>Moral distress is what nurses experience when they are unable to act fully on their moral intentions. It appears that when nurses are constrained from moving from moral choice to moral action, they experience anger, frustration, guilt, and powerlessness (Erlen & Frost, 1991; Fenton, 1988; Gaul, 1995; Holly, 1993; Jameton, 1984; Redman & Fry, 2000; Rodney, 1988, 1994, 1997; Rodney & Starzomski, 1993; Rushton, 1992; Varcoe & Rodney, in press; Wilkinson, 1985, 1987/88, 1989). It is worth noting that nursing and other disciplines need more empirical and theoretical work on the concept.

commented on the nurses' ability to provide good care under these conditions:

*So the number of defined needs on any given day and the number of staff available to meet them [are barely adequate], and you usually feel that ten percent on either side is manageable, obviously...if you're functioning at a hundred and ten percent, you're still not meeting all patient needs and you're working fairly flat out...the majority of nurses...want to do good, it's hard to do good when you're working [at 110%]. (Rodney, 1997, p. 222)*

Among the nurses we observed, the impact of being unable to fulfil their work obligations was substantial. It included guilt, fatigue, and taking sick time and stress leave. Guilt was identified, for example, by the practice leader we cited earlier: "The more knowledge you have the more guilty you're going to feel" (Rodney, 1997, p. 235).

A significant level of personal fatigue was associated with the "busyness" of nursing work. Nurses in both studies spoke of being exhausted at the end of most shifts. In the medical units the physical demands of providing basic nursing care to elderly and dependent patients were substantial and there was an almost desperate struggle to complete the required tasks before the end of the shift (Rodney, 1997). In the emergency units there was a chronic sense of urgency, of the need to be ever-alert and prepared for the next multiple trauma or disaster (Varcoe, 1997). The sense of fatigue was particularly apparent for those nurses who had dependent children at home. One nurse who needed to go straight home after work to look after her young child described how conflicted she felt if she had to stay late to provide extra care (Rodney, 1997). And nurses agreed that their level of busyness had increased over the preceding few years, making it increasingly difficult for them to balance the demands of work and home life. So while nurses face the same kind of home responsibilities they have for years (even if their partners are available and engaged in child care), they face increasing demands in workplaces such as those we observed.

Not surprisingly, nurses' psychological, social, and physical health was affected by the cumulative effects of being overworked and unable to provide the kind of care they wanted to give (see also Varcoe & Rodney, in press). Nurses who stayed on the job often coped by using sick leave or stress leave. Others left the department in search of better working conditions, or left nursing altogether. For instance, in one of the emergency units studied, five of the 12 nurses initially interviewed described themselves as burned out — and within a year of the study all five had left. One of them said:

*I think I'm tired. I think I am really frustrated by not being able to do something on a major scale. I see a lot of my mates that I work with frustrated in our area. In our department, a lot of people have left out of pure frustration. I thought I never would be, but I am now. It's money, it's management, it's things I can't really argue with...maybe we are not doing a good enough job... But if there is one thing that I hear in our department [it] is that our nurses really care and they really give 100%. But I think they are tired. Emergency is a challenging area.... It is so mentally draining. I feel sad. (Varcoe, 1997, p. 169)*

In summary, organizational priorities and processes implied a valuing of aspects of nursing work different from the aspects valued by nurses. Faced with excessive workloads, the nurses had to prioritize their work, sacrificing "invisible" labour for the more valued visible work (for example, administering medications or discharging a patient). The two areas of nursing practice most affected were emotional work and systems work. Rather than curtail their work in these areas, nurses compensated for unmanageable workloads by donating time. The costs to their own well-being were substantial, manifesting as fatigue, burnout, and moral distress. The invisible features of nurses' work were evident to the nurses themselves only against the backdrop of unmanageable workloads. Further, it must be noted that the nurses (and other health-care providers) did not acquiesce to economically driven directives that jeopardized quality of care. Rather, they acted based on values that were congruent with as well as running counter to such directives, and thus both supported and resisted the directives (Varcoe & Rodney, in press).

The findings of our two studies concerning the invisible costs to nurses are supported by the empirical and theoretical nursing literature. In fact, four decades of research on stress and ethics in nursing points to the fact that nurses have long dealt with excessive workloads (Rodney & Starzomski, 1993). And workload measurement systems, which measure the number and mix of nursing personnel needed to meet care requirements (Giovannetti, 1994, p. 331), have been found to routinely underestimate the actual work of nurses (Armstrong & Armstrong, 1996; Campbell, 1987, 1994; Giovannetti; Storch, 1994). Current research indicates that nurses' workloads and workplaces are becoming even more unmanageable. Nurses' emotional labour, in providing psychological, emotional, and educational support to patients, remains chronically undervalued and notoriously difficult to quantify (Benner, Tanner, & Chesla, 1996; Hiraki, 1998; Liaschenko, 1995; Liaschenko & Fisher, 1999; Nortvedt, in press; Varcoe & Rodney, in press; Yyelland, 1994). While health policy rarely considers the impact of the current climate of health-care delivery on the health and well-

being of nurses, there is mounting evidence of the profound costs in terms of nurses' psychological, social, and physical health (Armstrong & Armstrong; Burke & Greenglass, 2000; Canadian Nurses Association, 1998; Oberle & Tenove, 2000; Picard, 2000; Varcoe, 2001; Varcoe & Rodney; Walters, 1994). Throughout our fieldwork at all four study sites, we were struck by the difficulty faced by nurses in maintaining the standards of their practice and their own well-being.

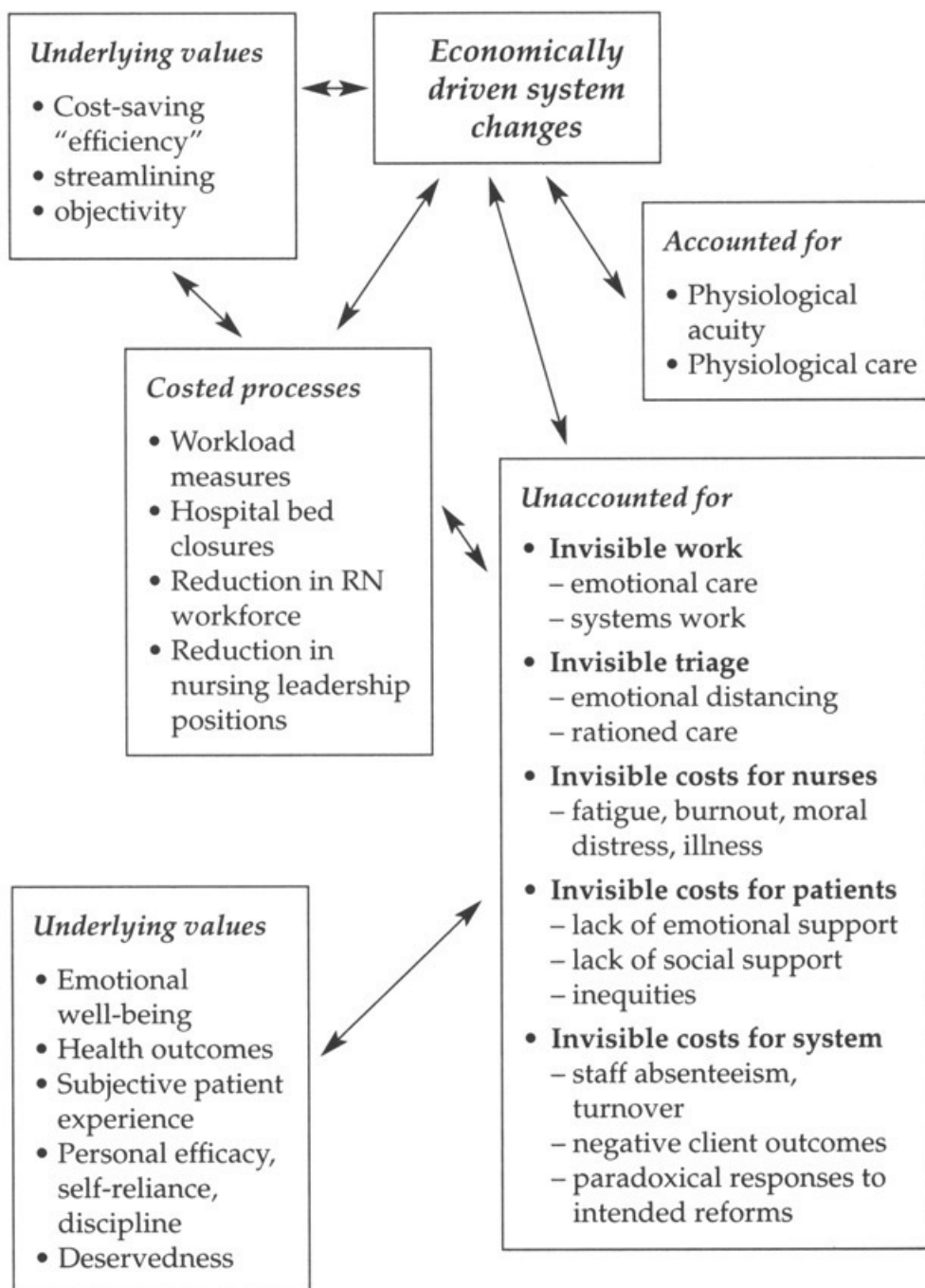
The consequences for *clients* of nurses' invisible work and invisible triage are even less visible in this era of health-care reform. Nonetheless, it was clear in our studies that clients received less emotional and social support than they and the nurses considered necessary. Also, throughout our fieldwork at all four study sites, clients, families, nurses, and other care providers expressed concern about what was happening to the recipients of care. Disturbingly, it was clear that nurses were often left to compensate for systems inadequacies by rationing care, sometimes based on dubious judgements of social worth. While there is an emerging body of empirical work supporting these findings (e.g., Adams & Bond, 2000; Aiken et al., 2000; Barry-Walker, 2000; Corley & Goren, 1998; Malone, 1996; Mohr, 1997; Mohr & Mahon, 1996; Reynolds et al., 2000; Shindul-Rothschild et al., 1996; Sochalski et al., 1998; Woodward et al., 1998), the evidence is certainly inadequate for a proper evaluation of the effects of health-care reform (including the attendant erosion of the quality of nurses' workplaces) on client outcomes (Aiken et al.; Sochalski et al.). Three leading researchers in the field warn:

What we know about changes in organization and structure and the potential for those changes to affect patient outcomes pales by comparison to what we do not know. However, this is itself an important finding: we are subjecting hundreds of thousands of very sick patients to the unknown consequences of organizational reforms that have not been sufficiently evaluated before their widespread adoption. (Aiken et al., p. 463)

A growing number of Canadians, ourselves included, believe that the "downsizing," "restructuring," and "re-engineering" that have characterized our health-care system over the past decade have not produced the expected benefits. Our findings indicate that the cost-constraint measures that have been so pervasive in Canada's health-care reform have exacerbated nurses' invisible work and invisible triage, with costs to nurses and clients that are only beginning to be noticed. Perhaps the invisible costs explain, to some extent, the failure of health-care reform to deliver on its promises (see also Figure 1). What does not get noticed cannot be adequately described or measured, and what



**Figure 1** *Published Nursing Research on Intimate Partner Violence, 1975–99*



*Note:* The authors are grateful to an anonymous reviewer for suggesting and providing an initial draft of this conceptual schema. The conceptual schema is *provisional* in the sense that the authors are not making causal claims. Rather, we want to more clearly lay out some of the connections that we have made between concepts in our analysis.

cannot be described or measured will not be addressed as health-care organizations plan and implement changes. Michael Decter, a well-known Canadian health economist, provided an effective metaphor at the 2001 Nursing Leadership Conference held in Ottawa. He stated that the planners of health-care reform a decade ago "built the sail boat but forgot to plan for the wind." Our research indicates that the wind is invisible but powerful. It includes intangibles such as clients' needs for emotional support, families' needs for respite in the care of their chronically ill loved ones, and nurses' needs for access to a supportive network of well-prepared colleagues and practice leaders.

### Explicating Values

How can nursing move ahead so as to make visible what has been invisible — or, to use Decter's metaphor, to harness the wind so that it moves us in the desired direction? We see the explication of values as a key.

What gets obscured in nurses' invisible work, the invisible triage processes in which they engage, and the invisible costs to nurses as well as clients are the values that come into play (see also Varcoe & Rodney, in press). For instance, values related to discipline, self-reliance, and personal efficacy underlie nurses' judgements about "frequent flyers"; and values related to clients' emotional well-being, subjective experience, and long-term health underlie concern with their need for emotional and social support. Similarly, values related to cost-saving, efficiency, objectivity, and "streamlining" underlie administrative and policy decisions to reduce professional nursing staff, lay off nurse leaders, close hospital beds or units, and so forth. Given the conflict between these various sets of values and the impact of such values on the well-being of the recipients of care — and on the well-being of nurses — we need a means to explicitly deal with them. Ethical inquiry is a methodology that can help us here:

Ethical inquiry is an essential part of the philosophy of nursing insofar as it (a) describes *moral phenomena* encountered in the practice of nursing; (b) addresses the basic claims of rights and duties, and goods and *values*, as they arise within the practice of nursing; and (c) assesses the language of rights and duties, and of goods and *values* as a rational endeavor. (Fry, 1992, pp. 93–94; see also Fry, 1999) (emphasis added)

Ethical inquiry is a means not only of analyzing the values that underlie what does and does not get measured, but also of examining the ways in which those values are socially constructed and reflective of broader

social inequities. For instance, a Canadian ethicist, in a value-based analysis of health promotion, warns that regionalization may place “the funding for needed health care in competition with health promotion, often with a budget that is reduced from the original allocation to health care services alone” (Burgess, 1996, p. 160; for other examples see Blue, Keyserlingk, Rodney, & Starzomski, 1999; Sherwin, 1992, 1998; Storch, 1996). Such analyses provide an opportunity for us to critically examine our assumptions so that future policy evaluations will be purposefully based on carefully articulated and ethically defensible goods and values.

Interestingly, philosophers and feminists have called for greater attention to values in economics in general and health-care economics in particular (Donath, 2000; Fuchs, 1996, 2000; Hausman & McPherson, 1993; Hubin, 1994; Weston, 1994). Donath argues that besides the dominant economic story that arises from competitive markets, there is another economic story — one about the production and maintenance of human beings — and that health-care settings are especially important non-household work sites in this “other” economy. She offers the example of the impact on unpaid caregivers (usually women at home) of cost-cutting measures in hospitals. Our research illustrates that this other economy is functioning, albeit invisibly, within the sites of competitive labour markets. It is therefore essential that economic evaluation be preceded by explication of values, if this entire other economy — whether in the home or in the hospital — is not to go uncounted.

Let us close by illustrating how ethical inquiry might support economic inquiry in nursing practice. The nurses with whom we worked in the two emergency units and two medical units were clearly distressed about the staffing allocations of professional nurses in their workplaces. Also, objective measurement tools such as workload indexes — if such tools were used at all — failed to capture their invisible work. Yet the staff nurses reported that they had no say in staffing decisions. What if staff nurses themselves articulated the elements of their work (both readily visible and less visible), in partnership with administrators and policy-makers, so as to provide a more meaningful basis for quantitative and qualitative evaluation of resources? What if all these players explicitly discussed the values they held regarding care? And what if staff nurses — nurses on the front lines of patient/client, family, and community care — actually had a meaningful say in subsequent health-policy decisions? For instance, what if they were able to influence the ratio of nurses to patients? Such initiatives, whether part of a participatory action research project or a health-care agency mandate, could go a long way towards improving the ethical

climate for nursing and interdisciplinary practice (Breda et al., 1997; McGirr & Bakker, 2000; Peter, 2000; Robinson, 1995; Street, 1998). Explicit ethical inquiry in such initiatives would help those involved to bring workplace values into the open, strive for equitable allocation of resources, and reflect on the kinds of societal changes required to rethink our values concerning nursing care and the vulnerable recipients of that care.

Perhaps most importantly, explicit ethical inquiry would help us to realize that the active involvement of frontline nurses in changing their conditions of work is a moral imperative in health-policy work. Health-policy formulation is not morally neutral. It has, in the words of Malone (1999, p. 18), an "irreducibly moral dimension." Nursing must come to terms with the fact that health policy has evolved in ways that overlook critical elements and compound the invisibility of nursing work (Health Canada Office of Nursing Policy, 2000). If it does not, nurses will continue to be seen as merely a commodity, and quality as merely a product of adequate supply. We must, as a profession, develop and demonstrate our expertise in ethical as well as economic inquiry. Our goal should be "to help put into the public space of language a role for human beings that is not merely based in market productivity but in having a socially meaningful and morally coherent life and death" (Malone, 1999, p. 21). As we indicated at the outset of this paper, those of us engaged in economic as well as ethical inquiry should continue to work towards a system that is more humane as well as more effective and efficient for all those involved in health-care delivery.

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