A volume in the series
The Culture and Politics of Health Care Work
edited by Suzanne Gordon and Siobhan Nelson

Nobody's Home: Candid Reflections of a Nursing Home Aide
by Thomas Edward Gass

Code Green
Money-Driven Hospitals and the Dismantling of Nursing

Dana Beth Weinberg
Foreword by Suzanne Gordon

ILR Press an imprint of
Cornell University Press
Ithaca and London
code green: money-driven hospitals and the dismantling of nursing / Dana Beth Weinberg ; foreword by Suzanne Gordon.

p. cm.

Includes bibliographical references and index.


1. Nursing—Massachusetts—Boston. 2. Beth Israel Deaconess Hospital Center—Finance. 3. Hospitals—Massachusetts—Boston—Finance. I. Title.

RT5.M4W45 2003
610.73'09744'61—dc23

200302118

Copyright © 2003 by Cornell University

All rights reserved. Except for brief quotations in a review, this book, or parts thereof, must not be reproduced in any form without permission in writing from the publisher.

For information, address Cornell University Press, Sage House, 512 East State Street, Ithaca, New York 14850.

First published 2003 by Cornell University Press
First printing, Cornell Paperbacks, 2004
Printed in the United States of America

Library of Congress Cataloging-in-Publication Data
Weinberg, Dana Beth.

Code green: money-driven hospitals and the dismantling of nursing / Dana Beth Weinberg ; foreword by Suzanne Gordon.

p. cm.

Includes bibliographical references and index.


1. Nursing—Massachusetts—Boston. 2. Beth Israel Deaconess Hospital Center—Finance. 3. Hospitals—Massachusetts—Boston—Finance. I. Title.

RT5.M4W45 2003
610.73'09744'61—dc23

200302118

Cornell University Press strives to use environmentally responsible suppliers and materials to the fullest extent possible in the publishing of its books. Such materials include vegetable-based, low-VOC inks and acid-free papers that are recycled, totally chlorine-free, or partly composed of nonwood fibers. For further information, visit our website at www.cornellpress.cornell.edu.

Cloth printing: 1 0 9 8 7 6 5 4 3 2
Paperback printing: 1 0 9 8

to my parents, Glenda and Alan Weinberg,
and
to the nurses, for the care they want to give
Contents

Foreword by Suzanne Gordon ix
Acknowledgments xv
Introduction 1
1 A Troubled Hospital 19
2 No Working Model for Nursing Practice 43
3 Dismantling Nursing 76
4 Power Contests and Other Obstacles to Providing Patient Care 98
5 Doctor-Nurse Relationships 116
6 Not Enough Staff 137
7 Was Quality Affected? 160

Conclusion 175
Appendix: Studying Change at BIDMC 193
References 199
Index 207
In 1998 my then graduate studies adviser, Mary-Jo DelVecchio Good, was hospitalized at Beth Israel Deaconess Medical Center with a life-threatening condition. Soon after she was transferred from the intensive care unit, Good, always the social scientist, could not help but notice that her nurses seemed frustrated and harried. Driven by curiosity and concern even in her weakened state, she began to ask questions and to interview her nurses from her hospital bed. Over the course of her few-day stay at the hospital, she listened to her nurses’ stories about their work. Several lamented, “This isn’t what I went into nursing for. It shouldn’t be this way.” They bemoaned that they could not give patients the care they wanted and had been trained to give. Prompted by Good’s compassionate listening, these nurses literally cried to her in her hospital room. They sought care and comfort from her even while she needed care and comfort.

For Good, the patient, hearing the nurses’ stories must have been a frightening experience. With her body physically weakened by illness, she depended on these crying nurses. She relied on their competence to monitor and evaluate her condition, to recognize signs of relapse, and to make sure she was out of danger. She needed them to bring her the right medications in the proper dosage at the appropriate interval, and she wanted them to talk with her about her condition and what would happen after discharge.

But Good, the social scientist who had spent two decades researching
how doctors learn, define, and argue about competence, found the nurses' experience intriguing. On this unit, in this hospital, the nurses found it difficult to do what they as nurses felt they should be doing. Their stories called into question not their own competence as nurses but the competence of their institution to deliver proper care for patients.

Barely recovered from her illness, Good returned to Harvard University with a gleam in her eye. She had sniffed out an important story that needed a writer, and I was a graduate student who needed a dissertation—a perfect match. Good sent me out to discover, “Why are the nurses crying?”

How could it have happened that nurses found their desire and efforts to care for patients impeded by circumstances at, of all places, Boston's Beth Israel Hospital? This, after all, was no ordinary hospital. Beth Israel was not only a Harvard teaching hospital but also one of the finest academic medical centers in Boston. It was the first hospital in the country to establish a patient's bill of rights. And historically it had been one of the best hospitals in the world to be a nurse. At a time when many hospitals treated nurses as a cheap, disposable labor force, Beth Israel refused to do so. It treated nurses not as doctors' handmaidsens but as professionals with crucial knowledge and skills to contribute to patient care. It was an exemplar of professional nursing practice, and nursing leaders and students from around the world came to Beth Israel to “see how it's done.”

In the nursing shortage of the 1980s, the hospital had no trouble filling vacancies. A generation of researchers studied the features of Beth Israel's nursing program and those of similar hospitals, institutions that became known as “magnet” hospitals for their ability to attract and retain nurses (Aiken, Smith, and Lake 1994; Kramer and Schmalenberg 1988). Even among these exemplary institutions, Beth Israel was the prototype, the gold standard. By most accounts, this hospital had been a paragon of competence.

But times had changed. In 1996, just two years before Good's hospitalization, Beth Israel Hospital had merged with its neighbor, the New England Deaconess Hospital. With merger problems and falling reimbursements, the hospital found itself in the middle of a crisis, a state of emergency that I call “Code Green.” BIDMC was losing more than one million dollars each week. In response, the hospital scrambled to restructure by streamlining its operations and reorganizing departments. BIDMC was not alone in its desperate need to restructure, nor were the hospital's nurses alone in their frustration with the results.

Across the country, a market characterized by increasing managed care penetration, competition, and restriction of Medicare and Medicaid payments provided the impetus for vast restructuring of health care organizations, especially hospitals, in the 1990s (Barro and Cutler 1997; Kuttner 1999; Robinson 1994; Shortell et al. 1997; Shortell, Gillies, and Devers 1995; Sochalski, Aiken, and Pagin 1997). Over the past decade, American hospitals eagerly borrowed various restructuring strategies from the corporate sector (Fennell and Alexander 1993; Lee and Alexander 1999; Mick 1990; Topping and Hernandez 1991). With shrinking or even disappearing profit margins, many hospitals found themselves in a Code Green. They focused attention on the financial aspects of their operations and sought ways to increase revenues while decreasing costs.

Increasingly, the professional health care workforce began to complain about their hospitals' responses to Code Green. The profit-maximizing behavior of healthcare organizations, they claimed, curtailed their decision-making autonomy and interfered with their ability to provide high-quality care to patients (see, e.g., the national surveys by Donelan et al. 1997; Shindul-Rothschild, Berry, and Long-Middleton 1996). In response to Code Green, hospitals adopted the values of corporate rationality, which entail an emphasis on productivity, cost-effectiveness, and efficiency. In adopting restructuring strategies from industry, consultants and others have guided hospitals to focus on quantitative improvements, emphasizing progress along measurable dimensions in financial and patient outcomes. With corporate bodies and caregivers all using standards and benchmarks to define quality, “care tends to get standardized and restricted to what fits in the boxes of printed forms” (Stone 1999:63; see also Gray 1991). This emphasis on standardization and throughput in health care organizations encourages an “assembly line” form of practice that interferes with the development of provider-patient relationships (Norrish and Rundall 2001; Scott et al. 1995). These conditions constrain providers' ability to respond to their patients' unique situations and needs.

In December 1997, 2,300 physicians and nurses published a call to action in the *Journal of the American Medical Association*. The dire language with which they described the threats of “market medicine” signaled the
assault on professional culture brought by increased administrative cost control:

Mounting shadows darken our calling and threaten to transform healing from a covenant into a business contract. Cannons of commerce are displacing dictates of healing, trampling our professions' most sacred values. Market medicine treats patients as profit centers. The time we are allowed to spend with the sick shrinks under the pressure to increase throughput, as though we were dealing with industrial commodities rather than afflicted human beings in need of compassion and caring (Ad Hoc Committee to Defend Health Care 1997:1733; for related discussion see Good [1995] 1998:xi).

At the heart of this indictment is a protest against the constraints a profit-driven system places on health care providers' ability to choose and to perform the care that they deem is in their patients' best interest. When hospitals adopt the values of corporate rationality, the balance of power in these institutions shifts in favor of administrators and away from care providers (Leicht, Fennell, and Witkowski 1995). For many clinicians, administrative cost control represents an assault on caring and professional autonomy. The divergence in values pits administrators seeking to protect the future viability of their institutions in the midst of a Code Green against health care professionals seeking to provide the care they want to give. The Beth Israel case sheds light on these conflicts. It shows what happens to people who provide care and to those who depend on that care—something often overlooked in restructuring—and provides insight into the current nursing shortage.

In 1996, Beth Israel Hospital merged with its neighbor, the New England Deaconess Hospital, another Harvard teaching hospital, to form the Beth Israel Deaconess Medical Center (BIDMC). At the same time, the two Boston hospitals and Mount Auburn Hospital in Cambridge formed CareGroup, a health care system that would treat one out of every nine patients in Massachusetts. The merger was considered a necessary step to compete in the Massachusetts health care market, which was dominated by Partners HealthCare, Boston's first major health care network. The New England Deaconess and Beth Israel Hospitals hoped to cut costs by integrating the two facilities. They planned to merge the hospital boards as well as all clinical and administrative functions. Public statements by the CEOs of the two premerger hospitals stressed the goodness of the match: both were teaching hospitals affiliated with Harvard Medical School, both placed a premium on quality patient care, and both enjoyed outstanding reputations as institutions providing high-quality care. The initial optimism glossed over profound differences in organizational arrangements around nursing at the two institutions.

Prior to the merger, the New England Deaconess Hospital built a reputation as a pioneer in the general restructuring of hospital care. The small surgical specialty hospital stood on the forefront of streamlining operations and implementing total quality management efforts. The hospital boasted that it increased efficiency and productivity while maintaining care quality and patient satisfaction. One strategy that the hospital used involved cutting registered nurse positions and replacing registered nurses with aides, who took on nurses' more "mundane" tasks (e.g., checking vital signs, bathing patients, and changing bedpans).

The Deaconess's cost-reducing strategy was in stark contrast to the premium that Beth Israel placed on its nurses. Beth Israel Hospital built its reputation around the individualized care that its highly skilled and educated nurses delivered directly to patients. In the 1970s, Beth Israel implemented a practice known as primary nursing, in which each nurse became responsible for the care of particular patients from admission to discharge. Even though other registered nurses cared for the nurse's patients during her off shifts, the primary nurse had twenty-four hour accountability for her patients' care. By following the patient's progress through the whole of the patient's stay, the nurse got to know the patient, to recognize changes in the patient's condition, and to plan the patient's care, thereby ensuring coordination and continuity of care. This system emphasized the knowledge and insights that a nurse, through prolonged
interaction with her patients, could bring to bear on their treatment. In line with the value that the hospital placed on nurses’ professional knowledge and experience, Beth Israel departed from the practices of many other hospitals. It paid its nurses salaries rather than hourly wages and offered them the opportunity for promotion without having to leave direct service. This was in contrast to most hospitals where a nurse seeking to advance had only a few options—to leave the bedside and become a manager or to go into a career in academia or consulting. Beth Israel implemented a program of clinical advancement: Nurses who expanded their skills and education could climb up four levels of clinical nursing, each of which brought increased pay and respect. (See Gordon 1997 for a full description of primary nursing practice and its historical importance.) Before the merger, one of Beth Israel’s ad campaigns referred to the high quality of patient care with the slogan, “It’s the nurses.” The catchy sound bite largely reflected the culture of clinical practice at Beth Israel. After the merger, however, references to the power of nursing in BIDMC ad campaigns were notable for their absence.

A 1997 Wall Street Journal article described the threat that Beth Israel’s unique and important nursing model faced from the merger and cost cutting:

But [the primary nursing] tradition may be in jeopardy. A year ago, in an attempt to boost efficiency and compete better with its rivals in an era of tight medical budgets, Beth Israel Medical Center started merging with Boston’s busy Deaconess Hospital. The impact of the merger and other cost-cutting measures, many doctors and nurses fear, could make the commitment to primary nursing too difficult to maintain. And if the concept can’t survive at its very birthplace, they say, it may be doomed at other hospitals, too.4

The article paints an unappealing picture of what care might look like if the hospital could not maintain its commitment to primary nursing. It contrasts the premier Beth Israel primary nursing practice with the care provided at the Deaconess: “Over at the Deaconess side of the hospital, two ‘patient-care techs’ with three months’ training circle the cardiac ward checking patients’ vital signs. About a year and a half ago, the Beth Israel side added a nursing student to do some minor tasks . . . but at Beth Israel, for now at least, taking vital signs remains a nurse’s duty.” The article continues, “In addition to being slightly busier, Deaconess—where a typical nurse with four or five years’ experience might make . . . roughly the starting salary at Beth Israel—appears to put less emphasis on nurses’ clinical judgments.” The key difference between primary nursing and this other model of care is whether patients have the benefit of a qualified nurses’ ongoing personal attention and clinical judgment.

Bolstered by the research about the benefits of the primary nursing model for patients and the lavish praise they received, Beth Israel nurses were convinced of the superiority of their model. But critics, particularly from the Deaconess’s Nursing Department, faulted Beth Israel’s primary nursing practice for being too resource-intensive and, thus, too expensive in the current financial crunch. The merged hospital’s worsening financial situation threatened the primary nursing practice Beth Israel Hospital had built since the 1970s.

Events in March 1999 brought the hospital’s dire financial situation center stage. Due to merger problems and decreased Medicare payments—a result of the 1997 Balanced Budget Act—BIDMC faced an operating loss of $73 million for the 1999 fiscal year. A team of consultants, working with management to engineer a turnaround plan for the hospital, had been buzzing around the hospital for months. At a Medical Staff Meeting in early March, the hospital leadership finally unveiled the outlines of this plan, which it dubbed “Genesis.”

Doctors and nurses filled a large auditorium to listen to a highly produced show given by the BIDMC management team. Angry whispers and murmurs rushed through the crowd as the PowerPoint slides flashed across the large screen. The slides presented detailed plans that many on the medical staff involved in hospital committees had already been suggesting or even working on, such as greater consolidation of the two hospitals. A dark joke circulating after the meeting suggested the widely held perception that the remainder of the Genesis team’s plan consisted of nothing more than cutting staff:

Q: What comes after Genesis?
A: Exodus and Numbers. (Fieldnotes, March 1999)

Although there was no reduction in the number of bedside nurses, frontline nurses felt the full force of the Genesis Project's budget reductions over the next few months. Over the next six months, changes at the hospital put the squeeze on frontline nurses by pulling them away from the bedside to perform other duties, increasing their patient loads, and leaving them shorthanded.

An angry nurse questioned the hospital's financial priorities: "It seems to me if we've got a couple of million dollars to spend on the Genesis Report, to tell them what they already knew, that they could have spent that money on patient care." She accused the administration of "backing off from a commitment to good nursing practice" and "playing the actuarial odds" with patients' well-being and "hoping there are not a lot of complications" (July 1999). Another nurse made a similar observation, linking quality-of-care issues to the hospital's current financial focus: "I used to believe that this hospital took excellent care of every patient, and I don't feel like that any more. I think that it's done with the primary focus on being expedient and cost-effective and [getting] patients in and out as quickly as you can because every minute they're here it costs the hospital money to care for them, one way or another." She emphasized that the result was "patched together and shoddy care" (June 1999).5

BIDMC management viewed as suspect nurses' claims about threats to patient care. The hospital administration characterized nurses' concerns about quality as mere resistance to change. They diminished the significance of nurses' response by attributing it to a "normal" and "expected" resistance to change. Nothing to really worry about. With nursing at the center of patient care, the old Beth Israel Hospital had structured admission procedures and support services around the nurses' needs in caring for patients. However, BIDMC's financial crisis necessitated an emphasis on cost-cutting and streamlining measures, such as shortening the length of stay and reducing support services. Administrators recognized that Beth Israel nurses, whose practice had been built around their relationships with their patients, mourned not having the same quality or quantity of time to spend with those in their care. In interviews, hospital administrators offered what became a familiar refrain, "Nurses need to adjust their standards. We can't go back to the way we did things before."

During an interview, I asked a nurse about management's assertion that nurses' concerns about not having enough time with patients reflected little more than resistance to change. She roared at me,

That's a crock of shit. Change what? Change from giving good quality care to giving no care... The things that aren't being done aren't things that you can catch up on later... If you don't see a patient for three hours, you can't somehow later on make up for the fact that for three hours you haven't evaluated the patient. So then you're shooting craps again... They're hoping there's not a complication in that three-hour period where they've got no nursing care. And that has nothing to do with change. That's poor nursing care. And it's poor nursing care that the nurse has no control over because she can't be two places at once.

Her angry response captured the perspective of many of the nurses I interviewed. Although nurses did indeed mourn the loss of the personal relationships that they were once able to develop with patients, their complaints about not having enough time related to pressing concerns in providing patient care. Not having enough time with patients meant not having enough time to evaluate them, to monitor their condition, to understand and plan for their needs after discharge, or to provide basic physical care. For nurses, spending time with patients was not an optional luxury. This was not about the nicety of holding someone's hand or making small talk about their children, but about not being able to provide what they considered necessary care to diseased, weak, vulnerable, and potentially unstable patients.

What happened over the course of three years at BIDMC shows us in microcosm what has happened in our health care system as hospitals have increased the demands on registered nurses while decreasing their time with patients.
From 1981 to 1993, the number of nursing caregivers at the bedside in hospitals declined by 7.3 percent (controlling for the type and severity of patients' illnesses and the rise in volume of patients), even as all other categories of hospital staff increased. Reductions in nursing staff—registered nurses (RNs), licensed practical nurses (LPNs), and nurses' aides—were more severe in states with high managed care penetration. The overall proportion of nursing personnel relative to inpatient volume and severity fell 27 percent in Massachusetts, 25 percent in New York, and 20 percent in California between 1981 and 1993. As a result, nursing personnel dropped from 45 percent of the hospital labor force in 1981 to 37 percent of the hospital labor force in 1993 (Aiken, Sochalski, and Anderson 1996).

In the late 1990s, hospitals began to change the composition of their already reduced nursing staffs by replacing RNs and LPNs with less-skilled nursing personnel, who also command lower salaries (Buerhaus and Staiger 1999). In theory nurses' aides carry out the "mundane" tasks involved in patient care, like emptying bedpans or changing sheets, and free up highly skilled RNs for the more "complicated" tasks requiring their expert knowledge and skills. In practice, however, nurses' aides were assigned the time at the bedside that RNs, while performing so-called mundane tasks, used to gather important clues to the patient's condition and response to treatment. The reduced number of RNs, meanwhile, became responsible for the care of a larger number of patients, while also supervising the care activities of a growing number of nurses' aides, who deliver care at the bedside but lack the skills or the knowledge necessary to recognize, correctly interpret, or communicate vital information about patients. Requiring this information to do their jobs of planning and evaluating care, RNs still needed time—a scarce commodity given RNs' new workloads—with patients to gather this information.

Individually, the nurses in this study shouldered the cost of struggling to deliver the care they deemed necessary. To recover what they considered necessary time with patients, the nurses at BIDMC sped up their work or worked overtime. Dedicated, busy nurses took no time to look after themselves—to eat or even to use the restroom. To protect patient health, nurses paid with their own health and well-being. Many showed signs of burnout from prolonged work speed-up and the frustration and effort of circumventing dysfunctional or inadequate hospital systems.

Many contemplated leaving the nursing profession. Others found it necessary to reduce their hours by becoming part-time or per diem workers.

Despite repeated efforts to bring these new facts of nurses' work life to the attention of administrators, the hospital leadership did not recognize nurses' Herculean efforts to maintain the level of care provided to patients. Confronted with these accounts, they likely saw nurses' efforts as unnecessary, further proof of an unwillingness to accept reasonable but more efficient care standards. Throughout my study, the hospital leadership insisted that nurses' claims of threats to care quality veiled attempts to protect the professional status nurses enjoyed in Beth Israel's glory days. Without glaring evidence of patient dissatisfaction or morbidity, administrators denied that care had been compromised. In management's view, nurses' complaints about time with patients were a matter of their own satisfaction, not patient safety; nurses wanted to protect their autonomy and control over the organization and over patient care. Administrators perceived such self-interested resistance as an obstruction to efficiency and the hospital's attempts to reduce its operating deficit.

In fact, the hospital leadership actively sought to gain greater control over nursing practice by reducing nurses' professional status and influence in the organization. The hospital leadership pushed out the nurse administrators who had led the hospital to international prominence. They broke apart the Nursing Department, distributing nurses to other departments throughout the hospital and making a large portion of nurses subordinate, not to another nurse or health care professional, but to nonclinical managers. Finally, they stripped nurses of their influence over hospital decision making by removing their seat at the executive table through the elimination of the Vice President of Nursing position. Thus, BIDMC joined the ranks of many other hospitals in the late 1990s: While the head of nursing retained a seat at the executive table, it was as the representative of "patient care services" and not of nursing alone (Clifford 1998). Nursing at BIDMC lost its voice as a separate and distinct professional discipline and its power in shaping organizational decisions and policies.

With news stories from across the country reporting clashes between nurses and administrators, it is clear that the conflict between the nurses and administrators at BIDMC goes beyond a local story about changes to
a famous model of professional nursing. The drama at Beth Israel seems to be playing out at hospitals across the country, with nurses, their professional organizations, and their unions complaining about not having enough time or support to care for patients. Nurses in several states orchestrated demonstrations and strikes to emphasize work conditions they consider unsafe for both nurses and patients. Some administrators claim that nurses—and particularly their unions—exaggerate the occasional horror story to generate public sympathy and support in labor negotiations with hospitals. These administrators denied problems in their own hospitals and suggested that the clamor disguised the real issue, which is not patient safety, but nurses’ fears for their jobs or desire for higher salaries. In short, these administrators suggested that nurses used the language of patient risk to increase their control over organizational policies and practices, not to communicate a real threat to the quality of care.

Similarly, BIDMC’s leadership approached nurses’ concerns as an either-or proposition. Either nurses were concerned about their own professional status, autonomy, and control, or they were concerned about patient safety and care quality. However, this distinction is meaningless because the issues of nurses’ status, autonomy, and control are closely related both to nurses’ professional satisfaction and to quality of patient care.

Led by Linda Aiken, a team of researchers from the University of Pennsylvania conducted a series of studies that demonstrate the importance of status, autonomy, and control both for nurses’ and patients’ well-being. In 1994, Aiken, Smith, and Lake found lower Medicare mortality rates “in a group of hospitals characterized by nurses as being good places to work” (772), Beth Israel among them. Staffing levels and the educational credentials of the nurses could not explain away differences in the number of patient deaths. Rather, the results indicate a larger story in which the organization of nurses’ work contributes to better patient outcomes. In this and later research they identify the organizational features that both enhance nurses’ satisfaction and improve patient outcomes: nurses’ status and representation in the hospital, their control over the resources required to perform their work, their autonomy in decisions about how to care for patients, and their teamwork and collegiality with physicians. The researchers found that these organizational arrangements “and their resulting impact on nurses’ behaviors on behalf of patients” enhance patient outcomes (Aiken, Smith, and Lake 1994:783; Aiken et al. 1999) and reduce nurses’ burnout (Aiken and Sloane 1997a).

Aiken and her colleagues examine how organizational structure influences outcomes for both nurses and patients by creating a more or less supportive environment for nursing care (Aiken and Sloane 1997a; Aiken and Sloane 1997b; Aiken, Sloane, and Lake 1997; Aiken, Smith, and Lake, 1994; Aiken, Sochalski, and Lake, 1997). They identify dedicated AIDS units and magnet hospitals, for example, as structures that promote more supportive contexts for nursing care. Dedicated AIDS units, due to the complex, chronic, and fatal nature of the illness treated and the opportunities for nurses to specialize in its treatment, tend to support favorable working conditions, even when the arrangement of specialized units in the same hospital do not (Aiken and Sloane 1997b). Similarly, magnet hospitals, hospitals that embody a set of organizational attributes that nurses find desirable (Aiken, Smith, and Lake 1994:771), prioritize nursing; for example, representatives of nursing may participate at the highest levels of decision making within the institution. The values and structures in place in magnet hospitals promote a favorable context for nursing care on units, specialized or not, throughout the hospital.

Restructuring could create fluctuations and changes in these important organizational arrangements—nurses’ status, their control over the practice environment, their autonomy, and their relationships with physicians—both throughout the institution and within individual units. That BIDMC did not bother to apply to the American Nurses Credentialing Center for recognition as a magnet hospital—one of Beth Israel’s distinguishing features—demonstrates just how susceptible to disruption these arrangements are. Such fluctuations and changes could have ramifications

---

* A number of news articles in 1999, the year I performed my research, covered conflicts between nurses and hospitals in states across the country, including Massachusetts (Dolores Kong, “Boston Area Nurses to Join Nationwide Protest over Staffing Levels,” Boston Globe, 4 Nov. 1999), California (Patrick S. Pemberton, “San Luis Obispo, Calif., Nurses Picket Medical Center,” Tribune, 11 Sept. 1999), Rhode Island (Brian C. Jones, “Providence, R.I., Hospital Union Protests Nursing Changes,” Providence Journal-Bulletin, 25 June 1999), North Carolina (Alan Wolf, “Nurses at Durham, N.C., Hospital Consider Unionizing,” 19 Feb. 2000), and Alaska (Eve Rose, “Anchorage, Alaska, Hospital’s Nurses Are Set to Strike,” Anchorage Daily News, 4 Apr. 1999). Nurses claimed that concerns over staffing and the quality of patient care led to their protests. This list is in no way exhaustive.
not just for individual nurses’ satisfaction and burnout rate but also for the quality of care patients receive.

In general, frontline employees bear the brunt of any restructuring effort. Not only must they carry out and adjust to any changes, but they must do so while continuing to perform the work of the organization. Yet we know little about how restructuring alters the organizational arrangements that affect employees’ satisfaction, motivation, or performance.

With the assumption that happy employees are also productive employees, a large body of research focuses on carefully planned restructuring strategies (such as job redesign and participation in decision making) that are specifically chosen and designed to humanize the workplace and to promote positive attitudes and behavior among employees. However, studies of this type of planned restructuring yield conflicting results about the effects on employees (see meta-analyses: Guzzo, Jette, and Katzell 1985; Kelly 1992; Miller and Monge 1986; Neuman, Edwards, and Raju 1989; Robertson, Roberts, and Porras 1993; Spector 1986; Wagner 1994; Wagner and Gooding 1987). One reason for these conflicting results is that this research often neglects to assess or report how restructuring actually changed organizational arrangements that influence employees’ attitudes and behaviors. Much of it focuses instead on the changes expected by researchers or managers. In complex organizations, however, expected changes may bear little resemblance to actual changes. Even when restructuring goes according to plan, the results may nonetheless be unexpected and even unwelcome.

The issue of examining actual, rather than anticipated, changes from restructuring grows even more salient in the case of strategies chosen not for their effect on employees but for their effect on an organization’s finances or performance—for example, mergers or budget reductions. These strategies often entail far-reaching changes to employees’ daily work lives—such as changes in the way their work is done, expanded job demands and responsibilities, and changes in their employment status and their pool of coworkers. However, these changes and their effects may not even enter into the decision process in choosing and implementing a strategy. The question of how these strategies change organizational arrangements that affect employees’ ability and desire to do their work has gone largely unasked and unanswered. Only a handful of studies have looked at the effect of this type of restructuring on employees. This book is one of the few that addresses the impact in a health care setting.

This book examines how restructuring at BIDMC produced the conditions that made highly educated and skilled nurses question their desire to stay in nursing and their ability to provide good care. The case presented in this book provides insight into the factors detracting from the nursing profession’s recruitment and retention of nurses.

Nurses constitute the largest single group of health professionals, and most nurses work in hospitals. Moreover, “[n]urses are the cornerstone of the professional surveillance system in hospitals because they are the only health care professionals at the bedside around the clock” (Aiken, Sochalski, and Lake 1997; NS16). Nurses provide the front line of care in hospital settings and have the most contact with hospital patients as well as the most direct impact on care received. To the extent that changes in organizational arrangements impair nurses’ motivation, satisfaction, or performance, adverse outcomes, mortality, and discomfort may all increase for hospital patients.

Surprisingly, the effect of organizational restructuring on nurses and their work has received little public attention. But, I contend, it is no accident that the worst nursing shortage in our nation’s history follows on the heels of unprecedented restructuring in the health care industry. While cyclical over- and undersupply of nurses is nothing new, this nursing shortage differs due to a combination of factors. This time around, the nursing shortage involves a sharp increase in demand in tandem with a decrease in supply. The average age among RNs is forty-five. Many plan to retire in the near future, just as the baby boomers’ consumption of health care services is expected to increase (Bednash 2000). There are not enough new RNs in the pipeline. Nursing school admissions fall yearly, and there are few RNs in the eighteen- to twenty-seven-year-old age range (Buerhaus, Staiger, and Auerbach 2000). Hospitals claim that they already feel the shortage and are having trouble attracting and retaining nurses. Unfilled nursing positions account for approximately 75 percent of hospital job vacancies. Moreover, a disturbing number of RNs are leaving the profession. A recent study of 43,329 RNs in Pennsylvania reported that 22 percent planned to leave nursing (Aiken et al. 2001). Hospital restructuring drove many experienced nurses away from the bedside and may have scared off potential new recruits.
Lawmakers, hospitals, and nurses' groups seek solutions to the problems of retaining and attracting nurses. A number of states have introduced legislation to ban mandatory overtime, and others are considering mandating minimum nurse-staffing ratios. The American Nurses Association has requested more money from the government for recruitment and education of new nurses. While many of these solutions address nurses' most immediate complaints, they may only treat symptoms rather than the underlying disease. The problem is that hospital restructuring has fundamentally changed organizational arrangements that shape nurses' daily work lives and what it means to be a nurse.

In Beyond Caring (1996), Daniel Chambliss identifies three core features of nurses' work, which he labels "missions": "The hospital nurse is expected, and typically expects herself, to be simultaneously (1) a caring individual, (2) a professional, and (3) a relatively subordinate member of the organization" (62). For nurses, caring involves working face to face with patients for an extended amount of time, a condition that gives nurses claims to special kinds of knowledge about patients (Anspach 1996; Chambliss 1996). It includes treating patients as human beings, not just diseases or ailments that need to be cured. The second mission, being professional, emphasizes that caring is a job that nurses must perform regardless of the situation or the characteristics of their patient. Professionalism requires that caring be performed with special competence, a bringing to bear of clinical expertise and judgment even under pressure and time constraints. For nurses, being a professional signifies a claim to special status and recognition that caring be performed with special competence, a bringing to bear of clinical expertise and judgment even under pressure and time constraints.

Professionalism also means that nurses' work is (caring), how they perform it (as professionals), and under what constraints (as subordinates to hospital administrators and to doctors). These three missions produce some of the conflicts inherent in being a nurse: "The directives conflict: be caring and yet be professional, be subordinate and yet responsible, be diffusely accountable for a patient's well-being and yet oriented to the hospital as an economic employer" (Chambliss 1996:62).

While these conflicts have long plagued nursing, hospital cost-cutting and downsizing in the late 1990s increased the dissonance among these aspects of nurses' work. In particular, hospital restructuring devalued the caring aspects of nurses' role, strained their ability to act as professionals, and emphasized their subordination to institutions that find it necessary to emphasize margin over mission. In the process, nursing, which became less attractive once women were liberated to enter male professions, has become even less attractive. But the tensions among these three aspects of the nurse's role are not unique to nursing; the same conflicts exist for all of the caring professions employed in bureaucratic organizations. To the extent that the shifted balance among nurses' caring, professionalism, and subordination to their hospital employers has made nursing less attractive, this is a cautionary tale for other caring professions employed in resource-strapped organizations, such as doctors, social workers, and teachers.

This book presents an in-depth view of changes that affected nurses at Beth Israel Deaconess Medical Center from January to September 1999. The book reports the findings gathered during nine months of intensive field research at the hospital. During those nine months, I shadowed nurses on six different units that served the adult medical-surgical population. I attended staff meetings, interviewed nurses and administrators, held focus groups with floor nurses, distributed surveys, and studied internal hospital reports and documents. I collected data about how organizational arrangements had changed and how nurses' work had changed as a result. I attended to the issues of power and control and their relationship to nurses' ability to perform their work.

In Chapter 2, I place BIDMC's Code Green and selected solutions in the context of changes in the hospital industry. Chapter 3 considers the very different nursing models in use at the two premerger hospitals and the way changes at BIDMC undermined nurses' continued use of these models to deliver patient care. The mistaken assumptions that led to the view of nurses as obstacles to restructuring and ultimately to the dismantling of the Nursing Department are described in Chapter 4. Using the case of the Emergency Department, Chapter 5 examines the effects of on-
going power conflicts—a vestige of the bungled merger—on nurses’ ability to provide care to patients. The consolidation of the Cardiothoracic Unit illustrates, in Chapter 6, the impact of physicians’ conflicts with each other on the relationships between doctors and nurses and on nurses’ control over their own practice. Through an analysis of the assumptions used to calculate the new nurse-staffing levels on the inpatient units, Chapter 7 discusses nurses’ perception that they did not have enough time to provide what they considered safe care to patients. Chapter 8 explores the dispute between nurses and administrators over whether restructuring compromised the quality of care at BIDMC. Chapter 9, the conclusion, evaluates the restructuring strategies that BIDMC pursued, the effects on nurses’ roles as caring and professional, and the implications for the future nursing workforce.

A Troubled Hospital

In 1995, Mitchell Rabkin recognized that the hospital he had headed since 1966 now faced some serious problems. Quickly approaching retirement, this icon in the Massachusetts medical community needed to think about how to safeguard his hospital’s commitment to its patients and employees and still compete in an increasingly hostile, competitive medical marketplace. With Vice President of Nursing Joyce Clifford, Rabkin had transformed this Jewish community hospital into one of the best-known medical research and teaching institutions in the world. Beth Israel Hospital, fondly known as “Harvard with a Heart,” stood out among the other Harvard teaching hospitals for its human touch. The hospital was a friendly place both to its patients and its employees. Modern Healthcare had listed Beth Israel among the top one hundred hospitals in the country, while Working Mothers Magazine recognized the hospital as one of the country’s best workplaces for women. Even with this focus on the human factor, Rabkin ran a tight ship. Despite ferocious cost-cutting on the part of Massachusetts insurers, Beth Israel operated in the black. Moreover, a 1994 William M. Mercer Analysis judged the hospital to be the most efficient of Boston’s six largest teaching hospitals. Despite these considerable achievements, the hospital was beginning to strain under the pressures in the health care market. It needed to take dramatic action to ensure its survival.

2 Ibid.
The conditions that necessitated dramatic action were not unique to Beth Israel Hospital or to the Massachusetts health care market. The pressures that Beth Israel faced and the choices its leadership made in response reflect broader trends in the U.S. hospital industry. To understand what happened to nursing at Beth Israel, we have to understand how the context in which nursing was practiced dramatically shifted in the mid-1990s.

**Changes in the Hospital Industry**

Over the past few decades there have been sweeping changes in the U.S. health care system. Over the last two decades, both public and private purchasers of health care services have pressured hospitals to contain their cost growth. The historical roots of these trends relate to the consolidation of purchasers of health care services. Increasingly, the purchasing of health insurance and health services, traditionally an individual affair, is now conducted by collective purchasers. This change began in the public sector in 1965 with the advent of Medicare and Medicaid. Consolidation also took place in the private sector through growth of the health insurance industry as it became increasingly common for employers to purchase group insurance to provide health benefits to employees (Starr 1982). By removing payment responsibility from individual consumers of health services, this growth of public and private health insurance increased access to and demand for health services. Meanwhile, technological advances improved or created the ability to perform new procedures and treatments and further fueled demand. This market environment spurred rapid increases in national health care spending.

At their inception, Medicare and Medicaid adopted generous payment policies to encourage physicians and hospitals to accept Medicare and Medicaid patients (Starr 1982). These programs provided fee-for-service payment for health care. This system encouraged hospitals and physicians to perform numerous services because they received payment for each service rendered (Robinson and Casalino 1996). This payment system provided little incentive for hospitals to scrutinize practice, to increase efficiency, or to limit costs. Charges for services varied widely from hospital to hospital and region to region. The federal government, footing the bill, attempted to control escalating cost growth in these public programs during the 1970s. In large part due to the incentives built into the reimbursement system, these efforts proved ineffective.

In 1983 the federal government attempted to rein in its Medicare outlays for hospital services by changing these incentives through introduction of a prospective payment system. Under prospective payment, Medicare paid predetermined amounts for various hospital services. Costs were determined not by individual hospitals but through a calculation that adjusted costs based, among other criteria, on region and type of hospital. Since Medicare accounts for almost 40 percent of hospital revenues, the program had considerable potential to move the hospital industry toward greater efficiency (PROPAC 1997). Instead, the costs for hospital services continued to rise, and Medicare payments fell below the costs of services (Guterman, Ashby, and Greene 1996). Rather than pursue greater efficiency, hospitals tended to shift costs onto private payers (Guterman, Ashby, and Greene 1996).

The employers who pay for health care in the U.S. employment-based system soon followed the government’s example and also sought to reduce cost growth. Managed care was chosen as the primary means for changing physician and hospital behavior. It substituted fee-for-service with payment systems that increased physician and hospital accountability and risk (PROPAC 1997) and introduced insurance company micromanagement of discrete services. Private insurers began to take a more active role in managing hospital care. They refused payment for services deemed unnecessary and, in some cases, capped total payments. With the number of individuals in managed care plans growing, the largest health plans could effectively use their leverage to negotiate favorable contracts with hospitals. Furthermore, new technologies made it possible to perform many inpatient procedures on an outpatient basis. Hospitals experienced competition from freestanding facilities to perform these services (Kuttner 1999). Large insurers pressured hospitals into deep discounts on services by threatening to take their business elsewhere.

Until the late 1990s most hospitals were able to manage cost-cutting pressures and still retain profit margins. Mounting cost-containment pressure from the private sector limited hospitals’ ability to shift costs to the private sector for uncompensated and underfunded care. Consequently,
hospitals sought greater efficiency (Guterman, Ashby, and Greene 1996). In the 1990s, as hospitals became more efficient, Medicare payments once again exceeded costs (Levit et al. 1998). The relationship of private and public payers reversed (Levit et al. 2000; PROPAC 1997), and the public sector's comparatively generous payments now subsidized the deep discounts demanded by the private sector.

The Balanced Budget Act (BBA) of 1997 moved to change this arrangement. The BBA mandated reduction of Medicare expenditures by $115 billion over five years, including a $71 billion reduction in projected Medicare hospital payments (Kuttner 1999). This legislation effectively removed the cushion for hospitals that depended on Medicare payments to cover their cost shortfall from managed care and other insurance contracts. Reports of losses in the millions of dollars for fiscal year 1999 reveal how close to the bone hospital margins have been cut. As a result, some of the BBA Medicare payment reductions have been reversed or postponed (Hallam 1999), and further rollbacks are being considered (Levit et al. 2000).

Teaching hospitals and hospitals serving poorer communities have been hard hit by the market crunch. These hospitals face higher costs to treat patients. These costs include teaching, research, treating more acute cases, and caring for the poor (Blumenthal and Meyer 1996; Reuter and Gaskin 1997). These additional costs impede these hospitals' ability to compete for managed care contracts on price (Reuter and Gaskin 1997). For example, academic health centers charge between 15 percent and 35 percent more per inpatient admission (adjusted for case-mix) than their community hospital competitors (Blumenthal and Meyer 1996). Medicare payments subsidize the added costs of these hospitals' teaching and social missions (Blumenthal and Meyer 1996). But the BBA Medicare payment reductions have sent many of these institutions into financial crisis.

Strong lobbying by teaching and other hospitals convinced Congress that the cuts were more draconian than intended, and hospitals received a billion-dollar “giveback” to offset some of the burden.3 However, this temporary reprieve did nothing to solve the larger issues of how hospitals might come out of Code Green while balancing cost-containment and social mission. Moreover, it came too late to offset the effects of the kinds of cost-cutting strategies employed by hospitals to deal with the pressures of managed care.

Hospitals' Search for Solutions

As soon as managed care became the nation's de facto health care policy, hospitals responded to market pressures with tactics to manage their internal operations and external environment. In the 1990s, hospitals devised a number of strategies to wring cost reductions out of their internal operations. Since labor costs (salaries, wages, and benefits) eat the largest chunk of a hospital's budget, over one-half on average (PROPAC 1997; Robertson, Dowd, and Hassan 1997), the most popular strategies target these costs. From 1981 through 1993, overall hospital employment increased by 11.3 percent, controlling for increased patient volume and acuity (Aiken, Sochalski, and Anderson 1996). In 1994, this trend began to reverse, with the number of hospital employees decreasing even as patient admissions increased (PROPAC 1997). Therefore, hospitals have placed greater productivity demands on each employee. Popular labor-cutting strategies included changing skill mix by introducing a larger proportion of assistants and unlicensed personnel and reducing the number of registered nurses, lowering staff-to-patient ratios, and cross-training staff to take on more functions (Shindul-Rothschild, Berry, and Long-Middleton 1996). At the same time, hospitals have restrained annual increases in employees' compensation relative to the rest of the economy (PROPAC 1997).

In addition to their efforts to save money, hospitals also pursued strategies to make more money. One common strategy hospitals used was to shift many of their services from an inpatient to an outpatient basis (Levit et al. 1998). Because outpatient procedures generally cost less than inpatient, private insurers under managed care favor ambulatory surgery, home care, and anticipated,” Health Management Technology, Sept. 1999; “HCIA: BBA Impact on Hospitals 'Blacker' Than Imagined,” American Health Line, 5 Oct. 1999.

As a result, the average medical-surgical patients in the 1990s were as acutely ill as critical care patients in the 1980s (Curtin and Simpson 2000). Moreover, these patients would be discharged as soon as they required less intensive care. These two trends, higher patient acuity and shortened length of stay, together and individually, increased the workload per patient day at a time when many hospitals were also decreasing their labor force. These trends concentrated a group of more demanding patients at the time when they needed the most care in hospitals in which employees were already being asked to provide care with less help.

Although the shift to greater outpatient care profited hospitals in some ways, it also left them with an oversupply of beds (Kuttner 1999). In response, many hospitals formed organized delivery systems or integrated networks (American Hospital Association 1999; Duke 1996; Levit et al. 1998), vertically integrating with both primary care and postacute care providers. Because physicians often play an active role in determining where their patients will be treated, partnering with primary care physicians provided hospitals with a greater competitive edge in capturing business (Duke 1996). Hospitals also sought access to revenue from postacute care services and pursued integration with postacute care organizations (e.g., nursing homes, rehabilitation facilities, home care, and hospice care) or converted former inpatient units to postacute care facilities. In the early 1990s, integration with primary and postacute care providers took the form of acquisition. In the latter half of the decade “virtual” integration, through exclusive contracts or strategic alliances, became more prevalent (Shortell et al. 1997). Through virtual and actual integration hospitals hoped to gain a greater competitive advantage in negotiating and competing for managed care contracts (Levit et al. 2000) and in ensuring a steady stream of patients from physician referrals.

Hospitals also pursued relationships with other hospitals in response to cost pressures and overcapacity (Duke 1996; Levit et al. 2000). These horizontal mergers and alliances served a number of different purposes depending on the relationships among the hospitals, but, in general, this strategy served one of two purposes: not “managing competition” but the elimination of the competition or the expansion of the hospital network to gain a monopolistic edge (Bogue et al. 1993). These strategies enabled hospitals to pool their market share, making the merged entity a larger competitor in the local market.
Hospitals serving noncompeting locales often formed multihospital networks. Participation in multihospital networks generates greater bargaining power with managed care companies due to the ability to provide multiple services in a variety of locations (Dranove, Durkac, and Shanley 1996). For small hospitals, these networks might mean a greater portfolio of services to help attract managed care contracts. Network expansion could shift the balance of power in negotiations with managed care companies that needed access to particular hospitals in the network in order to offer a full range of services to their customers (Barro and Cutler 1997).

In the merger mania that swept the hospital industry in the 1990s, hospitals competing in close proximity have tended to enter mergers. Between 1990 and 1996, 176 hospital mergers took place in the United States—more than in the entire previous decade (Spang, Bazzoli, and Arnould 2001). These mergers resulted in the closing of one of the hospitals, division of specialty functions between the hospitals involved, or, less commonly, parallel operations but with an integration of administrative functions (Barro and Cutler 1997). Not only did these mergers neutralize a rival hospital, but they promised hospitals cost-savings from realization of economies of scale. By merging with other institutions, hospitals hoped to expand their market share, gain stronger footing with managed care companies, and more easily access a stable customer base (Brazzoli et al. 2002; Bogue et al. 1995; Dranove, Durkac, and Shanley 1996).

**The Beth Israel–Deaconess Merger: A Problematic Solution**

Massachusetts General Hospital and Brigham and Women’s Hospital, the two largest of the Harvard teaching hospitals, took the Boston medical scene by surprise when they announced their merger in 1993. Full-page ads in the *Boston Globe* and the *New York Times* among others, announced that these titans of Massachusetts medicine created Partners HealthCare Inc. This new giant health care network—with 12,000 employees, 2,100 beds, and nearly 4,000 physicians—boasted it would meet all of the medical needs from primary care to hospitalization of a majority of Boston-area residents. This formidable competitor threatened to gobble up market share and starve out Beth Israel along with the other local hospitals. The situation required action. Rabkin and the hospital board believed that if Beth Israel wanted to remain a player in this market, it needed to team with another institution.

In 1996 Beth Israel Hospital announced it would join forces with New England Deaconess Hospital, its neighbor across the street. Individually the two hospitals had been losing market share to Partners HealthCare. Both hospitals considered the union a necessary step to compete and ultimately thrive in the Massachusetts health care market. The Deaconess had already merged with four community hospitals to form Pathways Health Network. But the five hospitals combined were only a little bigger than Beth Israel in terms of total revenues, assets, and the number of employees. Pathways perceived that it needed the greater clout, prestige, and referral base that affiliation with a strong Boston teaching hospital could provide. Together with Mount Auburn Hospital in Cambridge, these hospitals formed CareGroup, a network second in size only to Partners Healthcare. The newly formed Beth Israel Deaconess Medical Center (BIDMC) would be CareGroup network’s flagship hospital, its crown jewel, with 1,357 physicians, 7,660 employees, and nearly $1 billion in annual revenue. Together these CareGroup hospitals would play David to the behemoth Goliath that was Partners Healthcare. Alone they could not compete, but together, the hospitals thought, they might reclaim some of the market share now hoarded by Partners.

Unlike the Partners’ merger that joined administrative functions only, the Beth Israel–Deaconess merger required full integration and consolidation of the two hospitals. The two hospitals stood to realize a strong economic advantage—savings of millions of dollars—by combining over-

---


7 Alex Pham, “Mt. Auburn Set to Merge With Hospitals; Union Would Form $1b Health Care Network,” *Boston Globe*, 12 Mar. 1996.

lapping departments and sharing administrative expenses. They planned to merge the hospital boards as well as all clinical and administrative functions. The press heralded this dramatic change in management with optimistic newspaper reports touting the advantages of the planned combination. Beth Israel offered large cash reserves and a strong obstetrics service, while Deaconess brought strong programs in gastroenterology and cardiology to the marriage.\(^9\) Though hopes were high, the merger was also a risky proposition. Although it seemed Beth Israel’s best chance to remain a strong institution, the merger would change the hospital. The merged entity would no longer be Beth Israel Hospital, but something different. Perhaps the best of the two hospitals, perhaps the best of neither.

Three years after the merger, the gamble had not paid off. Despite the initial optimism, the Beth Israel–Deaconess merger did not deliver on its financial promise and even weakened the hospital’s situation.

Integration and consolidation of the two neighboring hospitals had progressed little by 1999, when I conducted my field research. Even making allowances for the sheer logistical difficulty involved in closing down hospital facilities and moving whole departments, the process proved more difficult than initially anticipated.\(^10\) Duplications in administrative positions and medical and surgical specialties burdened the hospital with greater expenses than expected. Under these circumstances, BIDMC had yet to realize any of the promised financial returns from the merger.

The honeymoon between Beth Israel and the Deaconess hospitals had long been over when my fieldwork began at BIDMC in 1999. Prominent surgeons and physicians, angry at the way the merger had been handled or displeased with new arrangements, left their positions at the hospital, draining its prestige. In May 1998, forty contract anesthesiologists serving the Deaconess campus quit en masse in response to a contract renewal offer deemed “unpalatable.”\(^12\) This left the anesthesiologists on the Beth Israel campus to cover both hospitals. Afterward, four unexpected surgical deaths occurred at the hospital. The Department of Public Health investigated the connection to the anesthesiology staffing crisis.\(^13\) Although no evidence was found to substantiate a link between the staffing shortage and the deaths, BIDMC suffered negative publicity. Prompted by events at BIDMC, the *Boston Herald* published an article with the headline “Deaths May Be Symptom of Medical Merger-Mania.”\(^14\) The report suggested that financially motivated mergers throughout the hospital industry have not been evaluated for safety and efficacy. Officials at BIDMC felt that the Boston-area papers took a heavy-handed approach in this and other articles and misrepresented events. Rumors about a “deep throat” in the organization abounded. Staff from both hospitals were disheartened by the bad press, and each side blamed the other for the tarnish on the hospital’s sterling reputation.

The hospitals remained two distinct entities. Although the hospitals neighbored one another, moving between them required walking two or three blocks outside. Walking from one end of the campus to the other took more than twenty minutes. This distance proved a challenge for staff to get back and forth for meetings or to see patients, and it was especially inconvenient during the inclement New England winter. In addition to the geographical distinctness, each campus had its own way of doing things: different paperwork, computer systems, and models of care delivery. These differences, some trivial, made it difficult for clinical staff to move back and forth across the campuses as needed.

In observations and interviews, a frustrated staff warned that these slight variations could hinder patient care. In an often-repeated example, the color used to flag physician orders needing to be filled differed on the two campuses, with the color used on one campus meaningless on the other. If a Deaconess doctor visiting the Beth Israel campus used the usual Deaconess color to flag orders, the orders would be ignored. In telling the story, staff members cautioned that this innocent mistake could delay patient care and potentially prove harmful. This trivial decision of which colors to use for flagging orders—a decision that could have been made with

---


a coin toss—took two years to make. Moreover, once it was made, the Deaconess staff griped that their color system had not been chosen. With growing anger, they complained that they were being forced to do everything the Beth Israel way.

POWER STRUGGLES AND MERGER DISAPPOINTMENTS

The issue of the color of the flags used on charts signaled a far deeper rift that affected every discipline in the hospital, including nursing. That this rift should occur would not surprise anyone who studied the problems of mergers in hospitals or other industries.

A small but growing body of research on the human factor in mergers and acquisitions explores why between two-thirds and three-fourths of mergers—not just in hospitals but in all industries—fail to deliver the financial benefits predicted by rational economic models (Cartwright and Cooper 1993; Marks and Mirvis 1992). The emerging answer is that these models have failed to take into account the human costs and consequences of organizational combinations. The responses of employees left behind to continue operations are crucial to a merger's success (Buono and Bowditch 1989; Buono and Nurick 1992; Cartwright and Cooper 1993; Covin et al. 1996), but the responses tend to be destructive due to merger-related stress, often sparked by culture conflict between the merging organizations (Lubatkin and Lane 1996; Marks and Mirvis 1992).

Cultural clashes between two merging organizations become prominent several months or more after a formal merger due to the difficulties inherent in integrating employees from two different organizations with different styles, approaches, and sometimes missions (Buono and Bowditch 1989). As Mitchell Marks and Philip Mirvis (1992) explain, mergers tend to produce an “us versus them” attitude. As a result, workers feel threatened by the newcomers’ beliefs and values about the best way of doing things. Such cultural collisions occur even in mergers between companies that seem to be culturally similar (Cartwright and Cooper 1993).

Research on human factors in mergers and acquisitions attends to culture clashes over the best way of doing things as primary causes of merger failure. However, these clashes are not so much a problem of incompatible cultures as of power relations. Behind these difficulties associated with cultural collisions is a larger sociological story about shifts in power among different constituencies in the merged organization.

Conflicts over power play a central role in the story of restructuring at BIDMC. Power is the influence one wields over a situation, “the ability to get things done the way one wants them to be done” (Salancik and Pfeffer 1977:374). Power may be considered as a finite amount, where one person’s having power means another person has less. Alternatively, it may be viewed as an expanding amount, which enables many people to be empowered at once. Daniel Katz and Robert Kahn (1978) explain that the amount of power depends on the situation, on whether there is commonality or conflict of interest:

Let us assume that A and B are working for the same goals, and that A will be influenced by suggestions from B and B by suggestions from A. The total influence exerted is greater than if A had merely given orders to B. And the effective outcome in productivity may well be greater and the return to both members greater. When, however, we are dealing with a conflict of interest and A and B are engaged in a power struggle, then the more A controls a given decision the less power B has. (322)

Katz and Kahn’s explanation illustrates how the view of power as finite applies in conflict situations, whereas the view of power as expanding applies in situations of common interest.

Employees coming together in merged organizations view decisions about whose way will be adopted as signals indicating who has power and influence in the new organization. These decisions are perceived as zero-sum games in which there are winners and losers. The source of merger-related stress may lie less in giving up one’s favored ways of doing things and more in the feelings of powerlessness associated with not making others do things one’s own way.

In the case of the BIDMC merger, parties from both of the premerger hospitals cast decisions about the best way of doing things in the new hospital as power conflicts. In this context of conflict, power became a win-lose proposition. Every decision about how to perform work could be
Interpreted as a power struggle, in which one side exerted power over the other. This situation rendered some employees powerful and others powerless in decisions. A zero-sum power struggle can have serious consequences when it renders individuals powerless to influence decisions. As Kanter (1977) explains, “When a person’s exercise of power is thwarted or blocked, when people are rendered powerless in the larger arena, they may tend to concentrate their power on those over whom they have even a modicum of authority.” (189). Such dynamics led managers and employees at the hospital to resist minor, even trivial, changes and to obstruct others in their attempts to get work done.

Emotion-laden discussions about whose way was best clouded efforts to integrate the Beth Israel and Deaconess staffs and campuses. In an interview, a physician astutely commented on the initial expectations that now bogged down the process to integrate ways of doing things on the two campuses: “We all sat around and said that what we are going to do is come together and then from the different ways that everybody does things, we’ll pick the best.” He portrayed the resulting problem as a fundamental disagreement over how to define “best” in order to identify practices that should be selected: “Nobody ever had the conversation of ‘what’s best to you? What does best mean to you? ... Define best and what it looks like.’ As it turns out, each of us defines it differently. And then when your best that you choose to run the hospital isn’t the same as my best, then I’m angry, because you’re not really out to do what’s best; you just want to preserve what is yours” (June 1999). Each decision represented an affront to someone’s way of doing things. The selection of one way over another came to represent a judgment that one side of the street did something right and the other side did it wrong. Each side fought vigorously to defend and retain its own way of doing things.

Senior administrators observed, in hindsight, that trying to ease into change had been the wrong approach. As one administrator explained, “We tried not to cause harm—for people to feel like they were being neglected or discounted or not considered in the equation. That was a mistake ... whatever somebody considered to be the way to go should have been done without an effort to preserve the other side. There were two of everything; they weren’t going to survive.” He compared the BIDMC merger to the Citibank merger in which “7,000 people would lose their jobs. They didn’t try to preserve 7,000 people, they didn’t even worry about them, and they just got rid of them ... In one sense, Citibank probably works better—they don’t care. Or, they do care, and they learned that you just do it and get it over with, and everybody starts to then heal” (March 1999). Senior administrators perceived that such unilateral decision making might have limited the conflicts that the merger fueled between managers from the two premerger hospitals; declaring one side powerless at the outset might have avoided the battles to preserve or exercise power that prolonged the change process.

Trying to cater to all of the constituents prolonged the change process and, according to numerous accounts, created unnecessary suffering. However, a hospital is more complex than a bank because decisions may literally be a matter of life and death. Each side thought that their institutional practices prior to the merger served patients’ best interest. Regardless of management stance at the outset, it would have been difficult to avoid conflicts over leadership and decision-making styles because staff perceived that so much hung in the balance.

The simmering conflict finally erupted in December 1998. The Deaconess surgeons, upon whom the Deaconess had built its reputation for excellence as a tertiary referral hospital, had grown increasingly dissatisfied and angry with current policies and process. Several prominent Deaconess surgeons demanded that the administration fire the Chief of Surgery, who was a former Beth Israel surgeon. They threatened to leave the hospital if their demand went unmet. This threat reverberated through the rank and file at the Deaconess, who felt that the surgeons’ departure would mean the final dismantling of their once-great institution.

In response to this organizational unrest, James Reinertsen, CEO of CareGroup, the parent company of BIDMC, delivered a landmark address to the medical staff in an emergency meeting on 23 December 1998. His speech to the doctors and nurses in attendance addressed the rift between the staff from the former hospitals: “I personally have become extremely distressed by ... the fighting in the cockpit ... It’s quite analogous to the pilot and the copilot and the navigator fighting at the front of the airplane while passengers are being flown. It’s unseemly and puts patients at risk,
and it must stop. My diagnosis is quite simple. I think we have badly bungled this merger."

Reinertsen described the initial optimism and enthusiasm that the merger "would create the single most powerful medical-surgical hospital in the area." He then asked how since the merger these views had transformed into "pessimism, and anger, and despair, and . . . almost hatred." His answer pointed to "a number of one-sided appointments to a lot of managerial and clinical positions" that favored candidates from the former Beth Israel: [The appointments may] have all been done individually on the merits, but that was a signal that was not very well received politically and started to cause . . . a lot of unintended victims to be created."

In this speech, Reinertsen, who never worked at either of the premerger hospitals, validated the bitterness brewing among the Deaconess staff. Although on paper the combination of the two hospitals had been a merger and not an acquisition, staff from the Deaconess experienced the merger as a takeover. They perceived that their hospital, only one-third the size of Beth Israel, had been swallowed up by its larger neighbor. Moreover, the composition of the new hospital's leadership reinforced the takeover perception: Deaconess administrators received second-string appointments at every step in the merger process. Two years into the merger, three-fourths of the top administrators from the Deaconess had left the organization for positions elsewhere.

A NEW WAY OF WORKING

Reinertsen conveniently laid the blame for the bungled merger at the feet of the Beth Israel leadership, namely Rabkin, whom Reinertsen had recently replaced as the CEO of CareGroup. In Reinertsen's view, when the Beth Israel leadership staged its takeover of the Deaconess, they imposed an inefficient system for decision making. The system had worked under Rabkin's charismatic leadership, but Rabkin had left his post at Beth Israel to become the head of CareGroup after the merger. In his absence, the Beth Israel management style had crippled the hospital in its turn-around efforts. Reinertsen emphasized that it was time for the BIDMC leadership to adopt a new way of working.

Prior to the merger, the two sets of hospital leaders utilized very different ways of working to solve problems. Beth Israel had a consensus-based decision-making style, whereas Deaconess managers utilized a more data-oriented process. The Beth Israel management style required lengthy discussions and depended on everyone feeling comfortable with a decision before any action could be taken. In the idealized version of this consensus-based process, objections would be grounded in people's expertise and experience. Decisions benefited from everyone's contribution and buy-in. The shared purpose and participation in the decision-making process worked to empower everyone involved.

However, in the postmerger environment, this decision-making process had broken down. The Beth Israel administrators, who dominated leadership positions in BIDMC, faced much more complex managerial responsibilities. Now that the "family" had grown, Beth Israel's consensus-based process proved too cumbersome to make the many decisions needed to move forward with the merger. Moreover, given the growing merger-related resentments on both sides, joint decisions had become an arena for power contests.

In an interview, an administrator described the way this management style made it difficult for even simple decisions to be made in the new postmerger environment. She explained, "It's sort of like your decision can get stopped anywhere along the line: Just when you think you're all set and everybody is signed off, . . . one administrative person ... says, 'ugh,' and all the work that's been done doesn't matter. It's not going to happen. That sometimes can happen for darn good reasons, but . . . there were plenty of times where it came where, 'you didn't consult with me.' Now, it's like luck if anything gets pressed through" (March 1999). Pettiness had crept into the process: People would veto plans just because they had not been consulted up front. Some former Deaconess employees even intimated that plans could be rejected just because of who suggested them.

This development was especially troubling in light of the Deaconess management style, which many described as "data-driven." The Deaconess leadership had borrowed from industry an innovative new approach to workforce efficiency and quality insurance. This process, known

15 James Reinertsen, M.D., address to the medical staff, BIDMC, December 23, 1998. Transcribed from videotape. All of the quotes from Reinertsen in this section are from this source.
as total quality management (TQM) or continuous quality improvement (CQI), originated in manufacturing. It involves the use of statistical methods to measure quality and costs and to uncover bottlenecks in the work process. This information is then used to “eliminate redundancies” in production and reengineer the work process (Appelbaum and Batt 1994:90). Eileen Appelbaum and Rosemary Batt explain the TQM process:

Objective measures of quality become part of employee evaluations. . . . Management information systems transfer data on employee performance to finance departments, where accounting systems incorporate measures of the cost of quality into financial analysis. All employees receive training in quality and customer consciousness, and often in statistical process control as well. The purpose of the training is to “align” the vision of all employees toward a common goal. In this sense, participation is mandatory or expected, rather than voluntary. (1994:90)

In the early 1990s, the Deaconess used this method to streamline its work process and eliminate staff positions and waste as part of a financial turnaround. Their early adoption of this technique placed the hospital on the forefront of innovations in hospital management and streamlining. Employees were trained in how to use data to understand the costs of different work processes and to assess the quality outcomes. In the idealized version of this management style, everyone shared the vision of reducing costs while improving or maintaining quality, and the organization continuously evaluated its processes. Managers from the former Deaconess insisted that under their system it did not matter who you were; power to shape decisions came from having the data to back your ideas.

Beth Israel managers and administrators remained skeptical about the wisdom in relying on data over and against personal judgment and experience. A nurse manager articulated doubts about depending on quantitative data, rather than on people’s experience and insight, to make decisions. She explained that at the old Beth Israel, “We got our work done through people. We didn’t get our work done through rules and regulations and charts and graphs. You can put anything on paper, and that’s what we did with consolidation. . . . You have all these different items that look wonderful on paper, and you sit there, and now it ain’t gonna happen” (May 1999). Another nurse manager expressed a commonly held view: “I think in our haste to get problems solved, there’s a lot of emphasis now on data. . . . Well, the truth is, data can be cut a lot of different ways. And sometimes to be totally driven by data is as wrong as to be totally driven without data” (May 1999). Managers from the former Beth Israel doubted the wisdom in relying on “data”—namely statistical measures—to the exclusion of qualitative experiences of patients and staff to modify practice.

In his speech to the BIDMC medical staff, Reinertsen emphasized that “the lopsidedness in managerial and leadership positions” contributed to “a lack of respect and understanding and acknowledgment of the unique ways of working that existed on both of our campuses,” particularly those of the Deaconess. He validated the anger felt by the Deaconess staff, who felt that their potential contributions to the merged hospital had been too quickly dismissed and overlooked. He stated that this lack of recognition was “as big an insult as you can do, and it’s painful, and it creates real victims.”

During his speech, Reinertsen proceeded, in what many former Beth Israel employees regarded as a negative and unflattering account, to blame the current merger problems on the inadequacy of the Beth Israel management process. Reinertsen detailed the breakdown in decision-making brought on by reliance on the unwieldy Beth Israel management style, which “involved a lot of conversation. It depended enormously on the presence of a really remarkable individual, named Mitch Rabkin for it to work.” He emphasized that without Rabkin around to “make that process work,” BIDMC “developed no way of working.”

Criticism from the new CEO, who had replaced the much-loved Rabkin was a hard pill for the Beth Israel folk to swallow. In 1998, Reinertsen replaced Mitchell Rabkin as director of CareGroup. Jonathan Cohn in an article in the New Republic described Reinertsen as Rabkin’s diametric opposite. “Rabkin, an endocrinologist known for his human touch,” the article stated, “personified Beth Israel’s glory days.” He urged collaboration among physicians and nurses, imbuing the hospital with an egalitarian ethic and “encouraged decision-making by consensus rather than dictate.” This was in contrast to Reinertsen: “With his crisp business attire, aloof manner, and talk of hospital efficiency, he
came across as more CEO than physician—exactly what the search committee wanted.”

Not only had Reinertsen acknowledged the Deaconess's power disadvantage in what was supposed to have been a merger of equals, but he blamed current merger problems on the inability of Beth Israel managers to lead without Rabkin. His praise for the Deaconess's achievements in TQM and the benefit of a data-driven system were perceived as a rejection of the relational style of the former Beth Israel leadership and a signal of changing values in the organization. Rather than placing a premium on relationships, the new leadership valued efficiency and measurement. These values would guide the hospital in its efforts to reinvent itself in the wake of not only a failed merger but escalating financial troubles.

ANOTHER TURNAROUND PLAN

If the merger brought BIDMC to its knees, then the 1997 Balanced Budget Act, with its cuts to Medicare payments, hit the hospital while it was down. The BBA hurt all of the Boston-area teaching hospitals, but it hit BIDMC, which was already burdened with merger woes, especially hard. Early in 1999, the hospital estimated that its shortfall for the 1999 fiscal year would be close to $57 million, a deficit of over one million dollars a week. Reinertsen sounded the alert. BIDMC was in Code Green.

The hospital leadership decided that they needed outside consultants to help them. BIDMC hired the consulting firm Deloitte and Touche to assess the hospital's cost-cutting needs and “opportunities” for budget reduction and revenue increase. An administrator involved in engineering the turnaround plan described the relationship between BIDMC and the consultants: “We are the client and they are the pro. They have come in here because, for whatever reasons, we needed the will and the spine to do the things that in fact we knew we needed to do. The reason you bring in consultants is because you need that little nudge that you otherwise can’t give yourself.” The “nudge” came in the form of advice about areas where other hospitals or businesses managed to cut costs. According to the administrator, the consultants “do a comprehensive survey of what they call ‘opportunities,’ which is an interesting choice of words. An opportunity to cut costs or to increase revenue, both go together. . . . [They] serve up a menu, and then the organization itself reacts and responds. . . . So, together you kind of shape where you are going to go for revenue improvement and cost cutting” (June 1999).

In March, the hospital rolled out its plan for radical restructuring to cut costs and increase revenues—the keys to remaining viable in this new health care marketplace. They dubbed the resulting restructuring plan “Genesis.” While the leadership had tried to give the program a name with biblical overtones and the sense of a new and important beginning, the medical and nursing staff jokingly but darkly renamed the program “genocide.”

Genesis proposed a “core process redesign” aimed at capturing $90 million for the organization through a combination of “cost reduction and revenue enhancement,” with particular focus on continued consolidation of the two hospitals. Projected cost reductions involved “approximately $23 million in labor costs from initiatives such as management and [General Medical Education] redesign, as well as reorganization efforts in lab consolidation, information services, pharmacy, nursing, and radiology” (internal memo to BIDMC leadership regarding Genesis Briefing Talking Points, 23 March 1999). It also involved restructuring of the administrative management team, a move that culminated in the elimination of eighty positions, breaking from the former Beth Israel’s no-layoff policy. This move also required a shifting of management duties and functions at the vice president level, which entailed the renaming and realignment of departments to reflect their functions in care delivery, rather than clinical disciplines.

While the clinical staff understood the hospital’s need to restructure and cut its budget, they felt excluded from this process. For them, the hospital leadership’s reliance on outside consultants signaled an emphasis on business values and a disregard for the medical expertise that used to guide


decisions. Many staff members felt that the hospital wasted money paying “big bucks” to “suits” who did not understand the intricacies of clinical practice. As a nurse manager explained: “This whole Genesis process is being designed by people who don’t work in the trenches. . . . They think it’s simple” (May 1999). An administrator described the common feelings of clinicians and others not directly involved in the redesign process “that somebody else, somebody out there, somebody up there who doesn’t understand my work is making these decisions, and no one tells me anything, and no one communicates with me. . . . Where in the world did they come up with these ideas? And if only they understood my practice and what I do, I could fix it, but no one ever asks” (June 1999). These feelings were all the more jarring because “everybody had the fantasy that it would be a redesign process.” With the organization closely scrutinizing all of its practices from admissions to purchasing to resident training, employees on the front line expected that they would be tapped for their opinions and insights about how to make processes more efficient, cost-effective, and patient centered.

An administrator explained, “These design processes promised in people’s heads that. . . . people in the front line would say this is what works, this is what doesn’t work, this is how you fix things. And I think, at least initially, that is not where things have started.” For the most part, frontline employees’ input was unsolicited; they did not participate in the task forces or meetings to decide the organization’s future. The administrator explained, “When you look at the guest list, it is executive directory, physician organization—it is very high level. . . . It is a restructuring not a redesign.”

Sharon O’Keefe, the new Chief Operating Officer and the woman driving many of the restructuring plans, had ambitious plans for change in the organization. She joined the BIDMC management team early in 1999, after having served as Senior Vice President of Patient Care Services and Operations at the University of Maryland Medical System and before that as a senior manager at the consulting firm of Ernst and Whinney. An administrator explained that O’Keefe envisioned a very different organization at the beginning of the next fiscal year. “When she says different, it’s where [managers] manage to our budgets and [make sure] that people perform. I mean it is very performance based. It’s a scary thought. You know, because your history doesn’t matter a whole lot. It’s how you perform, and it is a very business order. . . . O’Keefe’s vision is that managers who manage will have enhanced accountability” (June 1999).

Genesis focused on realigning departments—putting items under jurisdiction of the appropriate manager and into the right budget. These changes focused on paperwork and billing and accountability, but not on how processes actually happened on the ground. At the same time, managers and employees were going to be evaluated based on how well these processes worked—based on performance. But many of the changes proposed by Genesis had very real consequences for performance—for the front line’s ability to continue doing the work of the organization. Losing or gaining a new manager, coping with layoffs in one’s department, moving to another department, or dealing with newly created or consolidated departments while also learning new systems and paperwork had ramifications for how work would be performed. Yet the potential obstacles and their implications for clinicians and patients had not been examined. No one outlined how patient care would actually be delivered on a daily basis.

In reaction, clinicians began to question the values of the organization and its future direction. Another administrator explained that the organization’s current financial focus “lumped the nurses and physicians together more, all against the administration.” She explained that the clinical staff had united around patient care concerns, “It seems to me like they’re in the soup together” (March 1999).

Doctors and nurses alike expressed the feeling that the patient-centered values of the organization were taking a “back seat” to budget considerations. An administrator involved in the restructuring plans validated this viewpoint while also justifying the hospital’s stance: “It’s that cliché of no margin no mission. And that is kind of where we are. We’ve got to get to margin so we can get mission back again. . . . When an organization is really trying to right itself, that is the first order of business. I’ve had nurses say to me that. . . . our values have gone out the window. I don’t think that’s true. I think that the current value right now is on survival. It’s kind of a hierarchy of needs. . . . First things first” (June 1999).

The hospital was in dire financial trouble and needed to make significant financial gains before it could take the time required to thoughtfully
redesign processes. If the organization could not resolve issues of margin, it would not be around to concern itself with mission, administrators said. This was the justification for the focus on finances. A physician described the situation and the need to change with the times: “We’re all being put with a gun to our head, that if you continue to do things the way we did things, we are going to be a non-entity. . . . You can’t lose a million dollars a week and survive. . . . And we’re frustrated. . . . We don’t get the time with the patients that we once got. . . . It’s not a happy place for us. . . . But if you don’t make the changes, you’re going to be doing catering” (June 1999).

Despite the prevalence of this viewpoint among managers, many of the nurses I interviewed rejected this reasoning. If the hospital could not serve patients, then what was the point of its financial survival? How could mission be divorced from margin as the hospital pursued restructuring strategies? And what would happen to patients in the meantime while the hospital tried to respond to Code Green?

No Working Model for Nursing Practice

Before I officially began my research, one of BIDMC’s board members confided that even though Beth Israel and the Deaconess had officially merged and were supposedly the same hospital, he still would much rather be admitted to the Beth Israel part of the medical center. Why? Because of what he felt was a striking difference in the quality of nursing at the two institutions. The Deaconess nursing service could not hold a candle to the professional, personalized nursing care provided at Beth Israel, he said. During a board meeting, he related his preference to Joyce Clifford, the head of nursing at the merged hospital and the driving force behind Beth Israel’s prestigious nursing program. According to the board member, Clifford assured him the hospital leadership was working hard to implement Beth Israel-style nursing at the Deaconess. They would soon have the Deaconess nursing service “whipped into shape.” Instead, within a couple short years, Clifford, all of her management team, many of her nurses, and her nursing model would be the ones who felt “whipped.”

How could Clifford have been so wrong? The answer lies in an understanding not only of the different cultures of the two hospitals but also in the cultures of their nursing departments. Over the decades prior to the merger, the two hospitals had developed different nursing practices, and nurses worked from different conceptions of their role in patient care. Although Beth Israel strove to implement its professional nursing practice on the Deaconess campus, the culture around nursing at the Deaconess pre-
Doctor-Nurse Relationships

Melissa Fortunado, a nurse whose first and only jobs as a nursing assistant and then as a nurse had been at Beth Israel Hospital, experienced great trepidation and sadness on the dreary Monday she and three other nurses closed the Beth Israel Cardiothoracic Unit, 8 Feldberg. Each caring for only one patient, the nurses rode in ambulances across Brookline Avenue to the Deaconess Cardiothoracic Unit, Farr 6, to complete the merger of the units from the two sides. “It was sad,” said Fortunado, “I cried when I left the floor.” As they were leaving, her patient’s wife took note of Fortunado’s melancholy and in broken English said to her, “So you are leaving this home and you will go to another one.” “She made me break down,” said Fortunado, who said she felt like an idiot because she could not stop bawling in the elevator in front of the patient, his wife, and the two ambulance drivers.

When the nurses and their charges finally arrived on the new unit, Fortunado was too apprehensive to enjoy or be responsive to the warm greeting they received. She felt stressed, wondering, “where do I go?” and “what’s going to happen now?” How was she going to take care of her patients on the new unit? In her anxiety, she did not take a moment to relax and get the patient settled. Instead, she immediately blurted out, “He needs a new IV, and how do I get that?”

Even though one of the nurses from the Deaconess side worked with her that day and showed her how to do everything, Fortunado “felt lost. . . . I just had that one patient, but not having a clue of anything. It was just really weird.” The sensation of being lost and of not knowing how to function on the new unit was shared not just by the Beth Israel nurses who had moved to the Deaconess unit but by the Deaconess nurses as well. In the consolidation of cardiothoracic surgery, both sets of nurses were subjected to sweeping changes to their daily practice.

Everything from how to order tests to where nurses wrote their notes on patients were different on the two sides of the street. In preparation for the June 1999 consolidation of cardiothoracic surgery, the nursing staff from the three merging units had to decide which practices to adopt for the new unit. One nurse manager oversaw all three units, and she started working with staff several months ahead of the move to prepare. Nurses from both sides engaged in lengthy discussion about which practices were best. However, the adoption of particular practices was, in most cases, driven by outside concerns, not the consensus of the nursing staff.

Consolidating cardiothoracic care onto one inpatient unit involved the merging of three units. The two units from the Deaconess occupied the same floor, Farr 6A and Farr 6B, also called the Step-Down Unit. The A-side, the larger of the two units, received postoperative cardiac patients requiring standard care. The Step-Down Unit, one hallway out of four on the floor, housed patients who needed more monitoring than the basic inpatient unit provided, but not intensive care. Nurses on the A-side cared for four or five patients at a time on the day shift, while Step-Down Unit nurses generally had a smaller load of three patients per nurse. Because the A-side patients followed more predictable patterns, there was a high degree of routinization, guided by the surgeons’ use of standard medications and discharge plans for their patients. In contrast, the Step-Down Unit nurses developed specialization in dealing with their more acute and complex patients, and they exercised a high degree of nursing judgment in caring for them. Generally, the patients from the Step-Down Unit would be discharged to the A-side inpatient unit once stabilized and ready for more routine care.

On the Beth Israel campus, the Cardiothoracic Unit, 8 Feldberg, cared for more acute patients than did Farr 6A, but the patient load was similar. The 8 Feldberg nurses enjoyed a lot of flexibility in planning care for their patients, and they administered a wider range of drugs and dosages than the nurses on Farr 6A. The nurses on 8 Feldberg cared for patients as acute as those in the Step-Down Unit, but these “heavy” patients were inter-
spersed with the healthier patients who would normally be admitted to Farr 6A. In line with the hospital's emphasis on continuity of care, patients would be sent home with an appointment for a "wound check" two weeks after discharge. The patients returned to the inpatient floor for the appointment. At that time, their primary nurse checked their surgical scars for infection, answered questions, and instructed patients about medications and daily activities. In contrast, patients discharged from the Deaconess units had a visiting nurse check their wounds at home.

The hospital, in consolidating cardiac care, decided to merge the three units into one location on the Deaconess campus. The plan consisted of closing the Step-Down Unit, merging 8 Feldberg and Farr 6A, and expanding this new unit to include the entire floor. The decision to close the Step-Down Unit was made without consulting the Deaconess surgeons who had utilized the unit and worked with the nurses on the unit. In response to the decision, the nurses and surgeons circulated a petition describing the unit as essential to the hospital. However, the hospital moved forward with its plans to close the unit. The decision, which was made before the changes to the Nursing Department were implemented, seemed to be based on the hospital's commitment to primary nursing.

By getting rid of the Step-Down Unit, the hospital dispensed with the differentiated nursing practice from the Deaconess, where rank-and-file nurses managed a predictable patient population through standards and routine while more skilled, experienced nurses managed patient needs that involved greater uncertainty (see Chapter 3). The A-side nurses would have to raise their level of practice to accommodate a more difficult patient population. Now, like the 8 Feldberg nurses, all of the nurses would work with the wide range of patients admitted to the floor. The Deaconess A-side nurses needed to learn new techniques—including delivering medications through IV lines and using some new drugs—to care for these more demanding patients. This training, delivered through a series of inservice classes, constituted part of the preparation for the merging of the units.

While nurses had no input into the procedures that would be used to care for patients—this was the purview of the doctors—they scrutinized other aspects of their daily work. The nursing staff spent months comparing documentation—order forms, reports, nurses' notes. The hospital had not yet settled on standard documentation for patients' records, which were very different on the two campuses.

On the Deaconess side, nurses' notes were kept separate from those of other care providers—so that they would not "clutter" the medical record. Nurses' care plans and patient assessments were kept in separate notebooks at the bedside and entered into the patient's medical record only after discharge. These notes tended to be rather perfunctory. After filling in a worksheet assessment form, nurses then sometimes jotted down a line or two about the patient's condition or care plan on the back of the form. The nurses tended to communicate verbally any important information about the care plan or changes in the patient's condition.

In contrast, on the Beth Israel side, nurses wrote free-form "notes" in the same section of the medical record as the doctors and other care providers. In part because nurses were aware that these notes were not just for their own use but for other members of the care team as well, this format placed greater emphasis on recording a patient's progress and on developing the nurse's care plan. The Beth Israel nurses' notes were generally more thorough and descriptive than those from the Deaconess, but this note writing also took more time.

Because the newly merged unit could not dictate the form of the patient's record for the entire hospital, the new unit maintained the Deaconess practice of keeping the nursing notes separate from the rest of the record. For convenience, they also decided to keep the assessment worksheet that the Deaconess nurses used. The nurse manager did not, however, want nurses to slip into the habit of recording the information to fill in the worksheet and then neglecting care planning or skimping on documentation of the patients' condition. Seeking to reinforce primary nursing culture and practice, the nurse manager insisted that nurses use the more detailed documentation practices from Beth Israel—but, paradoxically, in the separate record—to help them document the nursing care plans more fully than was typically done at the Deaconess.

For the Deaconess nurses, this required a lot more writing and time, a burden many of them found irritating and frustrating. They felt, furthermore, that the note writing could not replace the verbal report. "There's a certain essence with nursing that you just know something. You know?" one of the Deaconess nurses explained, "If I went out there and said to
another nurse, 'That patient has that look. They just have that look to them.' And she'd say, 'Oh geez, okay, well, let me know if you need anything.' You can't convey that on paper. It's like their vitals are fine but something is just not right about them. It still needs to be communicated between the staff” (July 1999). The Deaconess nurses felt that the notes could not capture the implicit knowledge that nurses had about patients and could not replace communication between the members of the nursing team.

Nor were the Beth Israel nurses pleased with the new charting arrangements. “We used to write SOAP notes in the patient's chart, and right now those notes get kept... outside their room in that blue book until they're discharged,” one of the Beth Israel nurses commented, “And then it gets put in... their chart. So nobody reads them. Sometimes it's hard for us to find out information because if we are going through the charts to find out information on the patient, the nurse's notes aren't even in there.”

Other members of the care team—doctors, social workers, case managers, physical therapists, occupational therapists, etc.—put their notes right into the chart for everyone to see. With the new arrangement, no one, not even the nurses themselves, bothered to read the separate nurses' notes. When the notes only recorded vital statistics and nurses verbally communicated pertinent information, perhaps the exclusion of the nurses’ notes from the chart was not such a problem. But with the fuller documentation of primary nursing and less reliance on team communication, a lot of important information would be overlooked if no one read the notes. “I would rather them be in the patient’s chart because... we spend a lot of time with the patient, and we’re assessing them all day” (July 1999).

In standardizing practice, the nurse manager worked hard to solicit the input of both sets of nurses. The hope was that both sets of nurses would be able to retain the most valued aspects of their practice when the two units merged. However, it was not clear that these two very different cultures could be easily reconciled, especially when the overarching commitment was to the Beth Israel primary nursing culture. Many of the Deaconess nurses thought that because the nurse manager came from the former Beth Israel, she favored the Beth Israel staff and way of doing things. In an interview, Jill Dailey, a nurse who had worked in the Deaconess Step-Down Unit, voiced the complaints of many of the Deaconess nurses when she said, “This, to me, wasn’t a merger. This was a takeover of their clinical way of doing things. It’s been extremely frustrating. It seemed like, I guess, the Deaconess way just was always the wrong way” (July 1999). The Deaconess nurses did not seem to grasp that the fundamental characteristic of the primary nursing model—notes in the chart, which signaled nurses’ value to and full participation in the care team—had been lost.

While the clinical decisions seemed to favor the Beth Israel way of doing things, other decisions, in the spirit of compromise, favored the Deaconess practice. In particular, the Deaconess nurses stood firm on the issue of getting off of the floor to go to lunch and of leaving on time. The Deaconess nurses justified this practice by referring to an ethic of teamwork and camaraderie, by defining patient care as a team effort, and by insisting that it was important to care for nurses as well as patients. For the Farr 6 nurses, the practice of going to lunch and getting off the floor, even just for a few minutes, was an institution. Half of the nurses covered patients while the other half went to lunch together at 12 or 12:30. The Deaconess nurses on the oncoming shift also often coaxed the outgoing shift, “Just leave it; I’ll take care of it. Go home” (Fieldnotes, March 1999).

Fortunado, a Beth Israel nurse, described how these two practices were foreign to the Beth Israel nurses: “Over there we never got out on time because we were always sitting and doing our notes after work. We hardly ever went to lunch. If we did, we’d sit in the back room and have a quick sandwich, if that. You know, half the time you were going home and didn’t even get to the bathroom. It was kind of crazy. Over here it is still a little hectic, but we go to lunch everyday” (July 1999).

I asked Fortunado why she thought the Deaconess nurses managed to get out on time and to have a relaxed lunch but the Beth Israel nurses did not. She responded that the Deaconess nurses “didn’t have to stay and do notes after work.” To them, she explained, “This is a twenty-four-hour operation. If you didn’t get to finish something, the next shift can do it.” In contrast, the Beth Israel nurses “didn’t do that over there. If you didn’t finish it, you would stay and finish it” (July 1999).

When the two sides merged, they tried to combine Beth Israel’s pri-
mary nursing culture with the Deaconess practices of handing off work to other nurses for a half hour lunch break or at the change of shift to get out on time. But these handoffs seemed incompatible with the Beth Israel nursing culture. The twenty-four-hour accountability of primary nursing made it difficult for Beth Israel nurses to hand off patient responsibilities to the incoming shift. They had developed a work ethic that required them to take few if any breaks and to stay until all of their care tasks for the shift had been completed, even if it meant staying late. Such self-sacrifice was, to them, a sign of their much-valued professionalism.

The Deaconess nurses on the merged unit observed that it was often difficult to get the Beth Israel nurses to relinquish their care responsibilities and that some of the sense of camaraderie had been lost. Dailey observed, "We used to have fun here. We used to joke around, and we used to laugh a lot. We would laugh with the patients." She observed that now that the Beth Israel nurses had joined the unit, "People don't like to do that any more. There's no real joking around. Everything is very serious, everything is very Nancy Nurse-y, kind of. Try to keep all the ducks in a row, and try to look good in front of the docs ... I think we just had a very different, culture" (July 1999).

Despite their differences, the two sets of nurses worked together amicably. "I think we work together very nicely," Fortunado commented, "They were available for questions from us all the time. I've never seen anyone lose their patience. That's a lot—to have a lot of new nurses on the floor at one time, not just one, asking questions constantly ... just like trying to figure out the system. They were always very patient and more than willing to help, which helps tremendously" (July 1999).

Similarly, an observer of the consolidation process noted, "Since the consolidation of the three units, I've ... seen the nursing staff really pull together. I wasn't here for the actual move, that first week, but when I came back, that second week, you still heard a lot of 'East-West,' 'we-they.' And now it's ... 'Well, what's best for the patient?' And I hear less 'we/they.' And sort of 'we,' as we're a unified front" (July 1999). The nurses on the Cardiothoracic Unit hoped to combine what they valued in their practices. Despite some hard feelings and trepidation about changes, they had been able to reach consensus around patient care and strove to work as a team.

**Doctor-Nurse Relationships**

Despite the good working relationships among the nurses, neither side was happy with the results of the merger of the units. The central problem was the disruption of the smooth workings of the unit. "It's very frustrating because they are both used to being very proficient. And now, whatever it is, there are glitches that are hanging them up" (July 1999). Some of these glitches pertained to mastering new systems. At the time of the consolidation, the computer system used to prepare discharge papers and check lab results was being updated for Y2K. Nurses needed not only to get acquainted with each other and adjust to new paperwork, but also to learn the new program.

Other glitches related to broader merger-related issues. For example, the pharmacy and the laboratory had recently merged. The nurses had to learn a new set of phone numbers, names, and procedures for ordering tests or medications. As one nurse complained:

> It can be frustrating not knowing who to call, how to get in touch with somebody ... We've been here since May, and I still carry this [note card] around with me that has ... all different phone numbers that I might need ... It's getting better, but ... sometimes you feel like you are not able to spend as much time with the patient when you are trying to figure out things like this, and that's frustrating, but it'll get better—I think. (July 1999)

Like nurses on the other units I studied, the nurses on the Cardiothoracic Unit felt less efficient and resented the slowdowns that kept them from patients. The extra running around and time required to do formerly simple tasks frustrated them. But they acknowledged, through their grumbling, that the situation was temporary and would improve.

However, there was another set of obstacles around which the two sides showed less optimism. Nurses from both campuses displayed equal concern about what they perceived as a deterioration in their relationships with the cardiothoracic surgeons, a problem resulting from conflicts that developed between the Beth Israel and Deaconess surgeons after the merger.
In 1998, prominent cardiologists from the former New England Deaconess and Beth Israel Hospitals began to battle. In the interest of cutting costs and merging the two sides, the surgeons were being urged to standardize their practices—to use the same medications, tests, equipment, procedures and discharge protocols on their patients.

One of the surgeons, Andrew Simpson, said in an interview that it should have been a relatively simple matter to choose from among the practices of the two groups; one only had to look at outcomes and then at costs. Simpson, who was involved in the standardization process, explained that the two sides agreed to pick the methods that delivered “the same [or better] patient outcome . . . and lower costs. We're going to decide it that way. That's it. We're going to do it. OK. Fine.” Sound easy? It was not.

Even when the outcomes were the same and the costs were clearly different, the surgeons could not agree on a standardized practice. The surgeons who would have to change their practice would have to abandon established patterns that they had come to consider “sacred.” Forsaking their practice—whether it was performing a certain type of diagnostic test or using a particular brand of equipment—would, they felt, be admitting that their way had been “wrong all this time” and, worse, that the surgeons on the other side “were smarter” (September 1999).

Compounding the sense of competition between the two sides was an unfortunate incident in which Robert Johnson, a Beth Israel surgeon and the head of cardiothoracic surgery, “misfired a scathing e-mail” about one of the surgeons from the Deaconess. He questioned his colleague’s skill, “saying he would hurt himself slicing a bagel,” and then “accidentally sent the e-mail to the surgeon in question.”

Even though it seemed some balance could be achieved—an equal number of accepted and rejected practices from each side—both sides continually responded to the selection of the other side’s particular practice over their own as “a personal insult.” In surgery, a discipline known for its big egos and arrogance, it was hard to believe that there was no value judgment, no smugness, when one side was chosen over the other. Although Simpson and others went to great lengths to explain that no, the choice of one method over another was not a value judgment or a comment on an individual surgeon’s skill or intelligence, but rather a reflection of the “common goal” of doing “the best we can for the least amount of money,” no amount of assurance was enough (September 1999). The two sides could not be brought to some mutual decision.

None of the surgeons could tolerate being told that their practices were “wrong.” All were invested in seeing adoption of their particular practice. They grew increasingly angry at the obstinance of the other side. In the medical building, where both sets of surgeons had their offices, they indirectly hurled insults at each other, loudly sharing rude remarks near open doorways, so that doctors from the other team would be sure to overhear (September 1999).

Animosity between the two sets of surgeons created barriers to establishing a sense of collegiality and teamwork among the doctors and nurses on the merged unit. In the past nurses had known the surgeons on their units and enjoyed collegial relations with them. “You knew [the surgeons’] kids, their wives, what they did on the weekend.” Patricia Loma, a nurse from the Deaconess campus, said, “You had a very different relationship with them. So, when you had an issue with a patient, you could call them at home, in the middle of the night, three in the morning. You were appreciated; they would trust you.” These close relationships facilitated the sharing of information about patients and the planning and execution of their care: “You really felt like the patient was getting the best care because you were both on the same wavelength, you both knew when the patient was going home, what the patient needed. . . . And the patient really appreciated that because they could see it.”

On the new unit, nurses’ relationships with doctors from the other campus were strained. Loma complained that on the newly consolidated unit, “You get all these mixed messages because nobody is communicating as much” (Focus Group, August 1999). On the new unit, the nurses had not yet developed the close rapport they had previously enjoyed with the surgeons from their old units, and this detracted from their ability to work together as a team.

Surgeons from both sides became stubborn about the way they wanted things done and intolerant of the practices from the other side. The dis-

---

agreement proved very confusing for the nurses, who straddled two different sets of requirements while still orienting to the new unit.

Nurses' patient load often consisted of patients treated by both sets of surgeons. Nurses had questions about the new sets of protocols; they needed to know how to do things and what to expect in terms of patients' responses. Instead of being helpful, the surgeons responded with hostility to their queries. In a focus group, Jennifer Meyers, a Beth Israel nurse, commented, “They get so defensive when you ask them, 'Well, why do you want to do it that way?'”

Seeking to understand the rationale behind different treatment methods was not idle curiosity. Such understanding was critical to the nurses, who carried out the doctors' orders and monitored patients. Meyers explained that because she was accountable for the care she delivered to patients, "I want to know why I'm doing something differently. I was told this way, and that way makes sense to me. I want to know why I'm doing it this way."

Her desire to understand and learn met a negative reception, she said, with the doctors "giving me a derogatory remark, or mumbling and walking away, and getting pissed off and all defensive when you ask them a question. ... We'd like to know why" (Focus Group, August 1999). Although the nurses wanted to feel comfortable with the new practices, the surgeons interpreted nurses' questions as yet another challenge to their authority or as a deficiency in the nurses' knowledge or competence. Their reactions reportedly ranged from unresponsive to openly hostile. Both sets of nurses did not trust the doctors because they were not on the "same wavelength," knowing what the patient needed and why. At the same time, the nurses felt that the doctors did not trust them because they did not value their input enough to seek it or appreciate their questions.

Just as the surgeons from both sides became stubborn about the way they wanted things done and intolerant of the practices from the other side, they displayed intolerance if nurses treated their patients using protocols from the other team. The doctors wanted the nurses to strictly adhere to the protocols that had been used on their campus before the consolidation. Not knowing the nurses from the other side, they were not willing to budge—to allow the nurses some autonomy in deciding what to do—and accept elements of a care plan typical of the other side.

In an interview, Carol Larson, a nurse from the Deaconess, described a common occurrence: "I think what everybody is doing is just doing it the way that they were used to doing it." There could be some lag between the time the doctor made the order and it got communicated to the nurses. In the meantime, the nurses sometimes reverted to the treatment course they were used to using on their old unit. "So then what ends up happening is that when you have like a West [Deaconess] Campus patient being taken care of by an East [Beth Israel] Campus nurse—and it's sort of like well, 'I don't like it done that way.'"

The doctors would become angry at the nurses for using a different, though appropriate, protocol. Larson observed, "I think that everybody was sort of not trusting each other. Again, attendings [doctors] not knowing the opposite campus nurses, not knowing their abilities. So I think they might have been a little more protective of their patients and a little less tolerant of, 'Well, how come it's not being done my way?'" (July 1999).

Not only were the surgeons unappreciative of nurses' questions about treatment, but they were not physically present to communicate with nurses about patients. On the Beth Israel campus, the nurses and surgeons had gone on patient rounds together every morning. Meyers described the benefit of this arrangement: "You met with them every single day on rounds, and you knew at 7:30 what the whole plan was for the day" (Focus Group, August 1999). On the new unit, the Beth Israel attendings rounded less frequently with the nurses, and, the rest of the time, the nurses met with the residents and interns. Similarly, the Deaconess attending surgeons, who used to be a presence on the unit, showcased their displeasure with the consolidation by limiting their presence on the floor. They now arrived unpredictably and less frequently, and their residents and interns populated the unit.

Relying on residents and interns, who were still training and working under the guidance of the attendings, was not the same as working with the attendings. In the focus group, a nurse complained that even though there were at least two residents on the floor at a time, one from each service, they refused to answer questions about patients from the other service. When a nurse had a question about an attending's patient, she would approach the resident and ask, "Are you covering so and so." If the answer was "no," the nurse reported, then the resident did not want to be
bothered and refused to talk with her about the patient. She would then have to search for the other resident on duty, who might be in the operating room in the middle of a surgery and unavailable. Consequently, it could take hours to get an answer to a question about a patient: “You go six hours without knowing whether or not somebody is okay. It’s stupid stuff. Some of it is so dumb. But you have to talk to the doctor and nobody wants to take responsibility for it” (Focus Group, August 1999).

A nurse responded “in defense of our poor interns,” “They’re slammed. I mean, they are just overwhelmed with the number of patients that they have.” “They are just pushed beyond,” another nurse agreed. Not only were the interns and residents overwhelmed by the number of patients coming to the new, larger unit, but the new crop of interns and residents had only just taken their posts in July, a month after the consolidation. Their lack of confidence and skill made communication with the attendings all the more important and its lack all the more keenly felt by nurses, who required information about patients to plan their nursing care and discharge.

**A Decline in Nursing Practice**

These strained relationships with the surgeons challenged nurses’ ability to provide high-quality patient care. In despair, a nurse sent me an anonymous handwritten note, in which she confessed, “Overall, I believe the merger has had a negative effect on nursing care. I have seen my own nursing care decline in quality due to the changes.” While she recognized “that the change in environment and systems leads to delays in providing efficient care,” she identified other “road blocks” to providing high-quality care: “Equipment and supplies are not readily available. The physical layout of the unit makes providing care more challenging. The nursing assistants require a large amount of supervision.” Even more serious in her estimation was the lack of collegiality with the surgeons:

Prior to the merger, I delivered expert professional nursing care to my patients in a timely manner. I was much more satisfied with my career and with my interactions/relationships with physicians, surgeons, and other health care professionals. Since the merger, I feel less respected and valued as a member of the health care team. I would no longer describe my practice as collaborative. It is infrequent that I have an opportunity to discuss a patient or patient care issue with an attending physician. It frequently does not feel as though my input to the interns and residents is valued. I have heard residents describe . . . nurses as “confrontational” because of their approach to collaborative practice. (Anonymous note, July 1999)

In this nurse’s view, the surgeons did not value her perspective or insight into her patients, and some even rebuffed attempts at collaboration, misinterpreting it as confrontation. This lack of collaboration and consideration from the surgeons stripped her practice of a meaningful component of delivering “expert professional nursing care.” Nor did she feel she played as central a role in her patients’ care, and this feeling, she said, affected her own attitude toward her patients. Her own and her colleagues’ loss of commitment to primary nursing created, she felt, “a lower expectation to provide quality care to patients on the new unit. Nurses ‘know’ their patients less. Primary nursing is not a priority, and there seems to be less of a commitment to primary nursing. . . . I feel as though nurses are doing their 8 hours (or 12 hours) and that’s it” (Anonymous note, July 1999).

She pointed to problems “knowing” patients and to an accompanying decline in the sense of accountability for the whole of a patient’s care. Nurses did not plan ahead for the next steps in their patients’ care and recovery. Instead, they put in their time, attending to whatever care tasks needed to be accomplished in the immediate future, and then let the next shift take over. “Everyday I discover patients who are being [discharged] who have no discharge paperwork or teaching [about their medications and self-care] started.”

This anonymous nurse’s comments hinted at the problems that this lack of planning caused. It left nurses scrambling at the last minute to complete what—due to the new computer system and discharge forms—had become a three-hour process. With none of the paperwork or teaching done ahead of time, when nurses had more than one patient being discharged, they barely had time to attend to patients’ needs (Fieldnotes, July 1999).
The nurse concluded, “[N]o one is looking ahead. I find myself to be guilty of this, because I am running to keep up with the demands of my job” (July 1999). To this nurse, the twenty-four-hour accountability of the primary nurse had not been replaced by the twenty-four-hour accountability of the nursing staff. In her view, no one kept an eye on the big picture and ensured that care plans were followed and completed.

In interviews, other nurses echoed these sentiments. Dailey, a Deaconess nurse who had worked in the Step-Down Unit, echoed the sentiments of many of the nurses I interviewed when she stated, “I think that Nursing 101 has gone way down the tubes, way down the tubes in the past couple of months. . . . I’m constantly finding mistakes, people constantly leaving stuff for other people to pick up. And it’s been very disheartening lately.”

While she did not blame a lack of respect from the surgeons for the “disheartening” situation, she pointed to a lack of communication among members of the medical team:

The way they’re doing reports now, I don’t know anything about these people. . . . I don’t have time in the mornings to sit there and read a chart for forty-five minutes. . . . I’m relying on the other staff members to pass along pertinent information, and it’s not getting done. . . . I just found out in rounds that one guy has probably taken a hit to his kidneys. And I knew nothing about it, or why, what his history was for those problems. I used to know these patients inside and out, head to toe. And I don’t any more. That bothers me.

In addition to problems with “knowing” the patients, Dailey, like the anonymous Beth Israel nurse, also noticed nurses leaving tasks for others to accomplish, “There’s just been a lot of stuff that’s really gone by the wayside. It’s frustrating, very frustrating. . . . Some of these patients are kind of getting lost in the shuffle of things, with things not getting done, things kind of get put off” (July 1999).

Both of these nurses confronted the same troublesome issues. The merger compromised the things that they valued most about their practice. Of central issue to both nurses was the way aspects of patient care fell through the cracks. Without pertinent information on patients—about

their problems or the surgeons’ plan of action for them—primary nurses found it difficult to plan appropriate nursing care. The surgeons, in their turn, rebuffed nurses’ attempts to solicit information and did not welcome nurses’ insights or opinions about patients. Moreover, the surgeons disapproved of any divergence from their preferred treatment, particularly if it reflected a practice from the other side. With little shared information and so many constraints on practice, nurses were limited in their ability to make independent decisions and to plan care. Thwarted in their efforts to collaborate with the surgeons and feeling that they exercised little influence or authority over their patients’ care, nurses’ sense of having twenty-four-hour accountability for their patients dwindled. With their practice reduced to following the orders of warring surgeons, nurses resigned themselves to putting in their time and leaving the remainder of their unfinished work for the next shift. As a result, continuity of care could be compromised, with patients “getting lost in the shuffle” and not having their needs met.

**Resistance from the Surgeons**

In a study of physician resistance to a hospital merger, Rothman, Schwartzbaum, and McGrath (1971) suggest that organizational restructuring may threaten the mutual accommodations between professionals and the bureaucratic organizations employing them. As power is called into question, those concerned with losing power oppose and resist organizational change. Compared to other professional groups in hospitals, physicians are exceptionally well-positioned to mount effective resistance and opposition to change: They generate revenue, account for the hospital’s referrals and prestige, and occupy several positions on the executive board (e.g., Chief of Medicine, Chief of Surgery, Chief of Emergency Medicine).

When a merger or other organizational upheaval challenges physicians’ commitment to their positions or employing organizations by somehow threatening their status, physicians may circumvent the traditional bureaucratic authority of the hospital administration. They may buck the regular bureaucratic channels, with negative consequences for the orderly “transmission of information and ‘orders’ bearing on patient care” (Freid-
Indeed, in the case of the Cardiothoracic Unit, the surgeons thwarted the hospital administration's directive to standardize practice. They invoked their medical authority to continue the modes of treatment they had used prior to consolidation. Although the Beth Israel and Deaconess surgeons did not have the power to stop the physical merger of the cardiothoracic units, they were able, during the time of my fieldwork, to block the merging of practices.

In the first focus group that I held on the consolidated Cardiothoracic Unit two months after the consolidation, the nurses spent the better part of our time detailing how the lack of standardization was the biggest obstacle to delivering what they considered good nursing care. Nurses were very unhappy with the communication breakdown, aggravated by the extra work of treating the same problems two different ways, and worried about the effect the lack of coordination had on patients. "To me, I'm sick and tired," one complained, "To me, it makes me not like the job any more. Because I'm not doing my best. I feel like my hands are tied behind my back sometimes. Because you can give and give and give and do your best, but I just feel like we're roadblocked."

Another nurse concurred, "We feel the same way. We just feel everything is helter-skelter. But I just think people need to put on their brakes and get together, you know."

A third nurse agreed, "It's like it's maybe too much, too soon, too different. We need standardization, that's what we need. Standardization, across the board. And maybe the doctors need to talk to the other doctors... Because we're all in the same boat."

Later in the discussion, another nurse echoed these sentiments, "I just think we can standardize. We just need a little direction from somebody. God knows who. And then get things underway." The nurses blamed the surgeons for the current difficulties on the unit: "It's trickling down. It's from a surgeon's point of view that things are so different. And a lot of them aren't willing to budge" (Focus Group, August 1999).

To protest the merger, the surgeons insisted that, no matter how unfamiliar, nurses follow the particular protocols the surgeon used when treating that surgeon's patients. A nurse could not decide, for example, whether a patient should be scheduled to return to the unit for a wound check (the former Beth Israel practice) or should be sent home with a referral to see a visiting nurse (the former Deaconess practice). Although both courses were appropriate, the choice depended on which attending had performed the patient's surgery, and nurses had no latitude to decide this and other care plan issues.

However much the cardiothoracic surgeons might have felt out of control of the events at BIDMC, they nonetheless retained control over the nurses' work. Restructuring did not change the fundamental subordination of nurses to physicians. As doctors' subordinates (Abbott 1988; Chambliss 1996; Freidson 1970; Macdonald 1995; Porter 1995; Wicks 1998; Witz 1992), nurses at BIDMC suffered the effects of doctors' resistance and power contests. Fighting among the surgeons changed the nature of nurses' subordination—from one of collaboration with the surgeon making the final decision about a patient's care to one of total domination of patient-care decisions by the surgeons.

For an outside observer, this shift is easy to miss. Suzanne Gordon (1997) explains:

When nurses work closely with doctors, they often suggest the medication to be used or an alteration in the doctor's prescribed plan. But even if their input is accepted, it's often not publicly acknowledged. Only the doctor's orders—not the fact that the nurse may have recommended them—are recorded on the patient's chart. A nurse's participation in this aspect of patient care—and thus the collaborative nature of the health care enterprise—remains invisible. The written record, which reflects the formal chains of authority and command in the medical system, maintains the fiction that the doctor is solely in charge. (173)

Despite the sometimes invisible nature of nurses' influence in patient care decisions, the collaboration between doctors and nurses was a core feature of primary nursing practice. Nurses saw it as their job to advocate for patients, particularly when they felt that the physician should adopt a new course of treatment. In cases when doctors were not receptive to a direct approach, nurses took more indirect routes. At Beth Israel, where the nurses' notes accompanied those of physicians in the medical record, nurses could skillfully craft these notes about patients' conditions and lead physicians to what they considered the "right" conclusion.
On the new Cardiothoracic Unit, both Beth Israel and Deaconess nurses who previously felt that the surgeons on their former units treated them as trusted and valued members of the health care team, now found the surgeons decidedly unresponsive. With the attendings spending less and less time on the units, nurses lost the opportunities to influence patient care, even when the surgeon was one with whom they used to work collaboratively. With nurses’ notes exiled to the notebooks near the bedside, moreover, nurses now had few opportunities to communicate their insights and information relevant to decisions about patients’ treatment plans.

In an environment in which surgeons dictated the delivery of nursing care, nurses were desperate for the surgeons to get together to work out their differences and agree on a standardized practice. One nurse spoke for all when she insisted, “We’re nursing, and we should be able to say to them, ‘This isn’t right. This is not working.’” Unfortunately, the nurses did not feel empowered to make such forceful statements to the attendings. Their response was to helplessly acknowledge that while the attendings “know what’s going on,” the nurses did not have the ability to get them together: “You’re not going to get all four attendings in a room for nursing to talk to them. It’s not going to happen.”

When a nurse questioned, “Why not?” another answered, “Because they don’t have the time, and it’s not a priority in their life. They don’t care. They think about cutting [costs], and it’s not a priority for them.”

“They want things the way they want it to be, and they don’t want it to change. So it’s their ideals,” another observed.

The nurses had little patience for the surgeons’ ideological struggle. “It’s very different for all of us [nurses],” one said, “Because then we can never gel [as a team]” (Focus Group, August 1999).

Despite the fact that the discord among the attendings was interfering with the cardiothoracic nurses’ ability to perform the work of the unit, they passively accepted these conditions. They complained to the nurse manager, but they did not take steps to approach the surgeons themselves or, as a group, to insist that the surgeons come to some kind of truce. Their complaints and concerns were voiced among each other and in the break room, not in a public forum or directly to the offending parties.

During the focus group, one of the nurses complained, “It’s a very negative environment working here.” Another agreed, “I’ve never worked with such a dissatisfied group of people in my life. It’s sad.” The first responded, “We’ll blame it on the doctors, but I think they need to hear that. Because that affects their patients.”

Like nurses in the Emergency Department, nurses on the Cardiothoracic Unit recognized that serving the patients’ interests provided a common goal that could give them influence over doctors’ behavior. However, in this case, the nurses rationalized that that was not enough.

Again, during the focus group, the chorus of helplessness and hopelessness played its one-note tune:

RN: Oh, they’ve heard it.
RN: I don’t think they really care.
RN: They don’t go home and think about it.

Although a nurse had earlier observed that the doctors were trying to preserve their way of doing things because of “their ideals,” nurses also perceived that the doctors refused to compromise because of ego and a desire for control. Nurses perceived that the attendings were not concerned about the smooth workings of the unit, as long as their patients ultimately got the care the doctors wanted them to have.

The nurses on the Cardiothoracic Unit pointed to the lack of teamwork with the surgeons as impeding care. The 1999 Institute of Medicine report on medical errors (Kohn, Corrigan, and Donaldson 2000) supports their perception. The report claims that between forty-four thousand and ninety-eight thousand people die in U.S. hospitals annually as a result of medical errors and emphasizes that, “[although] almost all accidents result from human error it is now recognized that these errors are usually induced by faulty systems that ‘set people up’ to fail” (169). The report, which provides little detail about the internal organizational factors that contribute to faulty systems, nonetheless emphasizes the importance of teamwork in preventing medical errors (173).

The nurses did indeed feel that they were being set up to fail by the lack of teamwork on the unit. A nurse observed, “I would never say the pa-
tients get horrible care. I just think that it’s much harder for us to do our job on a daily basis.” Without an immediate threat to patients’ well-being, however, nurses thought they lacked the necessary leverage to change the surgeons’ behavior. While the nurses believed the attendings would surely come together if there were a crisis in care, nurses felt powerless to influence the attendings to negotiate a standard practice in the interest of preventing potential problems.

The surgeons were so intent on retaining and exercising control over their own practice that the teamwork and collaboration that had previously characterized that practice became the first casualty. So consumed with their egocentric conflict, the surgeons did not consider how their little war might affect the nurses or patient care. They had lost sight of the fact that they did not deliver care for patients by themselves and that their orders were not in themselves enough to provide good care.

With the Nursing Department in tatters, the nurse manager had no formal authority backing her request that the surgeons work out their differences. Even though the surgeons were battling at the expense of patient care, nurses, even those who had been trained to be assertive advocates for their patients, felt they could do nothing more than wait on the sidelines— even as patient care suffered.

Not Enough Staff

During our focus group, the nurses on the General Medical Unit angrily recounted a recent conflict with management over staffing on the unit. As the evening shift progressed—from 3 P.M. to 11 P.M.—it became clear that the nurse supervisor planned to pull one of the three nurses scheduled for the night shift to work on another unit that was understaffed. With authorization from the nursing directors, the plan was to limit the number of patients on the General Medical Unit to twenty and run the unit with two nurses. This would create a minimum staffing ratio of one nurse to ten patients. But what would happen to their ten patients, nurses worried. These patients were real people, not identical little dolls who could be tucked neatly into bed and found, safe and sound, in the same position the next morning. The patients on the unit were very different, highly unstable, and unpredictable. “We had three people so sick, like they could go any time. And then they had to pull one of us [and send her to another unit], and we were only left with two nurses on nights . . . It’s unsafe.” (Focus Group, August 1999).

Welcome, the nurses told me, to the postmerger budgeting system for staff called flex staffing. This program had been in effect since 1997. The concept behind flex staffing was that units would be staffed with enough nurses to accommodate their average patient volume. Units added nurses if the volume went up and subtracted them if the volume went down. At the old Beth Israel, patient units were staffed to accommodate their maximum, not their average, patient volume. If there were any open beds on the unit, then nurses would have a lighter patient load. The new system eliminated such “waste.”
Appendix

Studying Change at BIDMC

In June 1998, I approached the Nursing Service at BIDMC about studying the impact of the Beth Israel–Deaconess merger on the nurses there. Even two years in, the merger hung like a thundercloud over BIDMC, with worried personnel wondering when the storm would hit. Although the hospitals had merged names and administration, few changes had taken place because the leadership hoped to ease everyone comfortably into the changes. But the slow pace was causing anxiety and anger among the staff. The nursing leadership recognized the discord among the nurse managers from the two hospitals and the sinking morale among the rank and file, but they did not have the time or resources to investigate the problem. They welcomed and encouraged my interest, hoping my results would help identify problems and point to solutions.

Although I had initially intended to study the effects of the merger on nurses, the hospital faced other monumental changes that also might affect frontline nurses. Studying a changing organization is much like trying to paint a still life in the midst of an earthquake. There was a lot happening at BIDMC and at a rapid pace. Understanding the consequences of hospital restructuring for nurses required a careful examination of what had changed and what these changes meant. I spent nine months, from January through September 1999, collecting data at BIDMC.

Open-ended interviews with seventy-seven employees at BIDMC provide the core data for this research. Because I expected that individuals’ responses to organizational restructuring would be shaped in part by structural features of their position in the organization, I selected individuals
situated in different positions in the organizational hierarchy. In order to get a balanced view of the impact of the merger and consequent restructuring, I spoke with an almost equal number of people from each pre-merger hospital, thirty-six from the former Beth Israel Hospital and thirty-four from the former New England Deaconess Hospital. All interviewees were guaranteed anonymity (pseudonyms are used for interviewee names), and only four of the individuals approached for interviews declined.

Because I expected that individuals occupying different positions in the hospital hierarchy might have distinct perspectives on changes, I interviewed thirty-four nurses, sixteen administrators (eight from the nursing service), ten nurse managers, and seventeen other members of the health care team (e.g., physicians, social workers, case managers, and patient care coworkers). Since most of the current leadership was from the former Beth Israel hospital or was new to the scene, I interviewed several additional nurse managers and nursing leaders from the former New England Deaconess Hospital, many of whom had left their previous positions. However, my focus on the survivors of organizational change dictated that most interviews were with current employees of BIDMC. This interview sampling strategy helped me develop a more rounded view of the merger dynamics and cultural differences between the two hospitals.

Different units within the hospital were exposed to restructuring to different extents, which could create differences in nurses' experiences on those units. To explore this potential range of experiences, I used an embedded case study design (Yin 1994) of six units at BIDMC. Although the units had different practice areas, all served the adult, inpatient medical surgical population. This similarity in patient population facilitated comparing organizational arrangements and work conditions across the units. When my fieldwork began in January 1999, the units involved in this study accounted for one-third of the inpatient units in the hospital. These six units represented over one-fourth of the nursing staff working with the inpatient adult population, and just under one-fifth of the nursing staff in the entire hospital.

By the end of my fieldwork, only three inpatient units at BIDMC had consolidated with their counterparts from the other premerger hospital. Two of these units—the Emergency Department, which consolidated in 1997, and the Cardiothoracic Unit, which consolidated in 1999 while I was conducting fieldwork—are included in the sample of units studied. The remaining four units included Neuromedicine, Neurosurgery, General Medicine, and Vascular Surgery (including the Vascular Intensive Care Unit).\footnote{Technically, this is two units, but the vascular Intensive Care Unit is in close proximity to the vascular surgery unit and shares the same nurse manager and some of the same staff. Therefore, I analyze these two units as one setting and refer to them as one unit.}

In addition to collecting data from a variety of informants, I also used multiple methods to allow for data triangulation, “the checking of inferences drawn from one set of data sources by collecting data from others” (Hammersley and Atkinson 1995:230). Each of the research methods approached the question of changes and their effects from a different angle, thereby widening the research perspective and limiting the potential of any one line of questioning or source bias to exercise too great an influence on results. I conducted participant observation, interviews, focus groups, and surveys on each of the six units in the sample, and I also used a variety of internal hospital data sources.

Through observation, I examined differences in the way the units operated, in procedures and behaviors among nurses, and in work pace and stress. During observations, I shadowed individual nurses as they went about their daily routines and observed their work processes and interactions with patients and other members of the care team. While I mostly observed nurses on the day shift, I also tailend nurses during the evening and night shifts. Following nurses on different shifts allowed me to examine potential differences in work conditions and unit operation at those times.

On each of the units, I interviewed at least three nurses, the nurse manager, and at least one other staff member on the unit (e.g., a case manager, nursing assistant, or a physician). This sampling strategy allowed me to get the perspectives of the staff nurses and the people who supervised and worked with them on a daily basis. Encounters during my observations and recommendations of nurse managers and staff helped identify individuals with knowledge or experience relevant to my research questions and guided my selection of individuals for interviews. For the majority of interviews with nurses, I selected experienced nurses who had been at the
hospital since before the merger. I also made a point of interviewing several more recently hired nurses to compare their views about the quality of care and the situation at the hospital.

Open-ended interview questions provided information on what informants believed had changed at the hospital since the merger. I asked the same basic set of questions of all informants. (See Weinberg 2000 for all research protocols used in this study). However, the typical interview involved numerous interruptions; for example, pagers going off, phone calls, patients' families requesting information, patient care coworkers requiring assistance. Therefore, interviews needed to be as flexible as possible to respect people's work obligations. Interviews probed what had changed at the hospital, on the unit, and in particular for each informant. The protocol also focused attention on the relationships among coworkers and on the status and autonomy of nurses.

Often, before an interview, informants warned they had very little time, but most became engrossed in the interview and stayed beyond this limit. Some interviewees became emotional during the interview; several even cried. Informants seemed invested in their accounts of events at the hospital. Some informants may have used interviews as a forum to gripe, whereas others may have downplayed problems. While, no doubt, some patients' families requesting information, patient care coworkers requesting assistance. Therefore, interviews needed to be as flexible as possible to respect people's work obligations. Interviews probed what had changed at the hospital, on the unit, and in particular for each informant. The protocol also focused attention on the relationships among coworkers and on the status and autonomy of nurses.

While interviews addressed changes since the merger, focus groups concentrated on nurses' work conditions and ability to provide high-quality patient care. I conducted focus groups on each of the six units during working hours. A total of thirty-eight nurses, at least six on each unit, participated in the focus groups. These groups gathered to discuss their definitions of good nursing care, the factors necessary to facilitate it, and the extent to which good care was provided on their units.

The group dynamics in focus groups differentiated them from individual interviews. Nurses bounced ideas off each other during these group discussions, often finishing each other's thoughts or being reminded of events that had occurred. While private interviews might encourage exaggeration of problems, speaking before a group of peers might encourage minimization of experiences with quality-of-care problems.

Surveys expanded the reach of this research to the larger sample of nurses working on the six study units, not just the ones that I could interview individually or who could attend focus groups. The survey was based largely on the Outcomes of Hospital Care, Staff Registered Nurse Questionnaire used by Linda Aiken and her colleagues at the Center for Health Services and Policy Research at the University of Pennsylvania (see, e.g., Aiken, Sochalski, and Lake 1997). Their survey includes a slightly modified form of the Nursing Work Index (NWI) developed by Marlene Kramer and Laurin Hafner (1989) in their study of magnet hospitals. The NWI had been administered at Beth Israel Hospital in 1986, and within the University of Pennsylvania survey, in 1991 and 1998. Drs. Aiken and Sochalski of the University of Pennsylvania provided me with the survey data from 1986 and 1991, thereby allowing for an examination of changes in organizational arrangements over time (see Table 1 in Chapter 8).

I administered closed-ended surveys on the six study units to all of the staff registered nurses identified by the nurse manager as working regularly on the unit, for a total of 217 surveys. Surveys were anonymous, as requested by the Nursing Research Review Committee. Some 147 surveys were returned, for a total response rate of 67.3 percent. The anonymity of the surveys may have supported more candid responses than face-to-face encounters.

I used the surveys to assess the pervasiveness of the perspectives and experiences expressed in interviews and focus groups and witnessed during my observations. Many of the survey questions complement questions from the interviews and focus groups. The survey results speak to the perceptions in 1999 of a larger group of nurses about current organizational arrangements and their effects.

Finally, I used BIDMC newsletters, bulletins, internal memos, meeting minutes, and nursing division records to document actual changes, not just participants' perceptions of changes, at the hospital. These archival data lend some historical perspective to the analysis and could be used to reflect the accuracy of my informants' and my own observations.
References


