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Governance in operating room nursing: Nurses' knowledge of individual surgeons

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Abstract

This paper explores governance and control in operating room nurses' clinical practice. Traditionally, operating room nurses have been portrayed as "handmaidens" to the surgeons, a position which implies that nurses' bodies and the knowledge they use in practice are sites of discursive control by others. This paper unsettles this understanding by showing how operating room nurses studied ethnographically in an Australian setting are both disciplined by and actively shape practice through knowing surgeons' technical requirements for surgery, through inscribing them in discourses of time, and through having deep knowledge of the surgeons' "soul". We argue that as a form of governance, nurses' knowledge of surgeons is a subjugated form of knowledge, located low down on a hierarchy of knowledges. Furthermore, as a form of governance that has previously been unarticulated in the literature, it transcends the traditional lines of authority and control in the nurse–doctor relationship. The data in this paper are drawn from an ethnographic study that explored a range of nurse–nurse and nurse–doctor communication practices in operating room nursing.

Keywords: Clinical governance; Self-regulation; Operating rooms; Nursing; Australia

Introduction

This paper can be seen as a search for a productive understanding of operating room nursing, one in which nurses are attributed with some degree of responsibility for the governance and control of their practice. The impetus for this paper stems from the idea that ambiguity surrounds operating room nursing. On the one hand, operating room nursing is perceived as glamorous and attractive because of the close association nurses have with surgeons, the appeal of teamwork and the highly technical work (Happell, 2000). Yet, on the other hand, operating room nursing is devalued and alienated from the wider profession because of nurses' perceived subservience to surgeons where nurses are often conceptualised as handmaidens (Gruendemann, 1970, p. 349). While there is an increasing body of knowledge about social relationships in operating rooms (Fox, 1992, 1997; Moreira, 2004; Riley & Manias, 2005; Tanner & Timmons, 2000; Timmons & Tanner, 2004; Walker & Adam, 2001; Walby, Greenwell, MacKay, & Soothill, 1994), very little evidence provides insight to the subjectivity of operating room nurses or technologies of power that shape their practice. As a consequence, we asked the question: How is operating room nursing practice constructed and governed in the clinical setting?

To begin this exploration into the governance of operating room nursing we provide some background about the social positioning of this specialty area of practice, both within nursing and in the broader public

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domain. Next, we provide details of the theoretical and methodological approaches used in this study. Segments of data are drawn from a larger ethnographic study investigating communication processes and practices to illustrate different technologies of governance. We argue that while nurses are subjected to the disciplinary power of surgeons, nurses come to use their knowledge of them, gained through their close association, to govern and shape practice in operating rooms.

Background

The image of nurses as handmaidens to doctors, or what Sandelowski (2000, p. 116), has called the "third hand" (p. 116) is one that has applied across nursing as a whole. References to it are easily identified in contemporary literature (Berg, 1996; Brown & Crawford, 2003; Lupton, 1995; Sigurosson, 2001; Sweet & Norman, 1995). However, while it has been proposed that nursing in general outgrew the handmaiden image in the 1970s, it has remained a dominant perception about operating room nursing (Sigurosson, 2001).

Originally, the handmaiden image of operating room nursing was considered a sign of prestige. In days gone by, being closely associated with surgeons was regarded as a privilege, a sign of status and a position to be envied (McGee, 1991). Nurses derived power from their close association with doctors (Melosh, 1982). In more recent years the handmaiden image of nursing has been seen as derogative and patriarchal, and considered with disrepute (Gruendemann, 1970).

Ideas about exactly what the handmaiden image entails have not been clearly articulated in the literature and operating room nurses themselves have been silent in this regard. The criticism seems to emanate from outside the specialty area of practice, with operating room nurses faced with defending their work and practice from use of the term and its implications (Conway, 1995). Nevertheless, despite this lack of clarity, several implications can be drawn from the handmaiden analogy, which mostly centre on the idea that nurses' bodies and knowledge are the site for discursive control by others.

First, the handmaiden image emphasises manual work and the handing of instruments to surgeons during surgery where knowledge is centred mostly on bodily, task orientated skills and manual dexterity. This notion seems to imply that there are limitations about the type of knowledge that nurses have access to and use in their practice and that this manual work and bodily knowledge are insufficient to be of real worth in the production of nursing practice. Second, operating room nurses are depicted as having a uni-dimensional subjectivity, where other subject positions are made invisible or downplayed in comparison to this dominant image. Third, the handmaiden image implies that the body of the operating room nurse is the site of discursive control by others, in which nurses cater to the whims and needs of surgeons and are accountable to and respond to their command in clinical practice, rather than their nursing colleagues and managers. In doing so, the work of nurses is belittled and devalued by displacing nurses' own priorities.

In part, this devaluing of the handmaiden role has been fostered through its association with family symbolism:

> The doctor is represented as the wise and powerful father figure who not only has an exclusive access to a elite body of scientific knowledge and the practices that develop from it but whose knowledge, status, and autonomy enable him to benevolently control and direct others. The nurse is represented as the wife who acts in a role that has often been labelled "handmaiden". Her knowledge is the lowly valued practical knowledge and her role is constructed to carry out the tasks designated by the father/doctor (Street, 1992, p. 49).

The problematic identity of operating room nursing has been further complicated by nurses' lack of connectedness and interpersonal communication with patients. In line with broader social changes, in the middle part of the 20th century a shift occurred in the way the body of the patient was thought about (Armstrong, 1983). Prior to this point the patient was regarded as an objective, biological entity, where the relationship between the nurse and the patient was "mechanistic" and "passive" (Armstrong, 1983, p. 458). Since the 1960s the patient has assumed a new identity—one of a subjective, thinking and feeling being. Nurses have been encouraged to "know" the patient (May, 1992), to understand their experiences beyond a material existence.

Similarly, the concept of "care" was advanced as the philosophical basis of nursing practice and promoted for the professional and academic development of the discipline (Meleis, 1997). Caring was proffered as a truth statement in nursing. However, dominant discourses of care in nursing depicted it as a subjective and relational concept, dependant on interpersonal exchanges, connection and communication with the patients so as to understand their holistic experiences. From the perspective of operating room nurses as a whole, the notion of providing a relational form of care to patients is one that has been fraught with conceptual difficulty. It is as Hirschauer (1991) suggested, that anaesthesia renders "the patient's person out of his/her body and leaves it in front of the closing doors of the operating theatre" (p. 305). The focus of operating room nurses' attention is on the bodies of patients. By virtue