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Institutional Ethnography and Experience as Data[1]

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Experience, as concept, is contested among feminists as to its epistemological status, thus its usefulness in knowledge claims. Institutional ethnography (Smith 1987) is a feminist methodology that nonetheless relies fundamentally on people's experience. Not as Truth, nor the object of inquiry, but as the point d'appui *for sociological inquiry. This article offers a demonstration of institutional enthnography using observational and interview data that show experience as methodologically central to a trustworthy analysis. A moment in the work lives of nursing assistants in a long-term care setting is captured by a participant observer. The analysis produces two lines of argument. One is methodological; it is argued that nursing assistants' experiences are an entry into the social relations of the setting that, when mapped and disclosed, make those experiences understandable in terms of the ruling arrangements permeating both the organization and their own experiences. The other argument is substantive; the inquiry uncovers how a quality improvement' strategy in a long term care hospital in Canada is reorganizing caregivers' values and practices toward a market orientation in which care appears to be compromised. Use of experience as data in this approach holds the analysis accountable to everyday/everynight actualities in a lived world.*

KEY WORDS: experience; institutional ethnography; nursing; Total Quality Management; long-term care.

INSTITUTIONAL ETHNOGRAPHY AND 'EXPERIENCE'

This paper discusses how, in institutional ethnography, a researcher goes about exploring and understanding her own or someone else's every-

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day/everynight life in a methodical way. In the theoretical approach known as social organization of knowledge, (where institutional ethnography is located as a research strategy), experience is the ground zero of the analysis (Smith 1987, 1990a, 1990b). The analysis begins in experience and returns to it, having explicated how the experience came to happen as it did. The objective of making the analysis is to open up possibilities for people who live these experiences to have more room to move and act, on the basis of more knowledge about them. Dorothy E. Smith, long ago, called her work as sociology "for women"; more recently, she and other researchers who use this approach (e.g., Campbell and Manicom 1995:7-12) have claimed that this form of analysis offers something for all those whose lives are subject to ruling relations.

Recently, questions have been raised by postmodernists and poststructuralists about feminists' use of "experience" as a basis of knowing, in the context of a broader re-examination of earlier feminist scholarship. Some have usefully argued against the notion of a "unitary subject" of women's experience and against white, heterosexual, middle-class feminists' appropriation of women's experience as normative or exclusionary (e.g., Alarcon 1994). A related critique of feminist analysis shows up the inadequacy of explanations that ground feminist knowledge claims in something essential or ideal arising from "women's experience" and for which authorizing women's voices might seem to be a solution (Bar On 1993). Another set of important postmodernist/structuralist concerns (e.g., Scott 1991) I take to be about the questionable status of experiential accounts produced by people whose knowing is discursively organized. Experience is one of the concepts, along with agency, subjectivity, discourse and identity whose contestation has generated within feminism a fruitful rethinking of some of the traditional disciplinary methods in which feminist scholars have been trained and through which their conversations still take place.[2]

While these debates have motivated this paper, my goal here is not to add to the theoretical discussions around the possibility of knowing from experience. Rather, I am making a demonstration of what Dorothy Smith means when she enjoins us to "begin from the actualities of people's lives" if we want to understand what is happening to them. Smith is one of the feminist scholars for whom women's experience remains of key methodological importance, even as it has become contentious in postmodern/poststructural circles.[3] The aim of this paper is to show how to put personal experience into the center of a trustworthy analysis. I want to illustrate how the use and status of experience as data in an institutional ethnography sets in apart from "the authority of experience" that Scott (1991) challenges, and from Clough's (1993) view that experience is a construction of sociological conventions.

Institutional ethnography, like other forms of ethnography, relies on interviewing, observation and documents as data.[4] Institutional ethnography departs from other ethnographic approaches by treating those data not as the topic or object of interest, but as "entry" into the social relations of the setting. The idea is to tap into people's expertise in the conduct of their everyday lives—their "work", as Smith wants us to think of it, (a concept discussed further on p. 60 of this article). The conceptual framing of everyday experiences heard or read about, or observed, constitutes one of the distinctive features of an institutional ethnography, another is its political nature. Exploring how people's lives are bound up in ruling relations that tie individuals into institutional action arising outside their knowing, "institutional ethnography allows one to disclose (to the people studied) how matters come about as they do in their experience and to provide methods of making their working experience accountable to themselves . . . rather than to the ruling apparatus of which institutions are part." (Smith 1987: 178).

THE STUDY

The setting of the study[5] I discuss here to illustrate my argument about experience as data is a long-term care hospital[6] in Victoria, Canada. The experiences analyzed are those of some nurses observed and recorded by a researcher in the context of a study of the implementation of a "Service Quality Initiative"[7] management strategy in an institution that I call Dogwood Villa. Using one story from several months of observational fieldwork, I argue that this particular management initiative has the capacity to alter staff-client relations at the most intimate level. Contrary to the democratic-sounding explanations of the strategy, it attempted to enforce a different and more rule-bound kind of practice, as it also revised the hospital's ideology of care that previously had been organized around being "home-like." The new ideological accomplishment of the quality improvement strategy, I concluded, would be a creeping colonization of the minds and hearts of the care-givers with the goals and values of the market—in which competitiveness, productivity, and cost-efficiency, etc., are paramount. Here, the methodology of that analysis is discussed, and I argue that experiential data offer a secure and methodical basis for my conclusions about the quality improvement strategy. Of course, as a demonstration of methodology, I am dealing with only a fragment of data to illustrate "social relations" in this context, and how they provide for the account that I make.

Dogwood Villa's Service Quality Initiative is one of the family of Total Quality Management techniques that is altering the health care system sig-

nificantly. This study gave me an opportunity to examine the dailiness of organizational change processes to discover how such efforts—to improve management and make decisions more rationally—affect caregivers and their clients. Elsewhere, (Campbell 1988, 1992a, 1992b, and Campbell and Jackson 1992) I have studied and written critically about the methods that organizations implement to try to make more efficient and effective use of caring labor and other costly resources. These undertakings are urged on health care managers by the difficult fiscal constraints under which health care is provided. I have watched with concern as a managerialist approach to service provision spreads with little critical appraisal throughout the social health and service sector in Canada.

So in looking at what was actually happening in this research site, I was not entering it as a naive observer working in naturalist mode, nor was I looking for theory to arise out of the data, as a grounded theorist might. As an institutional ethnographer, I was informed by prior analysis of the Canadian health care system and its increasingly rationalist stance towards management. I was also informed by a social organization of knowledge approach, about which I need to say a bit more now.

SOCIAL ORGANIZATION OF KNOWLEDGE AND RESEARCH ASSUMPTIONS

Dorothy Smith's (1987, 1990a & 1990b) writings on the social organization of knowledge provide the conceptual framework of this study and its grounding assumptions about how my research assistants[8] and I would think about what we were seeing in our fieldwork. Our first working assumption was that organizational knowledge is text-mediated in contemporary organizations in post-industrial society and that the nursing work that we were observing and hearing about was organized through text-based practices that coordinated it, made it accountable, and so on.[9] We knew that these practices build their own textual realities. This meant that as we gathered observational and interview data, we operated on the assumption that we would find different versions of what was understood, even of what was actually happening, as people we talked to spoke from different ways of knowing the workplace and the work.[10] Implicit in this assumption is our understanding of the discursively organized character of everyday life in organizations (Smith 1990b:209-224).[11] However, we also accepted that while people understand their experiences in organizations through discursive mediations, they remain bodily present and are active experiencers of the everyday/everynight world from their various locations in it. Indeed, where one stands determines what one experiences, shaping to an impor-

tant extent what can be know.[12] "A setting known through special texts may appear to be different from how it is known experientially, and . . . this may create problems" (Campbell and Manicom 1995: 11) both for managers who rely heavily on textual accounts and for nursing personnel, whose work keeps them tied to local settings where knowing has a kind of bodily immediacy that also affects it. Managers who rely on texts for their knowing also experience their work, their human interactions, their environment, etc., but in this paper I draw out for research attention the experiences of front-line workers. I want to attend in my analysis to differences in the possibility of knowing that relate to the knower's location and everyday/everynight work as well as to how such local experiences are ruled discursively, and thus constructed ideologically as the same across knowers.[13]

The notion of bifurcated consciousness that Smith (1987:6) discusses with references to herself as a mother and an academic seems helpful here. She noted how, as a graduate student, it was possible and necessary to learn how to move between the world of babies and tending their bodies and the discursively organized university, entering each in its own (distinctive) terms. She made the move in both space and time: daytime here, nighttime there, and noted the disjucture between the two. For nurses who work in a similarly bifurcated mode on the job, things are not so clearly demarcated spacially. In the workplace, they are immersed in the everyday/everynight world of bodies and at the same time their own work of recording and translating their nursing into organizational texts articulates those bodily concerns and tasks to the conceptual order of the institution (Campbell 1984, 1988, Campbell and Jackson 1992). They construct their knowing of bodies into discursive mode, bifurcating their own consciousness. In other words, they know their patients in two distinctive, and often contradictory, ways—as real people with bodily needs and as text-based objects of professional attention. The latter may, and under modern managerial technologies often does, mean that the bodily knowing is subordinated to the text-based or discursive.

This brings me to the next grounding assumption that my research team and I carried into the research setting: that the power of subordinating local experiential knowing to the discursive is the basis of textually-mediated management and of what Smith calls ruling. As researchers, my team was always being attentive in our fieldwork to how the written word organizes what gets known and how it authorizes that version of it. We accepted that in those kinds of text-mediated procedures in the nursing setting, management works as a ruling practice.[14]

These are intrinsic features of Smith's social organization of knowledge that are also the premises of institutional ethnography and without which institutional ethnographic procedures and analyses don't make sense. Given

these premises that Smith (1987:117-135) argues are not theoretical in the ordinary sense, but are conceptual reflections of *actual relations* among people, the researcher goes into any new setting to see "how it works". It is not to test a hypothesis, but to examine the way that the social organization is put together such that people experience it as they do. In this approach, the researcher learns the standpoint or "takes the side" of those being ruled. The research explores and exposes how ruling affects people whose everyday/everynight lives come under the influence of specific ruling practice. One cannot know about their lives without their showing or telling it in one way or another. Thus, the researcher's attention to their voices.[15]

To carry out such an inquiry, the researcher begins with actual people involved actively in a social process, speaking from their experience. Writing fieldnotes is always a located social practice. Both the informant's account, and eventually the researcher's, are methodical in that they both rely on the relation to the located social process to discipline what is (can be) said. Insofar as the informant is speaking with the terms and relevances of her own life, she brings into the researcher's presence the actual social organization of that experience.[16]

Similarly to interview data, observations of everyday life, where the researcher captures the language used by participants, can be used to gain entry for analytic purposes into its social organization. The researcher is searching for traces of how the participants' actions and talk are conditioned. The researcher relies on the methodical nature of participants' behavior. Drawing on ethnomethodology, Smith (1987:161-167) has written about people performing their everyday activities as "work" that they sensibly and expertly organize, coordinated in relation to the local social organization and also coordinating it. Experiential data, whether from interviews or observations, thus inform a method, allowing researchers an entry to social organization for the purpose of explicating the experiences; by explication I mean to write back into the account of experiences the social organization that is immanent, but invisible, in them.

"HARMONIE BRIEFS": THE STORY

For an instance of the kind of explicative analysis I am referring to, I want to turn now to a story from my study—an incident observed at Dogwood Villa involving nursing staff. I use it to analyse and illustrate the social relations of the Service Quality Initiative operating in the hospital and altering the care of the residents. Here I want to show how the voices of nurses in this story (their methodical telling of their experiences) allowed me to recover and display the meaning of this management strategy and

make the argument about it that I have made. I also illustrate how to make analytic use of people's speaking of their everyday lives in ways that have the social relations "in" the talk. This is not rehearsed practice with some people knowing better than others how to do it. It is a way of ordinary talking where the speaker is making sense of the setting, for herself and for the listener. According to Smith, it is impossible to speak sensibly without speaking the social relations.

The analysis begins with some excerpts of observational data collected by a research assistant as she observed, on different days, the work of two nurses, one a clinical teacher, the other a nurse manager. The topic that the data excerpts address is the nursing staff's use of disposable diapers (called by their trade name Harmonie Briefs), for residents who are incontinent of urine, especially at night. The fieldnotes are presented with a minimum of explanatory comment (in square brackets). In the fieldnotes we see people in the setting talking about, puzzling over some questions about costs, the hospital's money, nursing plans, etc., as the researcher observed it; this provides the empirical ground for the analysis that follows.

> A Clinical Resource Nurse [a nurse employed as a teacher within the hospital], was presenting an inservice education class on the use of the Harmonie Brief to a group of nursing assistants. [These are the staff who actually change people's beds, make the decisions about diapering people and using cotton pads under them, repair the damage done by a leaking brief, etc]. The class was being held because concern about recent stats on laundry costs had been brought to the educator's attention by her immediate supervisor.
>
> The problem was that instead of reducing their linen [laundry] costs . . .many units were actually increasing these costs in spite of the use of the disposable product. The Harmonie Brief policy had been in place for about six months when the Clinical Resource Nurse reported that on [the] unit [in question], the cost of Harmonie Briefs was $651.00 per month. She explained [in her class to the nursing assistants] that the organization had budgeted $60,000. for costs of Harmonie Briefs across the whole hospital for the period in question and therefore, there was a need to recover $60,000. from the linen budget in the same period. She wrote these figures on a flipchart for the staff to see.
>
> The nursing assistants then discussed what this was going to mean to them. They saw that they either had to use less linen for bed changes or they had to keep the bed linens from being so soaked, since the cost of the contracted-out laundry service was calculated by weight.

This rather muddled explanation of the management concern about Harmonie Brief usage was not the end of the story. Fieldnotes made by the same researcher on the same unit a week later show the Director of Resident Care (a nurse manager) discussing Harmonie Briefs with her Nursing Team Leaders (Registered Nurses). At this meeting, they are deciding how the nursing assistants who do the hands-on care are going to be required to manage the laundry cost problem.

> One of the items discussed [at the Team Leaders' meeting] was linens and diapering. The general focus was on how it is "necessary to break even", according to the

Director of Resident Care. Hence, she and the Team Leaders discussed cutting back on pads that are used underneath the resident at night. It was decided that those residents with Harmonie Briefs on should not require more than one pad underneath them. A Team Leader was concerned that if the brief were put on too early [in the evening shift] that more than one [of the disposable products] might be used at night. It was decided that only one Harmonie Brief should be used per night. If a wet brief were discovered during the night, the resident should be padded, as using two briefs per night per resident would escalate costs.

It is important to note that this discussion is taking place among Team Leaders who work days and who will be leaving messages for evening and night staff.

ANALYSIS: SOCIAL RELATIONS AS METHOD

I begin analysing these data by assuming that a specific social organization coordinates what the participant observer saw and heard happening and what she made notes on. Through her notes, I as analyst can see how these nurses are engaged in bringing that social organization into new sites—through the class where nursing assistants are told about the impact on the hospital budget of the expenditures on the new disposable briefs, how that relates to the laundry budget and specifically that this is *the nursing assistants'* problem to solve. And later, I can see the nurse manager and RN team leaders developing new rules that will hold other nurses to the same routines that offer more economical use of the disposable briefs. My analysis begins in those experiences.

It is my task as institutional ethnographer to search out, come to understand and describe the connections among these sites of experience and social organization. My sense-making is not just insightful interpretation. Nor am I looking for it to be an instance of a theory. Rather, it is disciplined by the relations that organize or coordinate what actually happens among those involved—what they experience. The procedure is to make problematic (or a topic for inquiry) those everyday experiences to which the observer makes us privy. Being able to count on using social relations to discover the concerting of action across time and space is what makes the inquiry methodical. The research relies on the embeddedness of social relations in the talk and action of the participants to direct the inquiry. The question to be explored is "What are the social relations coordinating those experiences?" I needed to discover, for instance, how ideas about "breaking even" and "recovering $60,000 from the linen budget" had made their way into a clinical teaching session for nursing assistants and how, or if, those ideas were related to the hospital's Service Quality Initiative. What was concerting all these actions?

AUTHORITY RELATIONS RE-ORGANIZED THROUGH THE SERVICE QUALITY INITIATIVE

The authority relations operating among the nurses in this setting are easily identifiable in the fieldnotes. Hospitals rely on a distinctive mode of managing in which authority is vested in certain categories of employees. In the fieldnotes one can catch glimpses of traditional authority relations in the Clinical Resource Nurse teaching the nursing assistants about their role in "breaking even". It appears that she has been instructed by her superior to make the work associated with "breaking even" a topic for the nursing assistants. Nursing assistants take heed because they are required to, as part of their jobs. Another authority relation has the Director of Resident Services involving the Team Leaders, who are RNs, in planning how to pass on a new set of rules to their subordinates, the evening and night nurses. The nursing assistants, while occupying the lowest rung on the nursing authority ladder, still have power over the residents. They exercise a certain kind of authority with regard to caring work, and that is why these employees are being instructed in the economics of disposable briefs. These are all matters that can be empirically substantiated.

An interview I conducted with a Clinical Nurse Specialist (a Master's prepared nurse with a part-time university faculty appointment) showed that beyond the official authority relations, action in the hospital was being coordinated in a new manner. Her account of the work that went into the decision to purchase Harmonie Briefs offers a glimpse into the background of the experiences described in the field notes. My research task at this point was to inquire into the discursive organization of these events. I was looking for the practical basis of (what I came to see as) the re-structuring of relations among managers, nurses and residents at Dogwood Villa. According to the Clinical Nurse Specialist the decision to use Harmonie Briefs to supplement or replace entirely washable cotton pads had been made through a new process encouraging managers to work together across traditional department and disciplinary boundaries. According to her, this was the first time she had ever been part of such a multidisciplinary decision-making team. She was very proud of her own involvement, which had been to conduct clinical trials of a range of competing products and recommend one to the cross-department project group. This (Harmonie Brief) group also included the managers who made the hospital's purchasing and laundry decisions and were responsible for the budgets in these areas. The Clinical Nurse Specialist's clinical trials had identified which product would keep residents drier and thus protect their skin from breaking down. She had wanted to see if the disposable briefs made the residents more comfortable at night; there was some suggestion that changing wet beds during the night

upset the residents and sometimes resulted in residents hitting nurses. The Harmonie Brief project thus brought her interest in resident comfort and staff safety together with other group members' different responsibilities. Working together influenced everybody's practices. For instance, she told me that she was surprised to learn that the manager of the Purchasing Department, as a result of her clinical trials, had had to alter his regular (equity-oriented across-the-board) purchasing practices, in order to buy the product she recommended.

The Clinical Nurse Specialist's story of the Harmonie Brief project contained recursive elements (see G. Smith, 1990) that I now want to highlight, to illustrate the textual coordination of the organizational action of interest in this inquiry. Recurring in the interview were some of the Service Quality Initiative principles that I had previously seen in the management documents describing the project. When I returned to the management documents, I found these phrases: "managers were instructed to change their values as managers, to value and trust their staff, whose intelligence is to be incorporated, as well as their caring; . . . managers were expected to focus on process (how people interact to get the work done) and to work across departments, providing the social system and resources for employees to do their jobs". The idea was to bypass customary management practices where authority to act was entrenched in traditional practices of hospital management and supervision. Looking at the Harmonic Brief project as the Clinical Nurse Specialist described it, I could see that the way that this project group worked was consistent with new principles being taught to members to Dogwood staff in Service Quality workshops, etc. For example, the Clinical Nurse Specialist spoke enthusiastically about how a "communication workshop" she had attended as part of the Quality Initiative had helped her to work across the hospital's traditional disciplinary boundaries, avoiding barriers of status, hierarchy and discipline that interfered with discussing and implementing better solutions.

The new authority, according to the Service Quality Initiative documents, was to be found in reference to meeting the customer's needs. Before I could understand how that idea was translated into nurses' action in different hospital sites, I needed to explore further the notion of "customer" as it was being introduced through the Service Quality Initiative.

CUSTOMERS AND SUPPLIERS: MEETING EACH OTHERS' NEEDS = QUALITY

The new system, an internal Quality Initiative document explains, requires staff to act as "suppliers of service as well as customers receiving

service". The implementers of the Service Quality Initiative put great emphasis on everyone using the term "customer" as Dogwood Villa. This training began with the formal definition of the Service Quality Initiative emphasizing customer, as follows:

> Service Quality determines the way we work. It is achieved through processes that meet or exceed the expectations of our internal and external customers. The Service Quality processes focus on identifying customer-supplier needs and expectations, meeting these expectations, team work, doing the right things the right way, continuous review of our performance and feedback to customer-supplier. (internal memo, April 15, 1993)

It seemed that talking about "customer" was supposed to engage employees' involvement in thinking about their work differently, following the new principles. But "customer" was a contested notion. In meetings and discussions at Dogwood Villa staff interpreted "customer" to mean "the resident" and some found the new language uncomfortable, and pretentious. Some felt their professionalism was offended and refused to talk about the people they cared for as customers. But by and large, the care-giving staff did not take very seriously either the language or the whole Service Quality Initiative, seeing it as "just the latest fad, which will pass". Management staff were more faithful in using the language, perhaps because they felt more accountable for the project's success, and perhaps because modelling the new principles was part of their management performance, for which they were held accountable.

I began to see that how people talked about the project was itself part of the process of reconstructing the authority relations in line with the new ideal. As I came to understand this shifting form of authority, I was able to reflect back to how strenuously the hospital's CEO had objected when I had referred to the Service Quality Initiative as a management technology, in my research proposal (minutes of Dec. 13, 1993, IAS committee meeting). It was, he told me, not to be talked about in those terms. It must be seen (and promoted) as a participatory project, never as a management initiative. While this account, at the time, seemed to defy the facts of the matter, it begins to make sense, when we see the Service Quality Initiative as re-constituting authority relations.

In retrospect, I see that there were two incongruent and competing formulations of "customer" in use; the one was defined in the internal document, where employees were to be suppliers of service as well as customers receiving service, and the other was the commonsense one that staff operated with, where the resident was the customer. In practice, the distinctions were often blurred. The latter, the resident as customer, held positive implications for the nursing staff even when they objected to the language, because it was in line with well-established values of the hospital.

In this interpretation what was good for the resident was an acceptable rationale for any change in work processes. Staff liked the suggestion (set out, for instance, by the CEO to the management group, Jan. 4 1994) that "those most closely involved with a particular work process would be empowered to help design the work system to be used". Staff could identify with changes when the customer (the resident) was to be considered first. This came to be understood as "decision-making pushed down in the organization to those most closely involved with the work being done" which became a popular slogan used by Service Quality implementers. The slogan made the initiative seem to be a method of democratizing decision-making, allowing workers more individual discretion, in the name of resident satisfaction. And yet, in the Harmonie Brief story, we saw a high profile project in which the suggested changes in the work processes were not designed by those closest to where the work was being done. Nor were they straightforwardly "good for the resident".

As the fieldwork progressed, I saw that the flexible or squishy interpretations of "customer" were not simply a different choice of words. Rather, the Service Quality Initiative introduced a new ruling relation. "Employees as customers of each other's work", the version of customer that competed with "the resident as customer", legitimated an officially sanctioned approach to the work that organized employees' discretion in line with new organizational priorities. The new practices that the Service Quality Initiative legitimizes found their authority, not in established management hierarchies and professional practices, but in being consistent with the hospital's economic priorities. (At the time of the study, cut-backs, restructuring and budget deficits were on everybody's minds). The new social relations that coordinate work practices carry values organized around budget and cost-efficiency. In the field notes examined, one moment becomes visible in which these changing values penetrate nursing work plans. This is an important moment because it lets us in on how individual caregivers are incorporated into a changing value system, in an enforceable way. The clinical teaching session introduced a new kind of thinking about what was important in the work.

Much has been written on "quality management" strategies about which as Price (1994:69) says "consent to market values (is) strongly reproduced throughout the workplace". The critique made is that group discussion and input into re-design of work processes aim at intensifying individual worker commitment to the work group, to the productive task and to the product. Central to Total Quality Management and other quality management strategies is the idea of employees being part of a chain of suppliers of products to both internal and external customers, with everybody's attention being focused on how each can satisfy their own customer's

needs. ("Products" are here being understood as whatever it is that their work produces, even if, as in a hospital, it is changing bed linens.) Employees are asked to think about themselves as a link in this chain of relations extending throughout the whole work process. This strategy and the work organization that supports it is supposed to make individually relevant the issues of quality and productivity standards that each worker must be responsible for, to facilitate just-in-time delivery of products, satisfied customers, maximum valued added to the product, etc. In my analysis, the hospital's Service Quality Initiative attempts to bring these features of the hospital's problems with budgets (or the capacity to compete) to the individual worker and into his/her local decision-making and action.

SERVICE QUALITY INITIATIVE AND THE RE-ORGANIZATION OF CARING WORK

Using my conceptual framework, I see the Harmonie Brief story as an extension of the social relations of ruling into the individual effort of caregivers in the hospital workplace.[17] I now want to discuss briefly some effects of this new form of authority on those being ruled, especially the nursing assistants and the residents they care for. Returning to the fragments of data examined, I think that readers can begin to see how the cost-benefit plan that justifies the purchase of the disposable product is organizing actions that will be taken by nursing assistants. The requirement to "break even" on this project means not just that use of the Harmonie Briefs are to be rationed to match what would have been spent on laundry, but that decisions about how to nurse, decisions normally taken at the bedside on the basis of empirical data (and nursing knowledge) are to be replaced by general rules that relate nursing decisions directly to the hospital's fiscal concerns. While efficient management of resources is, of course, an important goal here as in all organizations, I contend that it is being accomplished in a process that fundamentally alters the caregiving.

That is why to make sense of the Harmonie Brief situation, it must not be understood simply commonsensically—as an instance where the nursing assistants are working for the resident as customer. This story is clearly not an instance where everyone focuses on how best to serve the resident. Nursing assistants, in the instance, stand in a particular consumer or customer relation to suppliers of other hospital services—those who are responsible for the contracted-out laundry services paid for by weight, to others who purchase disposable briefs, and to still others who must balance budgets. Nursing assistants' work creates varying levels of demand for those services and products. Because the overall goal for the Harmonie Brief

project within the new competitive environment is to "break even", the officially legitimized customer-supplier response is for nurses to curtail their use of the (scarce) services and resources. The analysis that began in the nurses' experience of a clinical in-service class when the budget for disposal diapers was related to a need to reduce the laundry costs thus comes back to illuminate and make sense of that experience.

These nurses are learning how to carry out their work in terms of its cost-efficiency, learning how to make clinical decisions that are coordinated in relation to the hospital's budget. Their own everyday/everynight thinking is dominated by the market relations that are penetrating the long-term care hospital and the caring relation. To hospital managers, this is the successful outcome of the Service Quality Initiative. But the story has deeper implications. Given the delicate balance nurses must maintain between adequacy of care for the hospitalized elderly and the conservation of hospital supplies, moving decision-making over the use of disposable briefs further away from the bedside is a matter with serious clinical consequences. Decisions about the use of the Harmonie Brief are being established by people several levels above the nursing assistants in the organizational hierarchy. The new rules that are meaningful within the context discursively organized by the Harmonie Brief group (e.g., clinical trials, cost-benefit analysis of disposable vs. washable pads) will look completely arbitrary in the context of the night nurses' experiential knowledge. Nurses are left in an ambiguous position. It seems that the hospital is sanctioning a less stringent attention to resident care. Should caregivers try to work around these rules for the good of the resident?

Checking back a year later, I found that the nursing staff, left with the responsibility of keeping the residents' skin intact within the constraints set by the new rules for use of resources have learned how to adjust their efforts to the new demands. They are happy with the nursing results of using the disposable product. However, most interesting for this analysis is how this hospital has adapted to its concerns about "breaking even": it has financed the extra costs of the disposable briefs by asking individual families to pay for them. When a resident's sensitive skin requires nurses to use more briefs then the rules allow, they must be paid for privately. Of course, not all residents have families, nor the money to pay extra charges; this is how inequity creeps into long-term care.

CONCLUSION

My analytic interest in this incident is of two kinds. I have examined how management strategies are helping health care institutions accommo-

date to the demands of fiscal restraint in a globalizing economy (Price 1994) and I have demonstrated a method of analysis that moves from the particular (experiences) to a general analysis. In regards to the former, I have shown how a strategy of "quality improvement" works as a means of transforming institutional governance, making nurses' individual professional action accountable to a set of goals and objectives formulated externally to it, in this case a cost-benefit calculation. Nurses are being taught to see the sense of these rules and to bring their thinking and actions into line with them. They are being expected to take up the ruling actions and perpetuate them. This, I argue, is much more than training in economical use of resources. The new relations undermine the integrity of care-giving and professional practice.

The Service Quality strategy examined helps to organize the authority relations that pre-empt local nursing expertise, suggesting how organizational action in a long term care facility can be made accountable to a political agenda of deficit reduction and reduced social spending. Here is (a piece of) the very complex business of bringing a new cost awareness into the everyday decision-making of health care workers. This Service Quality Initiative helps to insinuate ruling ideas into local settings where workers themselves will carry them forward.

The paper also makes a methodological argument about the use of people's experiences as data. Responding to the voices of nurses as they went about their work, I explicated the social relations that organize these nurses' thinking and acting. This is the way that institutional ethnography "makes sense" of people's experiences and draws broader implications from methodical analysis of local experiences. I can claim that what was happening amongst the nurses was part of something generalizable about "quality management" in that setting and indeed in the management of health care more broadly. This facility's Service Quality principles, the need to "break even" and so on, apply across the organization, not just to the nurses observed and interviewed. To further enlarge the claim, researchers could look for similar features of health care organization in other hospitals. So, while this incident may be specific to one time and place, and one set of actors and their experiences, the relations that organize those experiences can be demonstrated to be general.

Understanding how a management technology "works" as a ruling practice to influence nurses and nursing care helps to de-mystify this management practice, showing some of the ways that market forces penetrate the consciousness of care-givers. Here I made the empirical discovery that "customer" is a concept that operates in different and contradictory ways, its effects being to subordinate nurses' caring to concerns related to the market. This kind of knowledge may be crucial to the struggles that will

need to take place over health care in Canada, as public policy shifts to subtly incorporate a market orientation.

The relations of ruling do not disappear by learning about them, however, nor can they be shaken off by individuals, themselves. They are every-present in our lives, like the water that fish swim in. Knowing more about how our lives are tangled in ruling relations can help to reduce the frustration we feel about living and working in societies such as ours where things seem to get decided behind our backs, or at least outside of our control. For health care workers who find themselves in these kinds of situations, knowing how one's work setting and one's own decisions are being influenced may help them make useful choices about how to act.

But what does this article say about experience? It is certainly not that experience is authoritative And it is not "pure" in any essential way. One of the analytic points being made is how nursing assistants' lives (at least those experiences to which we are privy through field observations recorded here) are being discursively organized. In the analysis, those rather puzzling observations (of events that were perhaps just as puzzling to the participants) were the "entry" to understanding the manner in which a particular management discourse ruled the nurses' work lives. What was done and said in that work setting offered the clues, the traces of the social relations, that could be followed by the researcher, to be fleshed out and related back to the original field setting. Only then could that moment's experiences be read as the concerting by organizational actors of their local everyday work lives with ruling institutional arrangements. In the setting where this study was conducted, there were many contending versions of what was happening: some people said that the Service Quality Initiative was a participatory project to improve care; others said it was simply a management fad; others disagreed about whether or not it was a money-saving scheme. My analysis relies on experience to anchor what can be said to the actualities of nursing assistants' lives. Theirs is the standpoint from which the analysis is made. It is trustworthy to the extent that it accounts for their experiences. Perhaps the most important thing about experience as data is that, in institutional ethnography, it makes an analysis accountable to the everyday/everynight world as people live it.

ENDNOTES

1. Earlier versions of this paper was presented at the 13th Qualitative Analysis Conference "Studying Social Life Ethnographically", McMaster University May 28-31, 1996; and at

the Society for Studies in Social Problems Conference, New York, August 17-19, 1996. Support for the research is gratefully acknowledged from Industrial Adjustment Services, Human Resources Management Canada, on a cost-sharing basis with the research hospital, Sept. 1993-March, 1995; and from Social Sciences and Humanities Research Council of Canada Grant #816-94-0003 that funds a research network, "Understanding and Changing the Conditions of Caring Labor", 1993-1997. I also want to thank Rosanna Hertz and the paper's four reviewers for comments that, while I have responded to them in my own way, have certainly strengthened the paper.

2. e.g., Canning (1994) in social history; Code (1991) in philosophy; Nicholson (1990) in literary criticism, among many others.
3. See Smith (1996) specifically.
4. For some lively examples of published institutional ethnography, see Ng (1996), Diamond (1992), Walker (1990), Swift (1995).
5. The research was funded through a joint agreement between the hospital, three health care unions and the Canadian government's Industrial Adjustment Services in the Ministry of Human Resources Development. The goal of the IAS program is to help Canadian firms and their labor forces adjust to changes in the production environment. The hospital qualified because of its implementation of the Service Quality Initiative. The specific project for which funding was obtained was a formative evaluation of the initiative. The author was both the chair of the joint IAS committee and the principal investigator of the evaluation research conducted in 1993-94. One researcher worked half-time on the site during the nine month study period and was involved as a member of all SQI committees. Three researchers conducted participant observation in work sites and contributed fieldnotes to the analysis. Fieldnotes were supplemented by interviews with informants from all levels of the organization. Activities and documents associated with the Service Quality Initiative were also analysed. Periodic research reports were circulated to all staff, the executive and the Board of Directors. As befits a formative evaluation, discussion was encouraged and feedback incorporated into the data collection. A final report (submitted to IAS, the hospital and the union in 1995) is available from the author.
6. Americans readers may be more familiar with the term "nursing home" used to describe the same kind of facility.
7. The Service Quality Initiative was a locally developed and implemented strategy that owed much to the ideas and literature of Total Quality Management. Total Quality Management and Continuous Quality Improvement are popular management strategies employed in both industrial and human service organizations to improve organizational functioning. For a strongly optimistic account of how quality improvement strategies work in health care agencies, see Phillip Hassen's *Rx for Hospitals*.
8. Bev Miller, MSW, and Pat Larson, MN, graduate students at the time, were research assistants on this project and conducted much of the field research with great sensitivity; my analysis owes much to their grasp of the conceptual framework of the study and resulting attention to detail.
9. Ng (1996) shows how accountability relations influence an organization's goals and activities.
10. Diamond (1992) shows "reality" experienced and understood differently, from different sites in an organization.
11. A good deal of the work in any organization consists of turning events, experiences, transactions of the people whose lives are its concerns into text and acting on the basis of those textural accounts. Smith (1990b) has argued that this form of text-based interaction is ubiquitous in contemporary western societies, discursively organizing social relations in ways that can be investigated as practical activities.
12. deMontigny (1995) provides an dramatic illustration and analysis of how this happens.
13. In Walker (1990), "discursive organization" is shown to be practical activities of policy-making and governing.
14. For a fuller discussion of this, see Campbell, 1988 or 1992b.
15. As one reviewer of this article points out, the residents are also being ruled and the study might have used their voices, as Diamond's (1992) research did. It should be noted

that the social relations organizing any setting are consistent, no matter whose standpoint is used to explicate them.

16. This paragraph paraphrases an e-mail communication between D. Smith and B. Lloyd, and responsibility for its interpretation is mine.
17. For Canadian readers, this analysis has special implications. Our public health care system has not until recently been directly subject to competitive capitalism. This paper shows how, within the non-profit (publicly funded and administered) Canadian hospital system, market relations are being established and are becoming the legitimate basis of care-giving decisions.

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