A failed panopticon: surveillance of nursing practice via new technology

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New technology being introduced into nursing makes possible the surveillance of practice via an ‘electronic panopticon’. This paper reports on a qualitative study of these systems in the UK NHS, where the attempt to monitor nursing practice failed, not least due to the complexities of nursing culture and practice at ward level.

Introduction

Various writers have invoked the idea of the ‘electronic panopticon’ (Sewell and Wilkinson, 1992) to convey how computer systems can potentially be used as a method of surveillance in the work place, though opinions differ widely. For instance, Zuboff (1988) regards this as a largely positive development, while other writers, such as Lyon (1994), are more critical. Lyon draws on research into, among other things, the use of CCTV, the linking of government databases and electronic tagging to suggest that the panopticon is no longer limited by the walls of an institution, but has been extended in both space and time. Citizens can be monitored and, if deemed necessary, disciplined, when they are, for instance, at home, or out on the streets. Poster (1990) posits the idea of the ‘SuperPanopticon’, where all aspects of life are subject to surveillance, though he does not suggest that it has reached that stage (yet). The call centre is a good example of a modern high-tech workplace, where almost every aspect of the working lives of the employees is made ‘visible’ via new technology, and can be monitored and ‘corrected’. Opinions also differ about whether this development is ineluctable. Both Foucault (1991), and others (such as Poster (1990)) have tended to view the panopticon as an almost inescapable phenomenon. This view is criticised by Giddens, who points out that we must guard against taking this analysis too far, saying, ‘Foucault is mistaken in so far as he regards ‘maximised’ disciplinary power of this sort [i.e. panoptic] as expressing the general nature of administrative power within the modern state’ (Giddens, 1985: 185). That is, though panoptic power is extensive within the modern world, it is not (yet) all-pervasive.
In addition, other writers drawing on fieldwork-based studies suggest that the panopticon has not (yet) been implemented in its fullest form. Bain and Taylor (2000) describe how workers in call centres were able to resist, quite successfully, the technologically sophisticated measures that were put in place to observe and control them. Bain and Taylor also point out that detailed empirical work is still relatively rare in this field. This paper describes a study that is, in part, an attempt to address this.

Thompson and Ackroyd (1995) criticised Sewell and Wilkinson (1992) for over-emphasising the panopticon model, and suggest a re-focusing on employee resistance, which was one of the starting points for the study described in this paper. The danger here is one of over-simplification, of seeing relations between management and workers as being only adversarial and thus any action on the part of workers which was not exactly what management wanted as being ‘resistance’ to ‘management power’. While it is important to guard against this tendency, something else that we must not lose sight of is that, ultimately, as Giddens says, ‘surveillance in the capitalist enterprise is the key to management’ (Giddens, 1987: 175), that is, management are in charge, and will want to ‘watch over’ workers in order to ensure that their wishes are being carried out.

One of the few studies to expressly consider the issue of electronic surveillance in the NHS is the ESRC Virtual Society project, ‘Technology, work and surveillance: organisational goals, privacy and resistance’ (Mason et al., 2001). Among the systems that they studied (in a variety of settings) was an educational system for obstetricians and midwives, used in hospitals. While the primary purpose of this system was not surveillance, they show how it could have been used for these purposes, and they consider (among other issues) the ethical dilemmas that this poses. They argue that issues like surveillance via technology cannot be divorced from the wider social setting in which they are implemented. For instance, they show it was considered acceptable (by the midwives they studied) to share passwords for the system, thus rendering individual monitoring impossible (Lankshear and Mason, 2001). The study on which this paper is based would tend to confirm that surveillance can only be understood with reference to the wider social and organisational contexts in which it is implemented.

The NHS context

The particular policy context in which the systems were implemented is described below. However, there have been long standing tensions within the NHS between the nursing profession’s desire for professional autonomy, and the desire of the management (at national, Trust, and ward level) for control. Nursing has never achieved the degree of professional autonomy that medicine has, not least because the training and employment of nurses has been under the control of the NHS since its inception, in a way that medicine never has. As the nursing profession has sought to establish and enhance its professional status, it has used (to a large degree) a similar rhetoric to medicine’s to justify its claims to professional autonomy. Put simply, it is that the nurse’s primary duty is to the individual patient, rather than the employer, and that the nurse is accountable to the profession (as opposed to the employer). At the same time, the desire of NHS management at all levels to make visible and control nursing has increased since the 1980s. The introduction of ‘general management’ in 1983 made nurses managerially responsible to non-clinical managers for the first time.1 As pressure to control hospital costs grew, managers began to look at nursing as a potential area in which savings could be made, not least because nursing costs make up (on average) 50 per cent of the overall costs of running a hospital. Allen (2001) provides a good picture of the tension that these conflicting pressures create at ward level.

1 Historically, NHS nurses had only been managed by other nurses.
Study and methods

This study was of nurses working in three NHS Trust hospitals (referred to as Seaside, Southside and Westside) in the UK, who were required to use computer systems which produced detailed care plans for inpatients. The hospitals were selected largely for reasons of geographical convenience, and because they had all implemented different versions of the systems under consideration. All three were District General Hospitals, and were broadly representative of this type of NHS hospital. The study was confined to adult acute wards and to qualified staff (on NHS nursing grades D, E, F and G). No unqualified nurses or students were interviewed. 28 ward-based nurses (nine each in two of the hospitals, 10 in the third) were interviewed. A ward was approached to provide one interviewee. Usually it was whoever happened to be free at the time (or was thought by the ward sister to be free). In each of the hospitals the project managers who had implemented the systems were interviewed. Though project manager was a full-time job, they were all qualified nurses who up until becoming project manager had worked in the hospital, usually as a ward sister. Though the project managers were responsible for implementing the systems, they had no managerial control over the wards where the systems were implemented. This rested with more senior nurse managers, none of whom were interviewed in this study. The systems were intended to be used to plan care (using the nursing process (De La Cuesta, 1983) and the Roper, Logan and Tierney model of nursing (Roper et al., 1980)) on admission, and then be evaluated and updated throughout the patient’s stay.

Interviews were semi-structured, taped and transcribed, and then the data analysed using QSR NUD*IST. Data was coded by content, and then refined and developed to produce analytical categories. The main focus of the study was:

- Are computerised systems for the production of care plans resisted by the qualified NHS nurses who are required to use them?
- If this resistance exists then what forms does it take?
- If this resistance occurs, then why?
- How is any resistance situated within the context of the wider nursing culture? (Timmons, 2001)

Three broad categories were used to draw together related types of resistance. These were refusal to use the systems, attempts to minimise use of the systems and criticism of the systems.

Examples of all of the above, and other behaviour and attitudes that might be characterised as resistance were found in almost all of the field work interviews. Though the consideration of resistance within this study (necessarily) produced a complex picture, reflecting what is a broad and complicated phenomenon, resistance remains a useful analytical category. Resistance, as an idea, has not been stretched so far that it encompasses all aspects of the nurses’ relationships with the systems. For instance, compliance was nonetheless a significant factor in these relationships, resulting in the creation of the category of ‘resistive compliance’ as an attempt to summarise this relationship.

While it was not the original focus of the study, the ways in which the systems could be used as a tool of surveillance of nursing practice proved to be a significant issue. However, before going to discuss the systems’ use as a tool of surveillance, it is important to establish three things. The systems were not originally implemented for surveillance, and it was never their primary function. The stated aims of the projects were to improve nursing practice, to improve the quality of records, and to gain a better understanding of how nursing resources were used. However, the second point is that while they were not principally intended for surveillance, all of the systems were ‘surveillance-capable’. This was because of the detailed and attributable data that they collected about the nurses who used them. All users had an individual user name and password, and any activity on the system could be linked to an identifiable user. As the systems were intended to be used regularly throughout the working day, and collected information about most aspects of care given to (identifiable) patients, it was
possible to build up a picture of any one nurse’s work over the course of a shift or a week. In addition, the systems had ‘audit’ functionality (described below) that enabled management to keep track of how they were used.

The third point to be made is whether the management (in the case of these systems the senior nurse managers) wanted to use the systems for surveillance. This is slightly harder to establish. However, there are at least two conceivable reasons why the systems might have been seen as performing this kind of role. The first is the desire of management in most modern complex bureaucracies to be able to monitor what their staff are doing in the workplace. Due to the complexity of hospitals, and the discretion that professional staff (especially doctors, but also nurses) have in the performance of their work, this has historically been difficult for management in health services to do. A second motive is the fact that the organisation (in this case, the NHS Trust) is accountable for the errors or omissions of its staff. The trend of increasing litigation in the field of medical negligence, and the introduction of changes like clinical governance into the UK NHS meant that employers have become increasingly concerned to be able to monitor what their staff are doing. In addition, all of the systems were funded by the NHS Resource Management Initiative (Packwood et al., 1991), one of whose stated aims was to make more transparent resource usage by clinicians (doctors and nurses), and thus to make it more amenable to management control. So enhanced surveillance may well have lead, albeit indirectly, to increased control.

As well as the ‘surveillance-capability’, outlined above, the systems all had functionality specifically intended to monitor usage of the systems by users. The systems had features built into their software that meant it was possible to produce reports on how many care plans had been completed and in what time scale, and aggregate this data by ward or department. That this functionality was available within the systems’ software suggests that the designers who originally programmed the systems knew that resistance was at least likely to be a problem, and to some extent anticipated it. This is by contrast with the views of the project managers, who did not anticipate resistance, and were surprised they by the resistance that they did encounter.

Findings

Surveillance of usage

The main findings of this study are reported elsewhere (Timmons, 2001). However, to summarise them briefly, resistance to the systems did exist, and was characterised not so much by refusal to use the systems as a tendency to put off and displace using them, and by a great deal of critical discourse about them. However, the systems were used, and the term ‘resistive compliance’ has been used to describe this. Turning to their surveillance capabilities, two main aspects of the systems’ usage were monitored. The first was simple completion rates. At, for instance, Southside Hospital, there was an explicit target that care plans for all new admissions had to be completed within three hours of the physical admission of that patient to the ward. This was monitored by the project manager for the system, who explained how this was done:

What I do is every month do a snapshot audit of use. I go into each ward and look at each patient, and under all the functionality I count whether the patient has had it... So what I do is—percentage compliance for each functionality and then an overall percentage compliance for the ward.

This is one of the few areas where major differences between the three hospitals were apparent. Seaside and Southside Hospitals had quite structured programmes of audit to monitor compliance. The audits were regular, formal, and fed back into the nursing

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2 Clinical governance is the term given to a group of changes in the UK NHS (Department of Health, 1998). Crucial (in this instance) is that management have been made accountable for the clinical care delivered in hospitals. The situation has therefore arisen whereby a Chief Executive might be sued if it could be shown that a member of nursing or medical staff had been negligent.
management structure. By contrast, Westside Hospital had a more informal approach, with no regular reporting mechanism in place.

The second aspect was the quality of the information in the care plans. The fact that this was explicitly monitored tends to suggest that the project managers knew that there was a tendency for some users to do the bare minimum, and thus in order to see if the systems were being used ‘properly’, data quality was monitored, as this project manager explained:

The other thing I’m doing is a quality audit, . . . but this year I’m breaking it down into the directorates, . . . I go into detail about what information they’re putting in, how reflective it is of the patient’s diagnosis, how often is it updated, how often do you put an actual evaluation, . . .

When and how the audits were done again tends to confirm the idea that they were intended to measure and reduce resistance. ‘So I don’t tell them [the wards] I am doing an audit, I just do it.’ At Southside and Seaside Hospitals the data on compliance were aggregated into league tables (by ward), and circulated to the nursing management, and to the wards themselves. The project managers expressed frustration that the more senior nurse managers did not seem to take action on the basis of this information. However, the comments of some of the nurses interviewed who used the systems perhaps explain this apparent lack of action. Firstly, some of them were, ‘not particularly aware of being monitored.’ Others regarded the audits as being relatively unimportant; ‘It seems to be a real problem on here and we’re really pleased with ourselves if we get like 80 per cent of our care plans. They send the chart round you know the audits and they say that [name] ward has done the worst again. And we’re like ‘oh well, never mind, at least their patients are happy.’ One interviewee felt that there was no point in her attempting to improve the ward’s performance when her colleagues would not use the system:

Interviewee: Yes there is we have recently had an audit, and ours came back pretty poor, I don’t think it even reached half way of the standard. We are always forever being told that we have to use the computer more, we’ve got to use it. I know it’s been to do with the time.

Researcher: So you imply it’s been audited but it doesn’t make much difference?

Interviewee: No. As much as I personally try and do it, it always seems to lag behind because of other people not using it at all, so you think you’re slogging your guts out, to carry the ward, and it’s still coming back as not even reaching half way, so you think oh I can’t be bothered now.

Others resented being monitored at a distance, ‘Everyone knows there’s audits on it, and I think that was the stick rather than the carrot to get people to use because some manager in a far and distant office would say, ‘I was doing an audit of Waterlow scores’ and this ward came up with only six patients documented. I think most staff are aware of that most information that is recorded on the computer is used. . . . it’s what it’s used for is the big question; whether it’s just to beat staff, and say, ‘You didn’t meet the audit criteria’ or whether it’s to look at why you didn’t.’ The implication of the last part of this statement being that there were ‘good reasons’ why the system was not being used.

The audits did not secure compliance, for several reasons. Firstly the ward nurses knew that they could safely be ignored, as no sanctions seemed to follow on from poor performance. They took the view that while sister might get ‘told off’, no more effective action could realistically be taken by more senior nursing management. Secondly, the project managers were (to some degree at least) sympathetic to the idea that the ward nurses were too busy to use it, which might also explain why little or no action was taken. This tends to confirm the argument of Lankshear et al. (2001) who suggest that to describe relations between management and workers in purely adversarial terms is an oversimplification. In this case, there seemed to be a degree of understanding between the nurses and the project managers that the project managers
would push use of the systems ‘so far’, but not to the extent that it would ‘interfere’ with patient care.

What is particularly interesting about this phenomenon is the lack of concern expressed about relatively public criticism. If a ward were criticised for having, for instance, a high incidence of pressure sores, they would be much more likely to at least try to explain or defend their actions. It seems that poor performance in using the systems is ‘socially acceptable’ in this particular community, perhaps reflecting the idea that, for this group of people, the systems are relatively unimportant, and certainly not part of what defines them as nurses. For the nurses interviewed, what made a ‘good nurse’, in their view, certainly did not include use of the systems, and was more to do with ideas discussed by, for instance, Melia (1984, 1987) or Street (1991, 1995), such as caring for patients and getting through the work.

The use of the system itself to monitor its own usage is in tune with the aims of the overall programme of the Resource Management Initiative, as analysed by Bloomfield (1991), using the ideas of ‘action at a distance’ and the ‘fetish of calculation’. Bloomfield argues that the Resource Management Initiative sought to impose an order on the perceived chaos of NHS resource usage by providing (often for the first time) detailed numerical ‘objective’ information. This would then enable general managers to control clinical activity far more effectively than had ever been possible hitherto, or even persuade clinicians to control activity themselves. The provision of this numeric information from computerised systems at the centre of the organisation was intended to allow corporate managers (like the Chief Executive) to control clinical activity ‘at a distance’ even though they were removed from it. In the systems in this study, the audits of system usage attempted to provide ‘objective’ numerical information about the systems’ usage, enabling management to act in a ‘rational’ way, at a distance. However, in this case, the attempt failed. One of the interviewees pointed out the flaw in this strategy, ‘A very good score doesn’t mean that you have a coherent team who are using the system well.’ What she meant was that by focussing on numerical measures of the completeness of records, audits failed to address much more complex (but potentially more significant) issues of the ‘real’ quality of the nursing care provided. She implied that a ward could score highly on the audits of system usage, but still be providing poor care.

Surveillance of nursing practice

Turning to the use of the systems to closely and directly monitor nursing practice, rather than simply the usage of the systems (as discussed above) the idea that the systems were being used for this kind of monitoring was present in the interviewees’ statements, but not common. Not all of the interviewees were aware that their usage of the systems was monitored, let alone that the information that they put into it might be used to monitor the performance of their nursing work. Several interviewees talked about the information on the systems being used for ‘audit’, but it transpired that what they usually meant was audits of the usage of the systems, rather than audit of the quality or appropriateness of the nursing work that they had undertaken.

The only area where it was possible to discern any sort of monitoring of nursing work taking place was at Seaside Hospital, where an extra form had been added to the assessment part of the system, in order to collect information about the patients who had, or were at risk of developing pressure sores. Pressure sores can be a consequence of, among other things, long stays in bed, and inadequate nursing care. The information would enable comparisons between different wards to be made, and ‘problem’ areas identified and dealt with. Senior nursing management were also concerned to collect information about the incidence of pressure sores in order to be able to report to purchasers (District Health Authorities) about it. As one of the project managers said, ‘Going to our purchasers saying, “Look how wonderful we are. We only have x number of pressure sores that were healed before the patients were discharged and that was mainly because a, b were too long, c was too long etc.”’ However, none of the interviewees reported any action being taken by nursing
management (either at ward or hospital level) directly as a result of information derived from the pressure monitoring on the systems. So if the information on the systems was not really used to monitor what the nurses did, it is unlikely that it could have been used to control what they did. Far more effective methods for controlling what the nurses did and how they did it seem to have been things like the (external) threat of litigation (rather than any internal disciplinary systems), the nurses’ own culture and values (possibly an example of Foucault’s (1979) notion of governmentality at work), and the direct management of the ward sister/charge nurse.

This does not mean to say that the NHS Trusts could not see the surveillance and control possibilities that information systems offered. As Bloomfield (1991) points out, one of the reasons why the Resource Management Initiative was adopted in the first place was that it held out the promise of making doctors’ performance transparent, comparable and (therefore) controllable. As we saw in the extract above, one NHS Trust at least was alive to these sorts of opportunities for increased management control of nursing activity.

### Standardisation of nursing practice

An issue which some of the interviewees were more concerned about in terms of management control was that of the standardisation of nursing practice. There was some concern that use of the systems would result in standardised packages of care being applied to patients, resulting in the loss of professional discretion and skills. However, this was not an issue that was discussed by most interviewees. Perhaps it would have been more significant if they had been aware of how the future of the systems was being planned. At Seaside Hospital, this included the development of care pathways. Care pathways are a US innovation designed to reduce the costs of hospital care (or at least limit their growth), while at the same time improving the quality of care. For any given condition (say a heart attack or hip replacement), an expected pathway of that patient’s stay in hospital is mapped out (on day one, the following treatment/care should be given, on day two, and so on). The care pathway also contains milestones that the patient is expected to reach, so that by, for instance, day five after an operation they will be able to get out of bed. The use of standardised care pathways makes it much easier to monitor any deviations from the anticipated path, and thus (theoretically) enable intervention to bring the patient back to the intended (and cost-effective) route (Johnson, 1996).

The project manager at Seaside Hospital spoke extensively about the proposed implementation of care pathways as being the next stage of development of the care planning system, ‘Of course now care plans have been superseded in a lot of areas by care pathways. They are looking at it with regard to ‘it looks quicker because you tick boxes and don’t have to say anything’ So the perceived benefits of care pathways were not just that they should control costs and improve quality, but that they would be easier (and less time consuming) to use. However, she had some reservations about care pathways that suggest that she was aware of the possibility that they could be deprofessionalising in a way analogous to that described by Harris (1990) in terms of computerised care planning. As the project manager said, ‘The worry now from the nursing staff is that it has gone back to the medical model because the care pathway is looking at conditions, groups of people with conditions, whether it’s hip replacements etc. and as a nurse I’m not happy with that.’

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3 Though some of the proponents of care pathways would dispute this, one of the main reasons why there were introduced in the USA was as part of the movement towards what is termed in the US health care system, ‘managed care’. This is an attempt by those funding care (insurers) to limit the professional discretion (usually of doctors) and try to ensure that any given group of patients with the same, or similar conditions, are given a standardised package of care. This should mean that health care costs could be controlled (or at least predicted). This is why care pathways are for groups of patients, in the hope of standardising care, and thus costs.
One of the key developments within the professional project of nursing (Salvage, 1990) was the move away from being directed by doctors, and from using their conceptual framework (the ‘medical model’). Nursing models (as used in these systems) were thought to have enhanced the professional discretion of nurses, and thus made them ‘more professional’. Care pathways, focused as they are on the physical condition that the patient is presenting with, are seen as a shift back to the narrow biomedical view of the patient. They possibly neglect the ‘holistic’ focus that nursing has developed, and with their strict and detailed paths that patients have to follow, they could reduce the professional discretion that nurses have worked so hard to gain. One could argue, of course, that this is exactly what they are intended to do, as ‘professional discretion’ for nurses and doctors is ‘unacceptable variations in costs and outcomes’ for those managing and funding health services. This interpretation is shared by Barnes (2000) who argues that care pathways are part of a process where the ‘clinic’ is being transformed into the ‘enterprise’.

So while it seems unlikely that a process of Bravermanesque deskilling (Braverman, 1974) has taken place in nursing as a result of the computerised care planning systems, the possibility still remains that these technologies could be developed, through the use of care pathways, in a direction that might not serve the professional interest of nursing (or, perhaps, even medicine). The systems were not thought by the project managers or their superiors in the management hierarchy to function as any sort of ‘electronic panopticon’, though the possibility that they could be developed in this direction in the future was not ruled out. Komito (1998) shows how resistance to a computerised records system, in a very different context to the one in this study, could be explained at least partially by an attempt by a group of workers to protect their professional discretion.

In fact, the picture that emerges from the interviews is that for all of the various attempts that were made by the Trusts, the government and the professional bodies to regulate and control nursing work, the interviewees retained a high degree of discretion in terms of how they organised and carried out their work. Perhaps this is not surprising, for two reasons. The first of these is that the United Kingdom Central Council for Nursing, Midwifery and Health Visiting4 (UKCC), in the policies that govern nursing practice, does not set out to regulate in detail how nursing should be done, but instead adopts a model similar to that of medicine whereby nurses have freedom to practice as they see fit, but are accountable for that practice. In other words, nurses can practice how they like, as long as they are prepared to explain and justify their actions to the profession as a whole, if necessary. This is confirmed by Hn Tjora (2000) who says, ‘they [nurses] have had and still have considerable autonomy in shaping their particular nursing practice.’

The second factor is the labour market for nurses. The National Health Service has always found it difficult to recruit and retain nurses, and most Trusts (the ones in this study were no exception) have unfilled vacancies. Nurses and managers both understand this, and are aware that nurses cannot be too closely regulated, or they will leave for a more congenial environment. This phenomenon is not unheard of.

Some interviewees did nonetheless perceive a tension between the aims of the organisation, and the professional project in nursing. One in particular pointed out how the organisation would like to have patients’ care planned in standardised ways, which could be measured and compared, (in order to control quality and costs) and he thought that this conflicted with the professional values of nursing; holism, and the tailoring of care to the specific needs of each individual patient.

... because, say with the computer system, we are told that that is the process that we use, but for certain people, and I have identified it with some of the patients we have in here, there are better models to use, but we are restricted to just using this one. My understanding of ‘tools’ is that you

4 The UKCC is the professional governing body for nursing in the UK. Though established by statute, its members are elected by the profession. They lay down the regulations which govern the scope of nursing practice, and act as the disciplinary body for the profession. At the time of writing of this paper, it was scheduled for replacement by the Nursing and Midwifery Council.
use the right tool for the right job, so technically with some patients we have, we could be using the wrong assessment tool, like Roper [the Roper, Logan and Tierney model of nursing]. This is used as a general tool, but, as I say, I’ve been aware of other tools which would be better for some of the patients that I’ve [cared for]. That is the only problem I can see, they are very useful to guide you, you can get a consistency, hopefully with other staff members using them as well, which is the idea. But their effectiveness with certain patients I think is questionable, because it is used generally with everybody throughout the hospital, which I think is not appropriate.

This interviewee mentions ‘consistency’ across the organisation, cognisant as he is of the benefits (described above) that this standardisation would bring to the Trust, but his concern is that it is not appropriate for all patients, that is, it lacks individuality and specificity. Here, perhaps, is an example of how the system becomes the site of a struggle for interpretative supremacy about what nursing is and how it should be done. The Trusts (along with many other modern organisations) would like to control and bureaucratisate nursing work (at least, more than they have been able to historically.) Nursing is trying at the same time to defend (or enhance) its professional status and autonomy. While this struggle over what nursing is and what it will become takes place in a variety of different settings, one of the sites is the care planning systems.

One of the themes that comes out of this study quite strongly is not that nurses are resistant to technology or even that they are particularly resistant to computers, but that they are resistant to some of the ideas that the systems embody (like the nursing process or nursing models), and that they resist the managerialist project of the Trusts in attempting to regulate and bureaucratisate what they do. This resistance is not wholly successful, and it is diffuse, but one of the most important rhetorical techniques that the nurses use to defend and mobilise their resistance is the appeal to nursing’s ‘key’ or ‘core’ values.

Conclusion

In common with Bain and Taylor (2000), this paper shows that the world of workplace surveillance is more complex than the concept of the electronic panopticon would suggest. Though the technology implemented in all three hospitals studied was surveillance-capable, and while the managements of these hospitals had an interest in extending surveillance of nursing practice, this was not (largely) happening. This was because the nurses were able to ignore or circumvent the surveillance capability of the computer systems, as they knew there were few effective sanctions that the management were prepared to use to secure full compliance with the system. One of the ways in which they were able to sustain this position was by deployment of rhetorical strategies based on the perceived ‘fundamental values’ of nursing. In addition to this, the complexity of this situation is further borne out by the management’s (in this case the systems’ project managers) connivance or tolerance of the pattern of usage of the systems which the nurses had established. Being drawn from the nursing profession themselves, it is perhaps not surprising that that the project managers also thought (at one level) that it was ‘more important’ that ‘the patients are happy.’

While nurses within the UK NHS do not have the degree of professional freedom and autonomy in practice that doctors do, they still retain considerable discretion in how they order their work. They were not able to prevent the implementation of the care planning systems, but they were able to exert considerable influence over how they were (and were not used). A useful comparison is with the doctors and laboratory technicians studied by McLaughlin and Webster (1998). The doctors were able to resist the implementation of a computer system ‘successfully’, that is, they did not have to use it, whereas the technicians, a less powerful group had to use the system (more or less) as management intended. The nurses came somewhere in between the two groups in terms of their organisational power, and thus their ability to resist the system, and the monitoring of their work inherent within it. They were not able to resist the implementation, but were able to resist the surveillance. In this context, an attempt by NHS management (at several levels within the organisation) to monitor and control nursing practice was always likely to be unsuccessful, and indeed, it
proved to be. This does not mean that the nurses necessarily perceived the situation in those terms. In common with the nurses interviewed by Annandale (1996), the nurses interviewed for this study felt themselves to be increasingly closely monitored. It is possible that this is due to other monitoring mechanisms, outside the scope of this study, that would none the less make an interesting and worthwhile subject for further research.

References


Harris, B. (1990), ‘Becoming Deprofessionalized: One Aspect of the Staff Nurse’s Perspective on Computer Mediated Care Plans’, *Advances in Nursing Science* 13, 2, 63–74.


