Info-Santé: A Case Study of a Disembodied Health Care Service

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Abstract

This study offers an investigation into the history and practice of a teletriage nursing service, *Info-Santé.* An overview of the *Info-Santé* service's historical evolution amid cut-backs to the Quebec health care system in the early-to-mid 1990s, with resulting structural changes to health care delivery situates the study within the wider social and political context. The division of labour within the health care system and the place of the *Info-Santé* nursing service within the health care network are also discussed with a resulting inquiry into an 'ideal type,' that of 'Real Nurse.' Two focus groups and in-depth open-ended interviews were conducted with a purposive sample of twenty nurses working in an *Info-Santé* call center in Sherbrooke, Quebec. In addition, participant observation took place over a period of several months at the same site. Foucault's notion of the clinical gaze is transformed in the absence of a physical 'patient' in this exploratory case study. Results reveal that these nurses have developed a number of key strategies aimed at 'hearing' the caller's health problem. In particular, various qualities of the voice as well as the ambient sounds available through the telephone are critical components in the nurses' constructions of the callers and their problems, resulting in the creation of a 'disembodied' clinical gaze.

Résumé

Cette étude constitue une exploration de l'histoire et de la pratique d'un service infirmier de télétriage, *Info-Santé.* Un aperçu de l'évolution historique du service *Info-Santé* à la suite des coupures faites dans le système de soins de santé

québécois vient situer l'étude dans les contextes social et politique élargis. Ce regard porte sur la période des coupures qui s'étend du début au milieu des années 1990; il prend en considération les changements structuraux qui en ont découlé sur le plan de la prestation des soins de santé. Il est aussi question de la division du travail dans le système des soins de santé et du rôle du service infirmier *Info-Santé* dans le cadre du réseau de soins. De cette discussion naît une réflexion sur le concept du « type idéal », c'est-à-dire de la « vraie infirmière ». Deux groupes de discussion et des entrevues ouvertes et approfondies ont été réalisés. L'étude portait sur un échantillon au jugé comportant vingt infirmières travaillant dans un centre d'appel *Info-Santé* de Sherbrooke, au Québec. De plus, l'observation participante s'est déroulée dans un même site sur une période de plusieurs mois. Dans cette étude de cas exploratoire, la notion de regard clinique définie par Foucault se transforme en l'absence d'un « patient physique ». Les résultats révèlent que ces infirmiers et infirmières ont développé nombre de stratégies clés visant à être « à l'écoute » du problème de santé de l'appelant. En particulier, les diverses qualités de la voix et les bruits ambiants audibles par l'entremise du téléphone sont des éléments essentiels permettant au personnel infirmier de se représenter les appelants et leur problème. Il en résulte la création d'un regard clinique « désincarné ».

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Chapter 1 - Introduction

New technologies in the delivery of health care are altering the form and substance of many health professions and their practices, including those of nursing. This dissertation presents a case study of one such technology, a telephone nursing service in Quebec, Canada, called *Info-Santé*, and offers a sociological investigation into the history and practice of this "disembodied" health care service. In order to situate this study within the wider social and political context, including cut-backs to the Quebec health care system in the early to mid 1990s and the resulting structural changes, first an overview of *Info-Santé*'s historical evolution is provided. The division of labour within Quebec's health care system and the place of the *Info-Santé* nursing service as a partner within the health care network are discussed. Interviews with *Info-Santé* nurses reveal the notion of an "ideal type," that of "Real Nurse" that nurses juxtapose with their own nursing practices and which affects their professional identities. This study's findings indicate that this "ideal type" has real implications, affecting both the intra- and interprofessional recognition of individual nurses and the *Info-Santé* service as a whole.

In particular, this study focuses on the changing nature of the practice of nursing in the absence of a physical patient. Nurses' strategies, aimed at "hearing" the caller's health problems through various qualities of the caller's voice and ambient sounds available through the telephone result in the creation of a "disembodied" clinical gaze. Language, vocabulary, accents, pauses, sighs:

nothing that is available to the nurse's ear is taken for granted and all serve as clinical data to the experienced *Info-Santé* nurse. These auditory inputs add to the depth of the "disembodied gaze" in providing these nurses with indications of callers' social circumstances, education, social class and ethnicity among other social categories and attributes. Nurses make use of these auditory cues to form images of the callers and their environments, and adapt their interventions to correspond to the images they have formed. The processes by which these strategies are learned are examined and explicated. Newcomers to the service must learn to decipher all forms of auditory cues and meld these with traditional nursing knowledge to create new "disembodied" ways of knowing that are essential to the practice of telenursing. This study provides a unique inquiry into a "disembodied" health care service from the perspective of its nurses and in doing so, demonstrates key effects of health technologies on practices of nursing care.

Health care and its timely access are matters of primary concern in Canadian society (Clair et al, 2001; Marchildon, 2005; Armstrong and Armstrong, 2008; CIHI, 2009; Pineault et al, 2009). Reforms to health care service delivery over the past twenty years displaced care from familiar sites, particularly hospitals and doctors' offices, and moved them into the home, devolving care to individuals and their families, and to out-of-clinic practitioners. In Quebec, this reform is known as the *virage ambulatoire*, the shift to ambulatory care. This *virage* resulted in the closure of a number of active, acute care hospitals in the province, including several in the Eastern Townships (Estrie 05 Region), and in the early discharging of hospital patients following surgeries, births, and medical treatments. These structural transformations took place in a context of state efforts

to contain ever-increasing costs within the health care system. This devolution of care was made inevitable by the offer and acceptance of early retirement packages for health care personnel, aimed at decreasing overall salary costs, and the emergence of notions of "patient empowerment" and patients' increasing responsibilities for their own health care. The net result of these strategies was a decrease in direct access to clinical health care for the population.

A variety of policy initiatives to address this move away from traditional methods of health service delivery resulted in the eventual expansion of some existing services, particularly home care services, and in the creation of new ones. One such new initiative was the implementation of a telephone nursing service which takes advantage of innovations in telephone and computer technology to increase access to health services over wide geographic areas. Indeed *telehealth* is defined as "the use of information and communications technology to deliver health and health care services and information over large and small distances" (Picot, 1998, as cited in Goodwin, 2007: 38). Goodwin (2007) provides clarity with further definitions of a number of terms used within the context of telehealth. To this end, *nursing tele-practice* is defined by the Canadian Nurses Association as "a nursing specific application of telehealth that includes all client centered forms of nursing practice" (2001: 1 as cited in Goodwin, 2007: 38), while *telephone nursing* or *tele-nursing* is seen as one element of nursing telepractice concerned with performing *tele-triage* evaluation, and with giving telephone advice and health information according to that evaluation (ibid.). *Tele-triage*, then, is broadly defined as "the provision of telephone support by health professionals for client-initiated telephone inquiries and a system for directing

callers to the appropriate level of care, including self-care and informal care" (Stacey et al, 2003: 1). Triage in this sense is "the process of sorting patients into order of priority of treatment" (ibid). Within these definitions, the Quebec provincial nursing service *Info-Santé* is a telenursing service.

Available at no cost to callers, with no limit to the number of calls that can be placed, and requiring only access to a telephone, *Info-Santé* responds to callers' needs on a 24 hour, 7 day-a-week basis, thus providing the public with easy access to a front-line, primary health care service. The service plays a key role within the health care system, in the manner described above, and in serving as a response center for registered clients in long-term care facilities, within the public home care system, publicly funded medical clinics, and as a vital link for the *Santé Publique* and various other members of the health care network.

The use of telephone nursing services has been growing steadily in Canada and elsewhere over the past twenty years (CIHI, 2009; Goodwin, 2007; Cady, Finkelstein and Kelly, 2009; North and Varkey, 2009; Larsen, 2004; Holmström and Höglund, 2007). In the United States, the use of such services by hospitals or managed care facilities target relatively limited constituencies with the primary goal of reducing or preventing inappropriate emergency room visits in an effort to control rising healthcare costs (Goodwin, 2007). An example of this is the U Special Kids Program (USK) at the University of Minnesota. This service aims to provide coordinated care for "children with special health-care needs" (CSHCN) in Minnesota by planning and managing educational, medical, social and home health care providers to better address the complex care of children with health care needs of moderate to high intensity. The programme has strict admission

criteria and served only 50 children during a six month period in 2006 (Cady, Finkelstein and Kelly, 2009). While the US does not offer a public, government-sponsored national telephone triage service, about 100 million people across the country have access to some form of advice and triage telephone service with most of the calls related to the care of children (North and Varkey, 2009). Many of the call centres, such as Ask Mayo Clinic, are available only by subscription and provide service to primarily medium- to large-sized corporations for their employees and their dependents.

In contrast to the US situation, in the United Kingdom a 24-hour-a-day telephone nursing service, National Health Service Direct (NHSD) is provided through the National Health Service (NHS) to serve a population of 50 million residents, making it the largest of this type of practice (Goodwin, 2007). In place in England since 1998 and subsequently expanded to Wales in 2000 and to Scotland in 2002, the service is available to the general public seeking advice or information and provides nurses with computerized software to facilitate decision-making in the triage of callers to emergency, primary (general practitioners) or self-care (Snelgrove, 2009). The National Health Service also offers NHS Direct Online and a digital interactive television service (Larsen, 2004).

Australia's Health Department of Western Australia contracted telephone nursing services to an American firm which created HealthDirect in 1999 with the primary goal to reduce inappropriate and expensive consultations in hospital emergency rooms (Larsen, 2004). As a 24-hour public service available to all Western Australians, HealthDirect is toll-free and is supplemented by Mental HealthDirect services since the end of 2000.

Sweden's national telenursing service is a public, tax-funded service with "strong similarities" with the UK's NHSD and with HealthDirect in Western Australia as discussed above. At the time of their writing, the service was in the process of becoming a 24-hour, single-number-access service available nationwide (Holmström and Höglund, 2007: 1866).

In Canada, nine provinces and two territories provide 24-hour telenursing services to the entire population within their jurisdictions, with the ninth province's services implemented in 2009 (Scott, 2009; Goodwin, 2007; CIHI, 2009). Of these, British Columbia, Alberta, Saskatchewan and Manitoba as well as Quebec are publicly funded "insourced" services, while those in the remainder of the country have "outsourced" the delivery of telenursing services to private companies (ibid).

Despite the expansion of telenursing services, nursing in the absence of a physical presence of a "patient" is a little-known practice. This study explores and analyzes the particularities of, and the knowledge that allows for, this "disembodied" practice. It provides insight into the processes its nurses must necessarily implement, adapting traditional clinical knowledge, assessments and care of the physical body to adequately attend to the absent body's many ways of speaking. That is, to be effective, telenurses must adapt and expand their ways of knowing to privilege *hearing* the body. This study examines these sociological intricacies from the perspective of the *Info-Santé* nurses whose mandate it is to provide such services. The dearth of sociological investigation from the perspective of those who practice nursing in this area makes this contribution particularly important and responds to a call for such research from a nursing

perspective (Goodwin, 2007: 38). The study is situated theoretically within the boundaries of the sociologies of health and the body, the professions, knowledge, and communications and technology.

Theoretical Frameworks

Intuitively, we understand the health care network as being an interactive web of various health-related professions working, at least in theory, for the good of the patient (Kagan and Chinn, 2010). For Abbott (1998:2), an important element in the study of professions is "a fundamental fact of professional life – interprofessional competition". Indeed, Abbott sees the professions as making up "an interdependent system" wherein each profession has its own activities which are performed within various kinds of jurisdictions, "the link between a profession and its work" (ibid: 20). Given that jurisdictional boundaries are perpetually in dispute as professions try to maintain their hold on "their" own activities, Abbott tells us that, "It is the history of jurisdictional disputes that is the real, the determining history of the professions. Jurisdictional claims furnish the impetus and the pattern to organizational developments" (ibid: 2). An analysis, therefore, about the role of *Info-Santé* within the health care network, the inter-service and interprofessional difficulties that arise within that network as these affect the daily functioning of the service, and the place of nurses and nursing within this system, is enriched by this understanding of interprofessional competition. As Abbott reminds us, "Control of knowledge and its applications means dominating outsiders who attack that control. Control without competition is trivial" (ibid: 2).

Seen in this light, the push-and-pull of various professional constituencies that form the health care network is fundamental to the system and indeed, can lead to a questioning of the place of the patient within that system.

The clinical gaze, in and of itself, has been the subject of much academic research. No one can doubt that Foucault's influence in medical sociology has been pervasive and persuasive (e.g., Turner, 1987 & 1992; Lock and Gordon, 1988; Petersen and Bunton, 1997; Clarke et al, 2003). His major contributions to social science and to medical sociology have been to provide an integrated theory of power through his analysis of power/knowledge, making the body a central analytical object within medical sociology, and his concept of governmentality which is particularly salient in the emergence of the sociology of risk and the biomedicalization literature. He has implicitly and explicitly informed the thinking of many scholars and has provided a popular method of investigation with his notion of the "history of the present." For many twenty-first century scholars, Foucault's thinking is the heart and soul of medical sociology. This research is strongly influenced by Foucault's concepts, particularly his notions of the clinical gaze and the body which this study builds on to elaborate the notion of the "disembodied clinical gaze" that lies at the centre of telenursing practice. Knowledge, in the form of discourse, and power are also key concepts which inform this study's analysis of *Info-Santé* callers and nurses. The practice of *Info-Santé* nursing can be understood as a disciplinary power on the body, an example of bio-power exerting influence on the individual body of the caller and the population, the social body, in seeking as it does to commit each of these to

standards of medical, social and moral normalization. Thus, Foucault's notions of discipline and surveillance provide a powerful framework for the analysis of meaning, structure and social power as these are articulated in the structure and practice of *Info-Santé* and as these are made explicit by *Info-Santé* nurses themselves. These key Foucauldian concepts will be explicated in detail in Chapter 3.

Another key transformation in medical sociology has been in what can essentially be described as the focus of analysis. The earlier literature maintained a focus on the medical practitioner him/herself whereas more recent work has shifted to the patient and her or his individual body, including its internal workings. Though the individual body has always been the object of the clinical gaze, recent work has tended to be focused on the ways in which that gaze has been transformed (Clarke et al, 2003). This study presents just that, a transformed version of the clinical gaze, one which I call the disembodied clinical gaze.

Weber's "ideal type" (1988) is another foundational concept in the sociological literature that has been instrumental in the development of what I refer to as the "Real Nurse." The "ideal type" is a heuristic device which can be understood as a collective understanding of particular kinds of behaviours. An "ideal type" provides a model against which various social qualities can be compared, enabling one to construct hypotheses linking it with the conditions in the "real world" of social interactions.

Significance

As noted above, health care and its timely access are of paramount importance to the Canadian public. Despite the growing importance of non-traditional health care services such as Quebec's *Info-Santé,* studies to date have focused on the structure of these services, their cost-effectiveness and/or clinical effectiveness (Stacey et al., 2003; Hagan et al., 2001; Cady, Finkelstein and Kelly, 2009; North and Varkey, 2008; Knight, Endacott and Kenny, 2010; Goodwin, 2007), ethical dilemmas associated with such services (Holmström and Höglund, 2007), age-related trends of calls (North and Varkey, 2008); or nursing identity, power and resistance (Snelgrove, 2009; Leppänen, 2009; Larsen, 2004). Of these, only the studies by Leppänen (2009) and Larsen (2004) are offered from a sociological perspective. This study situates the *Info-Santé* service within the wider health services context and explains its historical roots within Quebec. It then proceeds to take the analysis further in examining the service from the perspective of *Info-Santé* nurses. No study to date has undertaken the scope that this perspective offers, giving voice to those whose work is to evaluate the medical and social needs of telehealth callers in the absence of a physical body before them. This perspective offers rich insights into the particularities of a unique nursing practice and its place within the health care system. It provides evidence of the evaluative process effected by *Info-Santé* nurses and demonstrates the aural availability of a number of key social categories and their use within that evaluative process. While Mishler (1984, 2009), Waitzkin (1991), Ostwald (1964), and others have examined doctor-patient discourse from a variety of

perspectives, this study provides the first attempt to understand the particularities of a "disembodied" clinical interview carried out by nurses from those nurses' perspectives. As such, it contributes to a growing sociological literature in a number of interrelated fields, specifically, health and illness, the body, communications and technology, knowledge and the professions.

The sociological importance of this study lies in its new and unique contributions in expanding our understanding of the clinical gaze and its application in contemporary biomedicine, in increasing awareness of this non-traditional nursing service and its practice and place within the health care system, reminding us of the varied, intended and unintended effects of health care policy-making.

Overview

The chapters that follow will lead the reader on a journey into the world of a relatively new and unusual nursing practice. That world comes to life as participants voice their perceptions of their daily experiences, ascribe meaning to, and act on those perceptions. As W.I. Thomas (1928) stated: "perceptions are real because they are real in their consequences" (as quoted in Palys, 2003: 9).

I begin with the methodology of the study itself, how it was conceived and executed in Chapter 2. A review of the literature is presented in Chapter 3, situating this study within the theoretical frameworks within the sociology of the body, health and illness, professions, knowledge, communications and technology studies and therefore providing the reader with reference points from which to

understand the analysis. Next, in Chapter 4, I situate the context of *Info-Santé*, tracing its historical development within the larger Quebec society, but with a particular focus on the evolution of the service within the specific research area of this project, the Eastern Townships region of Quebec.

Chapter 5 examines the role of the *Info-Santé* nurse in detail. This role is multi-faceted and largely misunderstood by those outside the service, be they nurses, health care partners, the public, or, indeed, family members of *Info-Santé* nurses. The study examines popularly held notions of the nurse as a version of Weber's "ideal type," (1988) and contrasts these with common misperceptions of the *Info-Santé* nurse. The misperceptions of the role and the nurses' daily practices are a source of ongoing frustration for *Info-Santé* nurses, as becomes evident in the data presented. One of the consequences of these misperceptions is their impact on recruitment and retention of nurses to the service, which ultimately may affect the service's viability. This research seeks, in part, to address these misperceptions in the hope that in so doing, the public's health needs will be better served.

One of my key interests in undertaking this study is in explicating the strategies of "gazing without seeing," that *Info-Santé* nurses must necessarily implement as a matter of daily practice. Chapter 6 presents the reader with a detailed account of these strategies, as richly recounted by the nurses themselves. Foucault's well known sociological notion of the clinical gaze runs throughout this study as an underlying theme. *Info-Santé* itself is a "disembodied," front-line health service, which seeks to evaluate, advise and refer its callers to appropriate resources within the health care system. Its nurses also provide callers with

important self-care techniques and/or alternate resources to address their needs, thus reducing unnecessary or inappropriate visits to emergency rooms and clinics. Integral to the strategies put forth in this chapter is the importance of the voice to the decision-making of *Info-Santé* nurses.

Expanding on this topic, Chapter 7 documents how nurses access and interpret various social categories, such as education and social class among others, through the caller's voice. The effects of these interpretations or perceptions on their telephone interventions are described by the nurses in the data presented. The findings demonstrate how the caller's use of vocabulary is instrumental in these interpretations.

Finally, Chapter 8 offers a conclusion, summarizing the key points of this study, the contributions to the sociological and indeed, nursing literature, and the implications of the study.

Chapter 2 – Methodology

Introduction

This dissertation made use of qualitative research methods and strategies. As a nurse working at *Info-Santé*, indeed at this particular research site, since 1996, I was able to make use of my history within the organization to situate the site within the evolution of the *virage ambulatoire* and of *Info-Santé* itself. Participant observation as a nurse, in meetings, information sessions, informal "office" conversation, and as an analyst of caller/patient discourse during calls has contributed to the data and my understanding of the field and its participants. Two focus groups with *Info-Santé* nurses to explore relevant issues and generate concerns and topics for further investigation in interviews formed the first phase of data collection. The primary data collection method consisted of 20 interviews conducted with nurses at the Sherbrooke *Info-Santé Centrale*. Primary and secondary textual data such as Ministerial documents, documents from the Order of Nurses of Quebec (ONQ/OIIQ), and the Association of *Info-Santé* Nurses (AIIIS), orientation material for new nurses, written internal directives, nursing and sociological literature and other relevant material were also collected and analyzed. Grounded theory method was used to analyze all data. *Info-Santé* is a 24/7 nursing triage, information and referral service. It is a provincial service offered in the Eastern Townships[1] of Quebec, by the *Centre de santé et de*

[1] Known administratively as the Estrie 05 Region

services sociaux - Institut universitaire de gériatrie de Sherbrooke,[2] hereafter to be referred to by its acronym: CSSS-IUGS.

Access, Ethics Approval and Ethical Concerns

My history within the research site eased potential access problems as local *Info-Santé* managers expressed willingness to cooperate prior to the inception of the research project and made valuable suggestions for secondary source data. I was even told that the openness of local managers to the project had a positive bearing on its approval by the larger institution, the CSSS-IUGS.

Ethics approval for this project, according to the *Tri-Council Policy Statement: Ethical Conduct For Research Involving Humans*, was obtained from McGill University for the period of May 26, 2009 through to May 25, 2010. This approval was coordinated with similar ethics approval from the research site, the CSSS-IUGS, effective June 16, 2009 for a one year period. The CSSS-IUGS also gave me permission to carry out the focus groups within the institution, and paid participants for their time.[3] It is important to note that I, as the researcher, was not paid for my time. Thus participants for the focus groups were known to the managers at the research site, the CSSS-IUGS. At no time, however, did the institution have access to the data collected.

[2] In English: Health and Social Services Center – University Institute of Geriatrics of Sherbrooke
[3] The institution also requested that the researcher mention its cooperation with the research project in the dissertation, in future publications and share research findings with the institution in the form of one of its regularly held noontime conferences. These were the only stipulations required by the research site.

Interviews were held at the site of choice of the interviewee. For the most part, these also took place within the institution; one took place at the interviewee's home. It is quite possible that participation in the focus groups was encouraged by the institution's offer of remuneration for the participants' time. This enticement was not offered for the interviews, however, and recruitment did not prove to be at all difficult. With the exception of two nurses, who left the service during the research period, all those who had participated in the focus groups later agreed to be interviewed. Five nurses who had not participated in the focus groups due to scheduling conflicts later agreed to be interviewed. Thus, it would seem that the monetary incentive offered by the institution did not unduly influence participation in the study as a whole. Participants do not seem to have been intimidated by the fact that the focus groups took place at the institution, indeed, most subsequently chose the institution as the site for their interviews. The institution was unaware of the identity of those nurses interviewed.

I have worked at the institution, specifically for *Info-Santé* as a nurse, since April, 1996. Therefore, my familiarity with the participants and managers raises another matter of ethical concern. While my history within the research site eased potential access problems and contributed to the development of the research instruments, this familiarity itself posed ethical questions. Interpretation of the data is likely to have been affected by my many years of nursing at the site. For this reason, I have included many, and sometimes lengthy excerpts from the participants, which demonstrate how it is that I arrived at my analysis. The institution's cooperation with the study may also have made me less likely to

portray the institution in a negative light, and created a reluctance to discuss any potentially negative aspects which may have arisen over the course of the study. It is my belief that this issue too has been overcome through my careful attention to my position and responsibilities as a researcher and that the participants' voices have not been silenced in this regard. For instance, throughout the phases of the research, participants were regularly reminded of my researcher's role, in contrast to my role as a nurse, to minimize taken-for-granted, "member" speech and understandings of the questions and discussions raised.

The Sample

With the consent of *Info-Santé* managers, I introduced the project to the nurses during two regularly scheduled meetings of *Info-Santé* staff on June 2 and 3, 2009. Nurses were given a brief overview of the project and were told that two focus groups would be conducted, one with senior nurses and one with more junior nurses, based on their time working at *Info-Santé*. They were also informed that individual interviews would take place at a later date and were made aware that they could choose to participate in a focus group and the interview or one or the other or neither, as they so desired and/or as their personal schedules permitted. It was explained that participation would be strictly voluntary and that signed consents would be required for the focus group and the interview.

Recruitment took place beginning June 20, 2009, following final ethics approval from the aforementioned institutions, and continued over the course of the next few weeks. This recruitment took place exclusively within the

Sherbrooke *Info-Santé Centrale* and thus was a purposeful, convenience sample, as is characteristic of the case study method (Creswell, 1994). Limitations of this method of sampling are primarily twofold. First, this is not a sampling method that can in any way claim to provide a representative sample and, second, for this reason, notions of generalizability of the study's findings are often seen to be limited to the group in question (ibid). In contrast to these limitations, Buroway (2009) extols the virtues of the extended case study method, and indeed, I have found that this method is most applicable to this study. As explicated by Buroway, the extended case study method and the "reflective science" that is brought to the method, allows for the extension of the ethnography to wider society's macrostructures and patterns within the broader historical context. That is, though this study is situated within the *Centrale* of *Info-Santé*, it is as well examined as a response to political and economic concerns and their resulting macrostructural changes within the health care system and thus its findings can be generalized to similar health care situations beyond this immediate study.

Participation was voluntary, with participants aware that they could withdraw at any time from the project. All participants were *Info-Santé* nurses, with a range of experience at the service from 1 month to 14 years. Seven of the participants hold full time positions. The remainder, though officially part-time staff, frequently works full-time hours; others choose to work only on a part-time basis, the minimum of which is 2 days per week, as stipulated by union contracts. Participants' time since becoming a nurse ranged from 2.5 to 41 years. Three participants were hospital-trained initially, all having proceeded to obtain their Bachelor of Science in Nursing (BScN). In all, nine of the nurses involved in this

study hold this latter educational status. Three nurses hold Master's degrees in Nursing; one has taken courses toward a PhD in Nursing. All other participants hold as a minimum a DEC, *Diplôme d'études collégiales* or Diploma of College Studies in Nursing, a three year technical nursing program, with 6 of these participants having taken courses toward obtaining a BScN. The nurses' range in age was from 24 to 62 years (Appendix G).

The Focus Groups

Two focus groups were held prior to the interviews in order to nominate prime concerns of the nurses and allow me to focus the interview questions according to the major themes arising from each of these groups. The two groups were formed in order to compare and contrast any possible differences in findings between senior and junior groups of nurses, as determined according to their time at the *Info-Santé* service. I chose this distinction based on the hypothesis that newcomers to the service would have perceptions of the overall themes seeking clarification. As Appendices F and G indicate, length of service at *Info-Santé* and length of time as a nurse are correlated.

Given that the participants in this case study are first language French-speakers, consents were administered in that language (Appendix A). Both focus groups were conducted by the researcher in French, digitally recorded and transcribed in French. Translations of excerpts presented in this dissertation are those of the researcher.

Prior to the focus groups, I met with nurses individually to explain the project, read over the consent with each nurse, and answered whatever questions each may have had. They were each given time to reflect on their participation before signing consent forms. The minimum time that nurses took for this reflection was one day, with a maximum of 10 days prior to the first, senior focus group and a minimum of one to a maximum of 23 days prior to the second, junior group's discussion. These differences are attributed to the timing of the two focus groups, with the senior group's discussion taking place 2 weeks prior to that of the junior group's meeting. The availability of potential participants to meet with me for individual explanations of the project and the consent form also contributed to the variations noted above.

Both focus groups were held in a conference room situated on the same floor as the *Info-Santé* service. This room is constructed to minimize sound transmission and is situated between the training office and a stairwell with the waiting area for the elevators directly facing the room (Appendix E for floor layout). Focus group probes, used in both focus groups, are presented in Appendix C.

Senior Group

Nine nurses consented to participate in the senior focus group. With a range of time at *Info-Santé* from 1.5 to 14 years, the average was 7.69 years, with a median of 6.5 years and a mode of 14 years. One nurse with 1.5 years of *Info-Santé* experience was chosen for this senior group having arrived at the service

with 31 years of full-time nursing experience. All other participants in this group had between 2.75 and 14 years of *Info-Santé* experience. The average time since becoming a nurse was 30.1 years with a median of 31 years for this group. These senior nurses are those who "train" ("orient" in nursing parlance) the newcomers, teaching them "how to hear" the caller/patient, how to elicit information that can then be assessed by the nurse in the absence of "physical findings." This senior focus group took place on June 30, 2009. The procedure was digitally recorded and nurses were given time to ask questions pertaining to the consent forms and their participation prior to the start of the group discussion. The discussion lasted 3 hours terminating with positive comments and nurses lingering in the room to talk.

> *"I'm not sure who it (the process of the focus group) helped more, you for your research or us. It is good to reflect on our practice, how we do it and to hear what others have to say. Some of the things said were things I had not necessarily thought of myself." – Researcher's notes*

> *"It was fun, I really enjoyed it."- Researcher's field notes*

Interestingly, two of the more junior nurses who had initially declined to participate in their upcoming focus group, approached the researcher on her arrival at *Info-Santé* the following day, asking for consent forms. Both signed the forms and did indeed participate in the second focus group, held July 13, 2009.

"In the end, I think I will participate. I did not think that I would have enough time with my move this summer, but everyone tells me it was a good experience and I would like to participate." – Researcher's field notes

Junior Group

This second focus group consisted of seven nurses, each having been at Info-Santé 2.5 years or less. The newest member of the team had arrived less than 1 month prior to the focus group's discussion. The average length of time working at Info-Santé for this group was 1.3 years, with a median of 1.125 years and modes of 1 year and 1.5 years (2 participants each). This group averaged 5.25 years since becoming a nurse, with a median of 3.25 years.[4] As was the case for the first group, nurses were given a period of time to reflect on their participation once the consent form was read over with them individually and their questions had been answered. On the day of the second focus group's meeting, July 13, 2009, participants were again given time to ask questions pertaining to the consent forms and their participation prior to the start of the group discussion. The procedure was again digitally recorded and took place over a period of 1 hour and 48 minutes.

[4] Two nurses were "outliers" in this group; one with 17 years since becoming a nurse had only worked part-time throughout her career: maximum 3 days/week in a long-term care facility. Thus while her knowledge of geriatric issues was strong, the number of years as a nurse is not reflective of her "active care" knowledge. This participant's time since arriving at *Info-Santé* was less than one year at the time of data collection. Another nurse with 7 years since graduation was also included in this group, primarily due to this participant's recent arrival at the service: 1.5 years. See Appendix G.

Interviews

As was the case with the focus groups, consents for the interviews were provided in French, the first language of the participants (Appendix B). These were distributed a minimum of 2 days prior to the interview and, following the same procedure as with the focus groups, were reviewed with each potential participant at the time of distribution in order that any questions could be answered. Most participants subsequently brought the signed consent with them to the interview; the remainder gave these to the researcher in advance of the interview appointment. Consents were again reviewed with each participant at the time of the interview and any potential questions were addressed at that time.

All 20 interviews were conducted in French with the exception of one fully bilingual participant who answered questions in both English and French throughout the interview. The individual interview questions were based on ideas generated primarily through the focus group process. Interviewing took place between July 28, 2009 and September 4, 2009. Demographic information was also obtained, particularly with regard to age, gender, nursing education, and nursing and life experience before coming to work at *Info-Santé*. It has been hypothesized by this researcher that these factors, among others, play a key role in the success of the clinical encounter with the disembodied patient. (See Appendix D for interview questions).

Interviews were semi-structured, and averaged about 41 minutes each, with a range from 21 to 87 minutes. As was the case with the focus groups, the

researcher made use of a purposeful, convenience sample, interviewing willing participants.

Interviews took place at a time and place chosen by the interviewees. As was mentioned above, all but one of these was held at the research site in the training room, situated on the same floor as the *Info-Santé Centrale*, in the center of the floor's wing beside the conference room (Appendix E). Access to this room was easier to obtain on short notice, not having to be booked in advance with the institution, as was the case for the conference room. A frosted panel beside the door to this room prevented participants from being seen by anyone in the hallway. The disadvantage to this room was the presence of telephones connected to the *Info-Santé* administrative line, which would occasionally ring and disrupt the flow of the interviews, though they were answered by the *Info-Santé Centrale*. The lone interview that took place in an interviewee's home was the subject of many more disruptions, as the doorbell and telephone both rang, needing to be responded to by the participant. A person seeking a neighbour of the interviewee walked into the interviewee's home to inquire of the neighbour's whereabouts. Another neighbour's lawn mowing provided more disruption, necessitating the closing of windows to allow the digital recording to take place. This was the first interview conducted and the experience led me to appreciate the need for a more controlled environment for the successive interviews. Issues of confidentiality, due to the nature of the subjects under discussion, were also important considerations in the selection of interview sites, rendering public sites such as

coffee shops ineligible.[5] Thus, the choices of the remainder of the respondents to have the interviews take place at the institution for their convenience, allowed for both a more controlled environment than was the case with the one home interview and provided for the necessary confidentiality to assure that answers were as unguarded as possible. Confidentiality of participants was assured by the researcher. All excerpts are credited to participants using coded initials to protect their identity.

All interviews were digitally recorded. Transcription of the interviews was done in French and, once again, the translations to English of the excerpts presented in this dissertation are those of the researcher.

Participant-Observation

In addition to the methods already discussed, the researcher conducted participant-observation. The researcher's ongoing status and more than 12 years of nursing at this site provided a history within the centre which allowed for the conceptualization of the construction of the disembodied caller/patient. As Bourdieu (1992) has noted, a thorough knowledge of the research site facilitates the development of questions for further investigation during the focus groups and interviews. For many calls, a fair amount of consulting takes place between and among nurses in the process of developing an adequate image of the caller/patient

[5] Nurses, as with other members of health care professions, are keenly aware of the need to protect patient confidentiality and avoid discussing patient related issues in public spaces. Thus, participants' choices of interview sites took this aspect into consideration.

before arriving at an appropriate assessment of the needs for care or follow-up. This process permitted me to gather insights into the processes of constructing the caller/patient by most, if not all of the centre's nurses, allowing for the notion that the image generated is, at times, a collaborative effort among nurses.

As a member of the workplace, I had access to informational and training sessions which allowed me to gather distributed materials and note observations, which were later transferred as field-notes to be coded and analyzed with the data obtained from interviews and focus groups. The researcher also attended the annual meeting of L'Association des Infirmières et Infirmiers en Info-Santé (AIIIS) which was held in November, 2008, in Québec City as one of two nurse-delegates sent by the Sherbrooke *Info-Santé Centrale,* at which I collected various documents for future analysis.[6]

Textual analyses

Textual analyses of training documents, internal annual reports, government documents, professional association, and professional order literature and directives as well as relevant web site information, nursing and sociological literature served as important components of this dissertation's data. These provided the historical, political, social and health contexts of the development and evolution of *Info-Santé* services and served to guide this research's sociological perspectives. It is critical that any analysis be grounded in the

[6] This researcher was chosen to attend this conference via a random draw from among all interested parties. Time and expenses were assumed by the employer, the CSSS-IUGS.

historical and political context of the organization under study to allow the researcher a fuller understanding of the issues at hand. This dissertation makes use of these critical aspects of analysis.

Data Analysis

Grounded theory methodology as articulated by Strauss and Corbin (1998) was used to analyze the data collected. This method of analysis is used extensively for qualitative data, deriving theory from the use of multiple stages of data collection, refining and interrelating categories of information. Thus, data was constantly compared with emerging categories in a dynamic process. The method also maximizes the similarities and differences of information by sampling different groups, and using field notes, focus groups, interviews, discursive materials and analytic material. Grounded theory, then, allows for the generation of theory as the research project develops and according to the significance of what emerges from the data.

I sought to code repeating patterns into various broad categories as these began to take shape, initially from the focus groups and subsequently, the interview data. Various explanatory themes also emerged from the data and these were duly noted and categorized. Comparison of the data emerging from senior and junior focus groups allowed for a form of time-series analysis, tracing changes in patterns over time spent at the *Info-Santé* service. Transcript pages were structured in landscape format, with a left-hand column devoted to the data

and a blank right-hand column for note-taking and coding, thus much of the analysis was done using basic manual coding procedures using a word processing program and colour and margin coding to pull out repeated phrasing and ideas from the transcripts. Atlas/ti, a qualitative analysis computer software program, was used in the analysis of Chapter 5, *The Role*; however, subsequent analysis was limited to the manual coding procedures described above. My limited familiarity with the software program in question made the manual methods more fruitful and more satisfying.[7] Given the manageable quantity of data produced in this study, manual analysis as described above was both feasible and rewarding. The three data chapters presented in this dissertation represent the major categories of interest to me that emerged from the data itself.

Implications of this research

This dissertation is a contribution to the sociological literature of health and illness, of the body, of the professions and of communication technology. New techniques for providing health services open up opportunities for new understandings of the body, how it is experienced and articulated to others, how such articulations are "heard" by service providers in the absence of a physical body, how meanings are attached to this "disembodied" clinical hearing. Such an environment, though virtual in many senses, creates real spaces for the emergence

[7] Much debate has taken place with regards to the virtues of Computer-Assisted Qualitative Data Analysis Software such as Atlas/ti. This researcher agrees with Adler and Clark in their belief that "much good qualitative analysis can be done without the use of anything more sophisticated than a word processor – and [we] are inclined to point out that much has been achieved with nothing more sophisticated than pen and paper" (2003; 499).

of theoretically rich knowledge. Within the ever-changing context of nursing, this dissertation provides an analysis of the practices and problematics of the profession in a new, technologically-based, virtual space.

Chapter 3 – Interrelated Frameworks of Analysis

Introduction

Technological transformations in the delivery of health care have affected the health care system as a whole and its numerous constituents. My research was motivated by an interest in how one such technology, the nursing health care service *Info-Santé*, has revolutionized the way we think about health care delivery and those who practice it, and how it has altered professional/client interaction and communication. The metamorphosis of the clinical gaze within the context of telenursing has been a key focus of this project. In the absence of the most fundamental aspect of traditional health care interaction, that of bodily and visual contact at point of service delivery, it is not surprising to find consequences that are multiple and varied. In order to capture the intricacies of some of these repercussions, this study gives voice to *Info-Santé* nurses' perspectives on their roles, their ways of "seeing" in the absence of a physical patient, and their capture of callers' social categories from various qualities of the available acoustic data. Thus, this dissertation elicits the theoretical connections from three conceptual spheres: theories of professions including professional identity formation and knowledge; critical perspectives on the body, health and illness; and medical and nursing communication. Each of these shares the feature of linking micro- and macro level perspectives to issues of power, inequality, and the body in persistent structural hierarchies within everyday life in general and health care systems in particular. In so doing, they offer possibilities for the analysis of knowledge

production and attempts to theorize the ways in which ideas and images are constructed within the social processes inherent in health institutions and systems. The theoretical tenets of symbolic interactionism and social construction are particularly salient in this dissertation.

Theories of Professions, Identity and Knowledge Production

Abbott's (1988) notion of interprofessional competition was introduced in Chapter 1 of this dissertation as an important framework for this study. His formulation allows us to think of inter-service competition from this same perspective, as health care services' jurisdictional boundaries and interdependencies form the basis of that system and these often work in tandem with or in conflict with one another. Within this framework, jurisdictions connect the profession to its work and are understood as areas of contestation between professions as each profession attempts to retain its control over its own activities. These competing claims to professional activities and their attendant ways of knowing are fundamental to the history of professions and thus to the functioning of the health care system (Abbott, 1988; Fisher, 1995; Strauss, 1985; Freidson, 1970; Good and DelVecchio Good, 1993; Atkinson, 1995). Indeed, Abbott's systems approach to understanding the professions offers insight into the repercussions of introducing a new service to a health care system, helping to explain inter-service rivalries and professional identity issues as jurisdictional boundaries are forcibly shifted with the inception and evolution of an additional service. Medicine's continuing dominance over nursing has an irrefutable impact

on these shifting boundaries of knowledge and practice (Fisher, 1995; Strauss, 1985; Freidson, 1970).

Others too have pointed to the dominating power of medicine. For example, Illich (1975) claims that medical power is such that health (as a goal) is supplanted in favour of the primacy of maintaining the authoritative power of medicine and medical workers, physicians in particular. The hierarchical character of the professions is reflected in the hierarchical structure of hospitals which, as a place of multiple work sites with each one interacting with and to varying degrees dependent on others, provides further evidence of the power relations inherent to health care settings, and makes explicit the dominance of doctors over other hospital workers, including nurses (Illich, 1975; Strauss, 1985; Fisher, 1995).

Knowledge production is intimately linked with a profession's power and jurisdictional boundaries (Abbott, 1988; Fisher, 1995; Strauss, 1985; Freidson, 1970; Good and DelVecchio Good, 1993; Atkinson, 1995). Atkinson (1995) provides an instructive initiative in his understanding of the various relations among categories of medical actors and the flexible, situational adjustments in managing hierarchical power relations within diverse hospital work sites. His fieldwork analyzes the language used by haematologists to gain insight into the "doctor-doctor" interaction in order to construct and reconstruct patients as objects of discourse. The interactions he presents are, for the most part, not within the patient's hearing. His interest is the "rhetoric of the clinic" and how this shapes membership, produces and reproduces medical knowledge and, particularly, how the "voice of science" as represented by the haematologists contrasts with the clinician's "voice of experience." His work allows for an

examination of what he calls "the interface between the clinic and the clinical laboratory" (Atkinson, 1995: 3). Indeed, he thinks "of medical work in terms of rhetorical skills which he calls "ethnopoetics" and goes on to remind us that the "clinical gaze" is shaped by language and is socially organized (ibid: 4-5).

Nursing's contested claims as an autonomous profession tend to centre on caring as the justifying attribute in distinguishing itself from medicine and as a foundation for professional identity (Fisher, 1995). Gendered notions long associating caring with women makes this problematic in Fisher's view especially in terms of reinforcing and perpetuating existing power differentials in nursing's relations with medicine. Fisher makes the claim that caring is a necessary yet insufficient discourse for securing professional status for nurses and nurse practitioners. In her view to attain such status, nurses must position themselves in line with current political discourses stressing equality of access to the health care system and cost containment, primary care, health education and associated notions of lifestyle changes. These must be twinned with consumer discourses promoting "a more egalitarian provider-patient relationship" with better information sharing and an increased decision-making power for patients (ibid: 222).

Caring is a concept that is repeatedly raised in both sociological and nursing literature (Reverby, 1987 & 2009; Austgard, 2008; Fisher, 1995; Fareed, 1994; James, 1992). Its meaning, however, is not clearly defined, remaining ambiguous and quite vague as a concept (Austgard, 2008; James, 1992). Reverby (2009) reminds us that caring is work, not only an identity, but an identity that is

historically created and not just an expression of subjective experience. Care is formulated by James (1992) as having three components: organization, physical labour and emotional labour. Comparing women's "carework" within the home to that of hospice nurses, James finds that hospice work, despite the family care model it purports to follow, is more closely aligned with hospital divisions of labour resulting in an inflexibility that conflicts with that model. Organization is the first component of the formula and includes both the division of labour and the organizing of physical labour. Physical labour is prioritized and given "primacy over both emotional labour and „organizing'" as tasks provide the framework for care and are understood as the fundamental component of paid labour's "work" (ibid: 500). Emotional labour will be addressed in more detail later in this section.

For Austgard (2008: 315) nursing care "comes naturally from common sense and practical training." Caring is also understood as a "moral practice" present in the relationship between patient and nurse, and is necessarily linked to professional knowledge and manifested in that relationship "through trust, open speech, hope, and compassion" (ibid: 316). Caring, for Eriksson, (2006, cited in Austgard, 2008: 317) is both a science and an art. In the absence of a clearly defined concept of caring, Austgard (2008: 318) calls for a definition of care and caring at the superordinate level allowing for a "unifying conceptual meaning" that will work to address all forms of nursing care.

Perceived as an attribute of caring, Fareed (1994) examines reassurance within the context of coping. Reassurance has been conceived as both a "purposeful, skilled technique" (Sullivan, 1954 as cited in Fareed, 1994) and as a

"non-therapeutic technique" by Hays and Larson (1963, as cited in Fareed, 1994). A behavioural approach to the term focuses on the activities a nurse does in order to perform "reassurance," with the conclusion that "explaining or giving information is a technique often used in the context of nursing care," however, as pointed out, this assumes that facts are the only elements to understanding (Fareed, 1994: 872). Coping is seen as contingent on self-understanding, linking identity and continuity with temporality (Benner and Wrubel, 1989, as referenced in Fareed, 1994: 872). Thus, reassurance builds on "self-worth, self-respect and self-esteem" and is experienced by the patient as receiving respect and understanding from the nurse who encourages him to identify and cultivate his own resources (ibid: 873). Despite this rather broad formulation of reassurance, the author calls for the development of therapeutic touch as technique of reassurance, leaving us with the question: how is reassurance done in the absence of the physical patient?

For Reverby (2009: 251) nursing's central dilemma is "the order to care in a society that refuses to value care," which she says traps nurses in another dilemma: trying to forge a link between altruism (seen as the foundation for caring), and autonomy (seen as the foundation for professional rights). Nurses and nursing continue to struggle to achieve the power that would afford them the *right* to care with autonomy (as opposed to being *obliged* to care) and pursue political efforts to revalue care (Reverby, 2009, 1987, emphasis mine). Nursing's dilemma, in Reverby's (2009) formulation, is tied to larger issues of gender and class within society, and is not likely to be resolved through any one group's political or professional power. Though she does not offer specific suggestions in this regard,

she claims that we as a society will all benefit from giving care and womanhood new value (Reverby, 2009).

Closely related to the care literature, emotional labour has been theorized as the "regulation and management of feelings" first by Hochschild (1983), and then by James (1989), Smith (1992) and Wharton (2009) among others. Shaped by the process of labour and developed from the social relations between caregiver and care-receiver, emotional labour can be both demanding and highly skilled. For James (1992) emotional labour is the third component in the "care formula" and which is seen by health service managers as marginal in comparison with organizational needs and physical care that comprise the dominant biomedical model. Inherent in the notion of emotional labour is the ideological association of women with emotion and the gendered division of labour and care in general.

The work on emotional labour offered by Hochschild (1983) is a keen analysis of "feeling management" in service sector jobs, professions and in the family, with a particular focus on the case of the flight attendant. Feeling management relates to the need for workers to control their own emotions and is transformed into *emotional labour* once service managers seek to control the process as a formal job requirement (Wharton, 2009). Using Hochschild's (1983) example, the smile of the flight attendant becomes part of her uniform, and is an integral component of the product being sold. Performance with voice-to-voice public contact is subject to similar emotional labour. Hochschild contends that the effect of this disconnect between display and feeling over the long term leads to "emotive dissonance," wherein feelings must change in order to accommodate the

display requirements of the job, resulting in an estrangement from the feelings themselves, an estrangement from oneself. Depersonalizing situations allows the worker to distinguish between her "self" and her "role," though issues of self-esteem become problematic when one sees oneself as doing "deep acting" a term described as a self-induced feeling created by "pretending deeply" versus "surface acting" in which one is able to deceive others but not oneself (ibid: 33). Hochschild tells us that deep acting often results in a defensive stance in which the worker must call upon herself to redefine the job as "illusion making" in order to take it less seriously and protect her self-esteem (ibid: 133). Another response is to "go into robot" by refusing to act at all.

Wharton (2009: 154) reminds us that the study of emotional labour has extended to the professions and presents evidence that "the structure, practice, and professional norms" associated with the caring professions "have the potential to increase or diminish workers' positive experiences of caregiving." The interactional demands of nursing can thus be understood as a proxy for its "emotional labour requirements," making emotional labour integral to the nursing job itself as a performance expectation and moulding both the organization and the experience of work, particularly within aspects of negotiation and reproduction of power relations (ibid: 155).

Within the professions, emotion management is suggested to be part of an informal socialization process, effectively teaching medical students, for example, how to manage their responses. The goal of emotion management is being able to display "the right degree of emotional detachment" to allow for the formation of their professional authority (Wharton, 2009: 153). Cahill (1999, as cited in

Wharton, 2009: 153) refers to these learning processes as "emotional socialization," and the professionals themselves are referred to as "privileged emotion managers" by Orzechowicz (2008: 143, as cited in Wharton, 2009: 152). The classic study Strauss produced with Becker, Geer and Hughes in 1961, *Boys in White*, used a symbolic interactionist approach to understand social behaviour as interaction that is in part shaped and controlled by accounting for the expectations of others. The study's elucidation of the socialization process and attendant practices, the "effort" in Becker's (1961) terminology or the "work" if you like, of becoming a doctor provides a template for understanding nursing as well and its particular socialization processes and attendant practices to initiate its new members to the "work" of becoming an efficient practitioner. Professional characteristics of expertise, power and authority are partly manifested through interactions on the job and in comparison to the service workers described in Hochschild's (1983) work, professionals' efforts are often guided by extensive training, resource support and greater recognition by peers (Wharton, 2009).

Peer recognition is a key facet of membership in a professional group and is addressed by Bosk (1979) who was interested in exploring qualities of membership to understand the ways in which a professional group encloses itself, determining its identity in the way it selects and rejects members; how performance is controlled by superordinates and how that control is either accepted or avoided by those in subordinate positions – here he points to the ways in which "norms of responsibility to patients and colleagues are articulated and how their violations are sanctioned;" and, how limits to knowledge and skills are dealt with by the professional (ibid: 4-5).

The theories of the professions and professional behaviour as articulated above are useful in their elucidation of key concepts for my research, namely: interprofessional competition and its manifestation in inter-service competition; medicine's dominance over nursing; the central place of care as the distinguishing feature setting nursing apart (from medicine) in its claim for professional status; and emotional labour as an integral component in the professional socialization process of nursing. Analyzing and understanding these concepts, the ways in which they intersect and function either antagonistically or synergistically but simultaneously in lived experience is one of the central interests of this research.

Critical Perspectives on the Body, Health and Illness

Foucault's concepts have been crucial to the theoretical framing of this dissertation. The following discussion is an attempt to articulate these concepts and demonstrate how they apply to this project. Foucault's conceptualization of the relationship between "power" and "knowledge" is especially important for understanding the theoretical underpinnings of this research. He elucidates the mutual productivity of power and knowledge, such that "the formation of knowledge and the increase of power regularly reinforce one another in a circular process" (Foucault, 1977: 224). Especially salient for sociological understandings of medicine and its institutions, Foucault considered that particular forms of power required particular forms of knowledge, thus he spoke of knowledge in the plural (Turner, 1997). Knowledge can in this sense be constituted as "situated," and as such can be seen not as knowledge reproduced but rather as recreated into

new, distinct but partial forms (Fisher, 1995; Haraway, 1991; Harding, 1991). The emergence of new types of health services then can be understood as requiring such a reconfiguration of knowledge (s).

One elucidation of power/knowledge is "the clinical gaze," a technology of power and a surveillance mechanism (Foucault, 1975, 1979). Beginning in late eighteenth century, clinical medicine emphasized visibility, on looking and seeing visible symptoms in patients. The clinical gaze is thus understood as an "act of seeing" including being able to measure and magnify (so as to render visible that which is not readily so; "what was fundamentally invisible is suddenly offered to the brightness of the gaze") and to make of the person his disease (Foucault, 1975: 195).

The clinical gaze then is a "dehumanizing practice" reflecting Cartesian notions of mind-body dualism (Scheper-Hughes and Lock, 1987; Turner 1992), seeking to gather information (Fox, 1997) and construct the body through the discourses and practices of health care practitioners (Lupton, 1997; Henderson, 1994).

More recent biotechnologies allow for a deeper penetration of the clinical gaze (Clarke et al., 2003). Henderson (1994) takes the intensive care unit, a prototypical site of biotechnological interventions, to explore both Foucault's concept of power/knowledge and to examine Foucault's notion of the clinical gaze and its power in medicine, making of the body "an object of inquiry" (ibid: 936). The consequences of that gaze are made manifest in the impersonal interactions between the doctor and the patient as the body is reduced to machine-like status, and vestiges of the personal are removed from the patient in the

clinical setting. The clinical gaze is in effect the method used in the collection and construction of knowledge. Nurses' use of the clinical gaze parallels this process and is concerned with both what nurses look for and where they look. Indeed, in the intensive care setting the patient's body is the object of panopticon-like surveillance, enclosed as it is in a glass-walled cubicle, attached to monitors, and subject to a variety of tasks requiring 24-hour observation[8]. The task-oriented nature of intensive care nursing is richly described as is the importance of "the chart" as pivotal to the organization of these tasks in the formation of knowledge about the body, while subjective notations regarding the patient's emotional and social statuses are minimal at best. Henderson concludes that the quality of the nurse-patient relationship is adversely affected by practices of the clinical gaze which give primacy to the documentation of biochemical and physiological measurements. The knowledge derived from such readings is seen as "powerful in promoting communication which the doctor deems meaningful" but which is "deficient in social and emotional sense," depriving the nurse the power of "the traditional role of „caring'" (ibid: 938).

Others (Ellefsen, Kim and Han, 2007) have sought to describe a "nursing gaze" as distinct from the clinical (medical) gaze while Liaschenko (1994:17)

[8] Foucault's (1977) metaphor of the Panopticon to describe the regulation and surveillance of bodies is useful here. The Panopticon is an architectural arrangement of a circular formation with a central tower at the centre. Individuals are isolated from each other in cells within the circular formation but remain open to constant surveillance from observers in the central tower. Though this arrangement is used by Foucault to describe the self-surveillance of the isolated individuals who are unable to determine when they are being watched and so regulate their behaviour as though they are always being observed, in such a medicalized setting self-regulation is more limited. The usefulness of the metaphor, in this instance speaks more to the differentials in power relations between those watching and those being watched: "The Panopticon functions as a kind of laboratory of power ... knowledge follows the advances of power, discovering new objects of knowledge over all the surfaces on which power is exercised" (ibid: 204).

argues that "nurses are the main instrument of the medical gaze," and Lees et al (1987) suggest that the nursing gaze is tied to the medical gaze. In Ellefsen, Kim and Han's (2007: 102) formulation, the nursing gaze is concerned with first, *normality* (the standard by which the patient's status is measured) and *needs* (based on the nurses' perspective of patient characteristics, social and emotional responses to illness and its experience) within the "ontology of client" and second, *clinical expectations* within the "ontology of practice" (understood as the nurses' awareness of medical diagnosis, clinical status and context). In this sense, "health is viewed both through an illness experience perspective and through a medical disease perspective" (ibid: 104). From these authors' perspective, it is the *needs* component as articulated above that distinguishes the nursing gaze from the clinical (medical) gaze.

With the clinical gaze thus formulated, the question this dissertation seeks to address is how the clinical gaze is accomplished in the absence of a physical patient?

Foucault's concept of *bio-power* is conceptualized as a reformulation of power/knowledge acting to extend the effect of the clinical gaze to discipline *populations* and thus act as "an agent of transformation of human life" (Foucault, 1978: 142-143). In its application and through its practice, bio-power seeks to compare individuals, their bodies and behaviours in scientific terms according to a constructed version of the "norm." Power thus exercised, constitutes "a political anatomy of the body," or *bio-politics* through which strategies of *governmentality* are operationalized. Governmentality is conceptualized as the intersection between "technologies of domination (including discourse)" and "technologies of

the self" (Foucault, 1988: 19). Governmentality and its discourses rely upon diffuse mechanisms of power which "encourage" compliance in individuals and populations through practices of self-regulation and surveillance (Foucault, 1991; Gordon, 1991; Lupton 1995; Turner, 1992). Discourses of compliance and normalization can thus be interpreted as exercises of power and should be seen within the wider societal context of power relations (Gastaldo and Holmes, 1999; Crawford, 1980; Conrad, 2007; Lupton, 1995, 1997; Armstrong, 1994, 1995). Gastaldo and Holmes (1999) remind us that some groups are more vulnerable to normalizing judgements, for example, psychiatric patients, the elderly, the poor, immigrants, natives, non-whites, and non-English speakers or minority language groups, depending on the social context.

Foucault's (1977) concept of power/knowledge has served as an important challenge to positivist notions of the neutrality of science and scientific knowledge, insisting as it does on the contextualization of that knowledge (Gastaldo and Holmes, 1999: 234; Turner, 1992). This contextualization includes relating science's regimes of truth, discourses that science accepts and applies as true, to those of the larger society. Science, then, is political and nursing is part of "the process of government" (Nelson, 1994 as quoted in Gastaldo and Holmes, 1999: 234). Foucault's insistence upon the examination of the effects of knowledge production, discourse dissemination and professional practices leads us to the conclusion that these act to "discipline" and are in fact means of "surveillance," as information is gathered about individual bodies and compared with others in the search for "normality" (ibid: 235). The constant shifting of power relations allows for possibilities for social transformations; the search for

these should begin with "an analysis of nursing practices in distinct clinical settings" (Gastaldo and Holmes, 1999: 235).

In contrast to claims suggesting *care* as a collaborative effort between nurse and patient, a Foucauldian framework portrays "care as an exercise of control over the patient, as embedded in prejudice, as a conflictive practice or as a site for dispute with other professionals, among others" (Gastaldo and Holmes, 1999: 235). Caring thus reappears as control of both the patient and his/her environment, along with the creation of knowledge that in effect empowers the nurse. Nurses' power relations in this formulation can be understood as both controlling and controlled.

Gastaldo (1997) also addresses health education as bio-power. Her notion is that health education is an exercise in power by health professionals which works to increase the efficiency of the clinical gaze and, at the same time, can be understood as a method for governing the population, as the population seeks to discipline itself through its use of health information (Gastaldo, 1997; Lupton 1995). Thus, health education's effect is to construct identities, telling us what it is to be "healthy" and "sick." The success of health education can be judged by people's behavioural changes effected without their feeling imposed upon to make those changes, thus it is, in Foucauldian terms, a positive or constructive power (Gastaldo, 1997; Foucault, 1977).

Foucault's notion of bio-politics is seen in the promoting of health as a political strategy wherein disciplinary power is operationalized through health care practices and policy. Indeed, the World Health Organization (WHO) has made health promotion an international strategy aimed not only at the individual

level but as an attempt to achieve equity through the reduction of social inequalities and in supporting community participation in health-related issues (Gastaldo, 1997; Ottawa Charter for Health Promotion, 1986). As such, health education policy can be understood as a "double-edged sword" in its capacity to both manage designated groups within the population, or to empower groups who would benefit from healthier lifestyles and making informed decisions (Gastaldo, 1997; Lupton, 1995). An overview of Brazilian national health policies illustrates Gastaldo's (1997) above contentions and gives a fine analysis of Foucault's notion of bio-politics as practices which discipline the body through training. The rules for access to Brazilian clinics, with patients lining up well before the health centre opens, provide a powerfully descriptive example of this discipline and one which applies as well in many Quebec clinics today.

Health education is considered by many as "good for you" but, as Gastaldo (1997) reminds us, it also serves to manage both individual and social bodies through its processes of expanding the clinical gaze to one which encompasses the whole of the population. It can thus be understood as both empowering and subjugating in its range of practices.

The rise of the ideology of individual responsibility for health illustrates the changing role of the patient (Crawford, 1980). While Illich (1975) felt that individual responsibility had been erased by the imperial nature of medicine and medical practices, Crawford (1980) draws our attention to the rise of self-help and self-care ideologies and how these attempt to transfer medical competence to the individual. Self-care, as a current trend in nursing practice, is itself seen as a form of social control via self-regulation and self-discipline though which discourses of

compliance and normalization act in line with Foucault's concern of self-surveillance (Gastaldo and Holmes, 1999). Nursing thus can be explained "as an agency of governmentality in the era of bio-power" (ibid: 238). The effects of power are not only coercive but also must be understood as positive and productive (Foucault, 1980).

Using the ideology of medicalization, the process wherein nonmedical problems are repositioned and treated as medical problems (Zola, 1972), Crawford (1980) explains his notions of healthism, the preoccupation with and primacy given to personal health and wherein both cause and solution to medical problems are seen as proximate in nature. Since Crawford's initial formulation, this notion of individual responsibility has not only retained its place in contemporary Western society but has become ever more pervasive especially in the "risk" literature and exemplifies Foucault's notion of self-surveillance (Lupton, 1995; Turner, 1992). The ideology of healthism has the effect of depoliticizing and undermining wider social efforts to improve health, and in this way protects the social order from scrutiny, critique and restructuring efforts aimed at the wider, more distal social causes of ill-health.

Carl May (1992) uses a Foucauldian analysis in his assessment of nursing work and nurses' knowledge, to conclude that discourse allows for an integration of "patient as *body*" and "patient as *subject*." His hospital-based study of nurses working in an oncology ward, describes nurses' knowledge as a blend of "foreground" and "background" knowledge. The former he describes as that which arises from clinical definitions of the body, and concerns the nursing work practices associated with those definitions. This knowledge is primarily made

available through communication between doctors and nurses, via either verbal exchanges or the patient's chart. The patient's *body*, then, is understood in relation to a "set of technical knowledge" and all those, professional and paraprofessional, who make use of that knowledge (ibid: 474).

"Background" knowledge is understood as the nursing work of gathering social information about the patient as an individual subject, getting to "know" the "whole" person by developing a relationship with the patient, in which the patient shares personal information with the nurse. The melding of these two forms of knowledge creates an image of the patient that has practical application to the nurse's work and gives meaning to nursing work. Ideological notions of nursing and nursing work can be located in this space; "getting to know the patient" is understood by one of May's respondents as "the nurse's 'traditional, listening, caring' role" (ibid: 482).

Gerhardt (1989) noted, this incursion into the social broadens the scope of what is available to medical control; now not just seen in terms of his body's pathology, the patient is also a "social" case (Armstrong, 1983). The reach of the clinical gaze increases as nurses are "getting to know the patient," demonstrating the nurses' exercise of power, which patients may in turn block by remaining silent or limiting what they reveal about themselves as an act of resistance. Thus, May concludes, the "reconnection of subject with object" as promoted within current holistic concepts of nursing, may in fact return to the patient the power to "enter into this process herself" (1992:486).

In conceiving of the hospital as a place of multiple work sites, Strauss (1985) examined the power relations inherent in the hierarchical nature of the

hospital and their effects among hospital workers as social actors and on the patient/actor, first as the recipient of "work" *done* to her/him and also, to the "work" *of* the patient. Thus, in his formulation, the patient/actor is not always a passive participant in her/his "care" (i.e. the "work" of others) but is often actively engaged in "being" (a) patient. Indeed, May's (1992) nurse respondents delineated "good" and "bad" patients, based on their ability to either facilitate of impede nursing work.

Strauss's (1985) analysis of particular actions as work is compelling, for instance the "work" of being a good patient, of dying with dignity, of living within the limits of debilitating illness. Such analysis invites the "patient" as an actor "back in" to the relation under analysis, something that some such studies neglect to the detriment of the overall analysis. The patient/client gives legitimacy to the role of doctor (or nurse) and vice versa. The roles are defined in relation to the other, to each other. The study of professions is enriched with an analysis of both the professional and her/his patient/client. They require each other to complete the relation.

Theories of Medical and Nursing Communication

Advances in (bio)-technology have had transforming effects on the organization and practices of medicine and nursing (O'Neill, 2004; Starr, 1982; Abbott, 1988; Freidson, 1970; Clarke et al, 2003; Haraway, 1991, 1993; Lock, 2000; Das, 2000; Leppänen, 2009; Snelgrove, 2009). Some of these technologies, for instance telehealth (Clarke et al, 2003; Botsis et al, 2008; Légaré et al 2010),

and telenursing (Goodwin, 2007; Stacey et al, 2003; Snelgrove, 2009) have direct bearing on communication among health professionals and between health professionals and their patients. Whether biotechnological advances lead to iatrogenesis (Illich, 1975), function as "the good gift" (O'Neill, 2004: 75 &77), or are constituted as "technologies of the self (Foucault, 1988:19), there can be no doubt that the biomedical revolution has consequences for individuals and society.

Clarke et al (2003: 166) remind us to render visible "the realms and dynamics of the social *inside* scientific, technological, and biomedical domains" such that spaces allowing for "greater democratic participation" shape "human futures *with* technosciences." Central to their argument is the notion that the strategies of biomedicalization[9] are contingent; that patients and health care providers respond to, negotiate and attempt to influence technological innovations and organizations to realize their own needs; and that while the forces of biomedicalization are often furthered, they are also resisted, as personnel negotiate their own stances within the particular circumstances of their practice. Biomedicalization's characteristics outlined above offer a lens through which the advent and evolution of telenursing as a practice can be understood.

Telenursing practices employ variations of sophisticated computer software which serve to standardize nurses' advice and minimize risk for callers by providing safe and consistent service all the while highlighting a notion of universal rationality (Snelgrove, 357). Guidelines or protocols, set out in

[9] Biomedicalization is the term Clarke et al (2003: 164) use to describe the resulting processes brought about by way of the evolution of medicalization through technoscientific innovations and "associated new social forms." It is characterized by five overlapping processes: political economic shifts; an increased focus on health, risk and surveillance; the technoscientization of biomedine; transformations of information and the production and distribution of knowledges; and the transformation of bodies and identities (ibid: 166).

algorithmic form, arrange symptoms according to a descending order of importance. Nurses choose the "right" protocol to follow to address the caller's symptoms. Some of these software programs direct the nurse through a script-like series of questions to ultimately arrive at the "proper" protocol (Larsen, 2005); while in others, questions are generated by the nurses themselves, based on their clinical nursing knowledge (*Info-Santé* protocols fall into the latter category). The more proscriptive programs are utilised in for-profit centres, such as those in Australia, where constraints on nurses' autonomy and time are more tightly imposed (Larsen, 2005).

As a practice that attempts to "see" and "see into" the physically absent body of the caller, telenursing also calls for the implementation of unique communication strategies. While new communication technologies proliferate online and also include increasing use of texting and blogging, the telephone has seemingly lost its importance as a communication tool. Indicative of this is Turkle's (2011) qualitative study *Alone Together – Why We Expect More From Technology and Less From Each Other* in which she examined the world of communication technology and the internet. Though constantly "on call" and carrying a BlackBerry, being "out of range" for an incoming call prompts the comment "thank goodness, I need a rest" from one of Turkle's respondents (2011: 202). Another respondent states, "a call feels like an intrusion. . . and if they [friends] call me, I feel like they are intruding ... After work – I want to go home, look at photos of the grandchildren on Facebook, send some e-mails and feel in touch. I'm tired. I'm not ready for people – I mean people in person" (ibid: 203). Turkle attributes this phenomenon to the telephone's "design flaw: it can only

happen in real time" (ibid). For respondents, the solution to the "problem" of the telephone is texting (ibid: 202). Voicemail can now be transcribed to text, and visual voicemail from Apple "saves you the trouble of having to listen to a message to know who send it" (ibid: 206). Blogging allows for a continuous news feed of everything and anything from mundane events to moments of celebration. Not having to attend to family and friends in real time by way of these technologies is in stark contrast to the telephone's very *human*-based communication demands and telenursing's key strategy: the voice, as it is available in real time, through the telephone. The telephone is, for telenursing, the technology that links nurse and caller; it is the conduit for the telenursing interaction as this is allowed for and supplemented by the highly complex call distribution and monitoring systems, managing and recording incoming calls from a wide geographic area.

The voice, however, is the means through which the consulting interview takes place. Mishler (1984, 2009) offers an analysis of the structure of doctor/patient interviews in seeking to elaborate the intricacies of both their form and content and in the context of discovering what makes for a "humane practice." In so doing, Mishler attends to various features of the talk that act to produce four distinct but interrelated phases: description, analysis, interpretation, and interruption. The doctor, through the use of his questions as the "voice of medicine," generally is able to control the "voice of the lifeworld," that of the patient. For Mishler (1984: 14), a "voice" specifies the relationship "between talk and the speaker's underlying framework of meaning," thus we can understand the "voice of medicine" to signify "the technical-scientific assumptions of medicine"

and the "voice of the lifeworld" to represent "the natural attitude of everyday life." Interruptions occur when the voice of the lifeworld interjects additional information into the typical pattern of these interviews which the doctor can then choose to ignore in order to regain control of the interview or grant meaning to the patient's account in attending to. Mishler points to the power asymmetry inherent in doctor-patient relations as evidence of the persistence of the biomedical model which erases the social context of meaning so vital to a complete appreciation of the patient and his health problem. For Mishler, the objective of a humane practice lies in empowering the patient through the recognition and respect of her lifeworld.

In his analysis of medical encounters, Waitzkin (1991) concerns himself with doctors' avoidance of their patients' social problems while focusing solely on their physical complaints, thereby bypassing patients' emotional worries and acting to reinforce many well known social determinants of illness (Wilkinson, 2005; Marmot and Wilkinson, 2006).[10] For Waitzkin (1991) structures of medical discourse through which professional dominance is maintained, must be altered to allow "patients to tell their stories" without marginalizing contextual issues that connect patient to problem (ibid: 273). Avoiding ideological and controlling uses of language, fostering a "progressive" and open relationship, avoidance of medicalizing non-medical problems, assessing the social origins of patients' distress and changing the "ideologic (sic) foundations of medical practice" are

[10] This is in contrast to Ostwald's (1964: 11) understanding of medicine's role where he sees the doctor as concerned "with total human functioning: the way the body works, how patients think, what they feel, and their activities in family and social situations."

Watizkin's proposed solutions to overcoming the harmful consequences of typical medical communication practices (ibid: 276).

In contrast to these analyses of medical encounters, Fisher's (1995) study was a comparison of doctor and nurse practitioner encounters. Marked differences were noted with doctors consistently seeking to maintain their professional authority and marginalizing social and biographical aspects of their patients' lives, while nurses demonstrated more fluidity in moving both to maintain and deconstruct the typical asymmetry of these encounters without marginalizing social and biographical contexts. Where doctors tended to reinforce dominant ideological gender assumptions (as was true in Waitzkin's (1991) analysis as well), nurses were less likely to make these assumptions. These differences affected both decision-making, ways of delivering care and consultation outcomes. Though Fisher noted struggles between patients and nurses in their encounters, these focused on treatment decisions and not on diagnosis as was the case for doctors. In the consulting encounters, nurses paid attention to the context of patients' lives in contrast to doctors who chose to ignore this aspect. These features of the nursing practice as distinct from the medical, indicate moves on the part of nurse practitioners toward "humane practice" called for by Mishler (1984) and the "progressive relationship" espoused by Waitzkin (1991).

For Ostwald (1964: 11), a principal focus of the medical interview is the patient's "sign-making behaviour" whether this is "linguistic, paralinguistic, or kinesic" each of which requires interpretation by the physician. However, it is the "communication without words" that is highlighted in this particular study. While representative of the traditional medical consultation, it is precisely this visual

form of body talk that is unavailable to the practice of *Info-Santé* nursing. In this sense, the " language of the body" is spoken through the body as a whole: the total appearance, height, weight, etc and including the "body images" incorporated by the patient as signifiers of assimilated cultural concepts; the surface of the body: qualities of the skin, colour, texture, hair distribution; the face: expressions, features, eye contact or avoidance; posture, movement and gait of the body; the hand and feet can not only indicate the presence of disease, arthritis for instance, but can also speak to work history, and perform signs of nervousness (finger-tapping, chewed nails, for example); and finally smell can alert the physician to a number of health problems such as diabetes or alcoholism. Gale (2011: 241) concurs with these notions suggesting that observation of the body "is key in osteopathy."

In addition to these visual and olfactory clues, body sounds are attended to since for Ostwald (1964:17) these are necessary to allow the physician to "get more than a fragmented and self-contradictory impression of what is wrong with his patient." Speech is analyzed from a content perspective and descriptions of the repertory of possible sounds including sighs, wheezing, coughing, laughter, and crying are addressed as well as speech intonations, pauses, voice intensity, and the rate of speech as these point to physical or emotional problems. Ostwald (ibid: 20-21) reminds us that "meaningful sound-making originates in the nuclear child-mother relationship" and is therefore culturally situated. He concludes by suggesting that an appreciation for acoustic signals is a neglected but necessary component of effective communication. These acoustic signals shape the limits to the practice of "seeing" an *Info-Santé* caller.

In her study of complementary and alternative medicine (CAM), Gale (2011: 243) considers that observations and "the words of the patient should be triangulated" with touch (palpation) to allow for a complete image of the embodied patient. "Body-talk" for Gale is the notion that of the embodied patient as an active recipient of healthcare wherein the body communicates its needs and distress whereas "body-story" conceptualizes the interactional character of the therapeutic encounter. Narrative constructions inherent in these alternative therapeutic encounters challenge "biomedical and Cartesian notions of the primacy of mind over body" (ibid: 249). Gale considers CAM a form of body work which demands a "listening to" as well as a "working on" component to the mutually derived, though still asymmetrical, relation between patient and practitioner.

In addition to these eminent works, a number of nursing studies (Larsen, 2004; Leppänen, 2009; Holmström and Höglund, 2007) have examined communication between nurses and clients within the particular context of telenursing. These have focused on a range of nursing rather than communication issues per se, but are necessarily manifested through communication strategies. Leppänen's (2009) and Larsen's (2004) concern is with understanding how power operates in interaction between nurses and callers with a focus on how that power is linked to nurses' professional autonomy while Holmström and Höglund (2007) present an analysis of five themes of ethical dilemmas arising from telenursing practice interactions. Detailed findings from these studies will be incorporated into the data chapters to follow.

Aranda and Street (1999) study nurse-patient interaction in the context of life-threatening or terminal illness in order to assess the extent to which nurses are "authentic" or "chameleon-like" in their relationships with patients. "Being authentic" incorporates the value of being genuine and presents the dominant view of the nurse-patient interaction while "being a chameleon" allows the nurse to "become the sort of nurse the person (patient) required" (ibid: 75). This latter approach can be understood as emotional labour (Hochschild, 1983; James, 1992; Wharton, 2009) and adds to the concept of reassurance described earlier in this chapter (Fareed, 1994). Being a chameleon involves structuring the relationship with the patient and/or the family in order to deliver what is considered "good" holistic nursing care, often through the use of strategies to enlist the patient's cooperation with treatment such that the patient is enticed into being a "good" patient. The emotional labour of the "chameleon" is seen as potentially harmful to the patient. Aranda and Street's (ibid: 81) call for structuring nurse-patient relationships "in similar ways to social relationships" would seem to exclude an understanding on the part of the authors that all interaction is social and mutually constructed.

The theoretical underpinnings presented above provide an overview of this study's analytical framework. This synopsis illustrates the intertwining of many of the concepts described as these provide the groundwork for the upcoming chapters.

Chapter 4 – The Emergence of Info-Santé

Author's note: a version of this chapter entitled "Info-Santé: A Brief History of Telephone Health Care Consultation in the Eastern Townships" was published in the *Journal of Eastern Townships Studies*, 2009 (34):77-86.

Introduction

How does a population learn health self-care strategies? How do people know where to turn when they or a loved one is ill? How do they know where to go to consult a physician for a health problem? How do they know when a health problem is serious enough to require a physician's intervention? In the not-so-distant past, in the rural settings of the Eastern Townships of Quebec, the setting of this case study, they would perhaps have picked up the telephone and called their local general practitioner for advice. The general practitioner would listen, evaluate the problem and decide if he needed to head out to see the person at her/his home or if the person could wait until the next day and come in to his office to be evaluated. Or perhaps he would tell the person that the problem was simple enough to manage at home, and would offer care suggestions. Perhaps he would only listen, providing a supportive role for an anxious person on the other end of the line. Only in the direst of situations would the general practitioner suggest going to the hospital. One could say that this, then, was the initial version of a "disembodied" health service, in that the initial health evaluation took place over the telephone, in the physical absence of the patient.

One advantage held by the general practitioner of these past days was his/her knowledge of the social circumstances of the patient. Small communities lend themselves to frequent opportunities for personal contacts between health professionals and their patients, outside the doctor's office, allowing for a physician's intimate understanding of many of the determinants of health at play in a particular patient's or a whole community's health status. Under these circumstances, it is easy to see that the telephone assessment referred to in the above scenario, is informed by a pre-existing professional and perhaps personal relationship, and is not a first encounter as is the case with calls to the nursing service under investigation. Thus, a more holistic view of the patient was available under these conditions to inform that "disembodied" telephone consultation.

With the passage of time, and the advent of Medicare, much has changed. Medical care has become much more sophisticated; general practitioners are less willing to sacrifice their private lives to the demands of patients at all hours of the day and night, indeed "contemporary doctors reject the notion of medicine as a "calling," reflecting the rejection of religiosity in a secular world" (Turner, 1995: 28-29). It is noteworthy in light of the frequent mention of doctor shortages that the number of "family doctors grew from 95 to 98 per 100,000 population from 2001 to 2007. Yet the percentage of people with a regular family doctor fell from 88% to 85% nationally, ranging from 74% in Quebec to 93% in Nova Scotia in 2007" giving support to Turner's claim (CIHI, 2009: 65). As a population, we seem to have more demands of what we want from physicians, we seek to be more engaged in our own treatment and are "less tolerant of mild symptoms and

relatively benign problems" than we were in the past (Guadagnoli and Ward, 1998; Barsky and Boros, 1995 as cited in Conrad, 2007:46). We want fast relief from pain or discomfort, we want immediate attention for our problems, and we want all the latest tests to confirm our own or our doctor's suspicions. We have become health care consumers and we expect the health care market to perform like any other marketplace (Conrad, 2007).

As a result of these particular changes, coupled with an ideological shift concerning the traditional medical model of delivering health care and political pressures to reduce health care spending with a move away from the hospital setting and toward more ambulatory care (known in Québec as the *virage ambulatoire) Info-Santé* was born (CSSS-IUGS, 2006; Gouvernement du Québec – Ministère de la Santé et des Services sociaux : Direction générale des programmes, 1994; Gouvernement du Québec – Ministère de la Santé et des Services sociaux : Direction générale des programmes et Direction générale des services de santé et de médecine universitaire, 2007).

The purpose of this chapter is to trace the evolution of the *Info-Santé* service in the Eastern Townships and situate that evolution within a particular ideological paradigm, thus providing the reader with a context for the findings from the case study to be presented in subsequent chapters.

Restructuring Care

Universal health care systems are increasingly under threat by extensive reforms within the health care sector, putting at risk fundamental underlying

equity principles of those systems, namely: equal access to health care services for equal need as well as equal use of those services for equal need (Hanratty, Zhang and Whitehead, 2007; van Doorslaer, Masseria, and Koolman, 2006). It is important to note then that everyone has basic needs for care and that need will vary according to one's geographic, demographic and or socioeconomic situation (Hanratty, Zhang and Whitehead, 2007). The restructuring of health care nationally and internationally and the resulting shift toward ambulatory care was a consequence, at least in part, of neoliberal ideology (Navarro, 2007; Coburn, 2004; Sen, 2003). In the early 1990s, the Canadian federal government followed other Organization for Economic Co-operation and Development (OEDC) countries in seeking to reduce substantial deficits and deal with a weakening economy by decreasing public spending in general, and health and social service transfers to the provinces in particular (CIHI, 2009; Detsky et al. 2003; Armstrong and Armstrong, 2009). The period of 1992-1996 saw an actual reduction in health care investment in Canada: "In 1992, health care consumed 10% of the gross domestic product (GDP). By 1996, it had fallen to 8.9% and would not reach 10% again until 2002" (CIHI, 2009: 18). Indeed, cash transfers from federal to provincial governments decreased in proportion, on average from "30.6% in 1980 to 21.5% in 1996" (Detsky et al., 2003: 805) This, in turn, forced provincial governments to slash health spending and seek alternatives to high cost hospital stays in order that they, too, could balance "their budgets and ...pay down their debt" (CIHI., 2009: 19; Detsky et al, 2003: 805).

Medicine is thus understood as being "increasingly integrated into the organs of the state: just as the economist and the merchant are responsible for the

economy of material values, so the physician is responsible for the economy of human values...It is absolutely necessary that the physician contribute to a rationalized human economy, that he recognize that the level of the people's health is the condition for economic gain" (Agamben, 2002: 145). Turner too reminds us of the Marxist view that professions "exercise control on behalf of the capitalist class, under the auspices of the state" (Turner, 1995: 132).

An understanding of the context of *Info-Santé* within the Quebec health care system is enriched through a discussion of how primary care operates as a critical component within that system. Primary care is defined as "that level of a health care system that provides entry into the system ...provides person-focused care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere or by others" (Starfield, 1998, as quoted in Macinko, Starfield and Shi, 2003: 832). Primary care "has been shown to exert a positive influence on health costs, appropriateness of care, and outcomes for some of the most common medical problems" (Macinko, Starfield and Shi, 2003: 832, citing Bindman et al., 1996; Engel et al., 1989; Kohn and White, 1976; Moore 1992; Roos, 1979).

Research into primary care has often focused on matters of access (Romanow, 2002; Clair, 2001). Since primary care is, by the World Health Organization's 1978 definition, the first level contact with the health care system, matters of timely access to primary services for individuals and families are crucial (Marchildon, 2005; Armstrong & Armstrong, 2008; Macinko, Starfield and Shi, 2003). Indeed, a strong primary care system has been shown to have a multitude of significant positive health outcomes, to significantly reduce some of

the effects of socioeconomic inequalities, and is particularly effective in reducing premature deaths from a number of key preventable or treatable illnesses. Despite the evidence supporting the positive impacts of strong primary care, health reforms within the Organization for Economic Co-operation and Development (OECD) countries have not been shown to give prominence to improved primary care (Macinko, Starfield and Shi, 2003). Problems with access have become more apparent as primary care doctors seek more regular working hours while the population has increased demands for expanded office hours to respond to changes in workplace and family commitments (Armstrong & Armstrong, 2008).

New technologies and perceived political imperatives to manage costs of the overall health care system, particularly by decreasing the use of secondary and tertiary health services, have resulted in the restructuring of health care services to increase the availability of services provided in the community (Armstrong & Armstrong, 2008; Macinko, Starfield and Shi, 2003). [11]

Among the increasing range of services available to people in their homes is the advent of telephone advice services such as *Info-Santé*, a publicly-funded telephone nursing service that is available throughout the province of Québec on a twenty-four-hour, seven-day-a-week basis. This level of accessibility provides the population with a much-used resource in the current health care atmosphere of increasingly restricted primary care services and provides this accessibility from the caller's home, workplace or wherever the caller may access telephone services

[11] Secondary health services are those services provided by specialists, such as obstetricians and dermatologists, within the community. In Quebec, these services are primarily available by referral from a general practitioner. Tertiary care refers to highly specialized, and highly technological, advanced treatments, such as heart transplants, available for the most part at large teaching hospitals or dedicated centres for specific health problems that are equipped with state-of-the-art facilities.

(CIHI, 2009; Pineault et al, 2009; Goodwin, 2007; Stacey, 2003). The use of such a service is also intended to reduce inappropriate emergency room consultations (Goodwin, 2007; Stacey, 2003; CIHI, 2009; Gouvernement du Québec, *Cadre de Références*, 1994, 2007). In keeping with the goals set out in the Ottawa Charter for Health Promotion (1986), *Info-Santé* has as part of its mandate, health promotion and prevention of disease and injury through health education (Gouvernement du Québec, *Cadre de Références*, 1994, 2007). Details of this mandate are presented in later in this chapter.

What is Info-Santé?

Info-Santé is a 24/7 nursing telephone service offered through the CSSS (*Centre de santé et de services sociaux* – Health and Social Services Center – initially known as *Centre local de service communitaire* or *CLSC*) system, to provide health and referral information[12]. Its history in the Townships dates back to September 14, 1995 with the opening of its services in Sherbrooke, but the concept of *Info-Santé* within the province of Quebec goes back to 1981 (CSSS-IUGS, 2006; Gouvernement du Québec – Ministère de la Santé et des Services sociaux: Direction générale des programmes et Direction générale des services de santé et de médecine universitaire, 2007). Though this chapter focuses on the service's growth in the Eastern Townships, a brief sketch of its evolution within the province provides a useful context.

[12] *CLSCs* do still exist throughout the province, but within the *CSSS* system and with a more limited mandate than prior to the introduction of the *CSSS* system.

In 1981, a similar type of service was initiated in Montreal as part of the access to ambulance emergency services. The Pope's visit to Québec City in 1984 and the visit of the Tall Ships that same year saw the initiation of a telephone referral centre developed in Québec to respond to the anticipated health and reference needs of large numbers of visitors to the City. Subsequent to these two large events, the service was expanded and refined. The *Ministère de la Santé et des Services sociaux du Québec* (MSSS) in 1991, approved the dissociation of *Info-Santé* services from those of the ambulance service, *Urgences-Santé* (CSSS-IUGS, 2006; Gouvernement du Québec – Ministère de la Santé et des Services sociaux: Direction générale des programmes et Direction générale des services de santé et de médecine universitaire, 2007).

The official opening of *Info-Santé Montréal* took place in 1992 and was followed by similar openings across the province. The principal functions of the newly created *Info-Santé* service, as laid out in the 1994 *Cadre de Référence – Frame of Reference,* were: "*l'accueil/évaluation, l'information/conseil, et l'orientation/référence*," in English: initial contact/evaluation, information/advice, and orientation/reference (14-15).

As noted above, the opening of the *Centrale Info-Santé Estrie* in Sherbrooke took place on September 14, 1995. By the end of 1996, each CLSC in the province offered the *Info-Santé* service. This includes each of the seven CLSCs that make up the Estrie 05 territory, namely, Asbestos, Coaticook, Haut-St. François, Granit, Memphrémagog, Sherbrooke (which itself was initially composed of two separate CLSCs – Gaston-Lessard and SOC), and Val St. François (Gouvernement du Québec – Ministère de la Santé et des Services

sociaux: Direction générale des programmes et Direction générale des services de santé et de médecine universitaire, 2007; Info-Santé CLSC, 2002).

Coinciding with the birth of *Info-Santé* services came the closure of two acute hospital care facilities located in Sherbrooke that had long served the entire Eastern Townships. July 1995 saw the merger of the Centre Hospitalier Universitaire de Sherbrooke, Hôpital St. Vincent and Hôpital Hôtel Dieu as a new entity under the name of the Centre Hospitalier Universitaire de Sherbrooke, the CHUS. April 1st, 1996 saw the merger of Sherbrooke Hospital with Hôpital d'Youville, a local geriatric centre, to become the *Institut Universitaire de Gériatrie de Sherbrooke* - The University Institute of Geriatrics of Sherbrooke, more commonly referred to as the *IUGS*. This was closely followed by the complete closure of the *Pavillion* St. Vincent of the CHUS in 1997. These large institutional closures and mergers necessitated a vast restructuring of health services in the city of Sherbrooke and precipitated the forced redeployment of medical, nursing and ancillary personnel. Indeed, nurses displaced by the closure of these acute care facilities were among the first to staff Sherbrooke's *Info-Santé* central office, the *Centrale*.

These major restructuring efforts saw the number of acute hospital care beds in the city of Sherbrooke reduced to 720 beds from 1200 under the previously existing structures. The expected savings over the following three years was predicted to be 20 million dollars (*The Stanstead Journal*, January 24, 1996, p. 17). The need for a health information and referral service was of growing importance to serve a population now "confused" as to where to turn to seek services (ibid).

From its inception in 1995, a "centralized/decentralized" model of the *Info-Santé* service was used in the Estrie region (Info-Santé CLSC – *Bilan des opérations 2001-2002,* 2002). This model allowed for the local provision of the service by each of the seven CLSCs mentioned above during regular weekday hours (from 8:30 a.m. to 4:30 p.m. – Monday to Friday). All evening, night-time, weekend and holiday service was provided by the Sherbrooke *Centrale* office. This practice freed the local, individual CLSCs from the responsibility of providing the service 24/7 on site, while still allowing its citizens access to the service on a continual basis (ibid).

Shortly after the initiation of the service in the Estrie region, *Info-Santé* also became first responder for *Urgences Détresse* after 4:30 p.m. on weekdays and for all weekend and holiday services for each of the CLSCs in the 05 Estrie Region. This social service component of the CLSC deals with calls of an urgent nature such as suicide attempts, abuse/violence and emergency housing, to name a few. As was the case initially with health calls, such social service calls continue to be handled locally by each CLSC during regular weekday hours. The service also responds to after-hour callers to the suicide prevention service, *JEVI*. Such calls are directed to on-site or on-call social workers or psychologists after an initial evaluation of the client's needs by the *Info-Santé* nurse. The Sherbrooke *Centrale* was one of the first in the province to initiate such a joint health and emergency social service undertaking (Info-Santé CLSC –*Rapport annuel 2002-2003,* 2003).

Over the course of the next several years, contracts between various CLSCs in the region and the *Centrale* allowed for the transfer of calls during

specific periods, for example, during the lunch hour. Slowly, these contracts expanded in scope and became the norm. In 2000, the CLSC Val St. François contracted the entirety of its *Info-Santé* service to the Sherbrooke *Centrale*, becoming the first of the region's local CLSCs to do so. By the end of 2002, most calls, day and night, from the Haut St. François and Memphrémagog CLSCs were being responded to by the Sherbrooke *Centrale Info-Santé* (ibid).

This notable increase in the transfer of calls from the various CLSCs to the *Centrale* led to ongoing discussions concerning the eventual centralization of the service (Info-Santé CLSC –*Bilan des opérations 2001-2002,* 2002). A variety of reasons lay behind these transfers of calls to the centralized office. As mentioned above, CLSCs normally operate during daytime hours only, although some services are available until 9 p.m. The volume of calls at the initiation of the service was quite low, allowing individual CLSCs to assign *Info-Santé* duties to nursing staff already assigned to other nursing tasks (for example, appointments with patients to change dressings). From logistical, efficiency and human standpoints, leaving a patient to answer a phone call was problematic and became more so as the volume of calls increased. The *Centrale* also allowed for more uniformity of responses. Since its nurses were not required to do tasks other than respond to calls, nurses working at the *Centrale* gained experience in addressing the wide variety of requests made by the callers, allowing for the evolution of *Info-Santé* as a new nursing speciality. The centralization of all *Info-Santé* services in the Estrie region was effective on a 24/7 basis as of April 1st, 2002 (Info-Santé CLSC –*Rapport annuel 2002-2003,* 2003).

Since that time, the service has continued to evolve. Ties to the *Santé Publique* have been close since the inception of the service and form a critical component of the initial and ongoing mandate of the service (*Cadre de référence*, 1994 and 2007). These important links allow for the shared surveillance of potential patterns in emerging public health problems, such as cyanobacteria-(blue-green algae) associated symptoms, clusters of infectious diseases, and food or water intoxication/contamination difficulties and planned responses, to name but a few.

The service also has historically linked CLSC home care clients with nursing or medical services should sudden changes in client needs arise. With the establishment of GMFs (*groupe de médecine de famille* – family medicine group) in the area in 2002-2003, *Info-Santé* took on the role of responding to callers requiring after-hour medical services as well as responding to registered vulnerable clients' needs in a number of specific nursing residences, advising and/or linking these with appropriate nursing or medical services (Info-Santé CLSC –*Rapport annuel 2002-2003,* 2003; Hébert et al, 2005).

By 2006, further restructuring of health resources within the region had seen the merger of the now-combined CLSC *de la Région Sherbrookoise* with the *Institut Universitaire Gériatrique de Sherbrooke*, under yet another new acronym/name, CSSS-IUGS or the *Centre de santé et de services sociaux - Institut universitaire de gériatrie de Sherbrooke* – or Health and Social Services (MSSS). This designation allowed for investment in intensive English-language training for nurses as the *Ministère* prepared to implement *Info-Santé* services first under a province-wide automatic distribution of calls and, second, under a single

province-wide access number. To this point, English-language calls to the service in the Estrie Region had been hovering consistently below 1.43% of all calls received, and representing only a very small proportion of the English-speaking population of the area (Info-Santé CLSC, 2002, 2003, 2004; Info-Santé Centrale Estrie, 2006).

By the end of January, 2007, the Estrie Region *Centrale* was "virtualized" the technical term used to allow for the automatic distribution of calls across the fifteen other *Info-Santé centrales* in the province, according to waiting times in each of the various areas. This required a number of web-based technologies and an intricate telephone system to be set in place during 2006 (Info-Santé Centrale Estrie, *Rapport Annuel 2006-2007*, 2007). This "virtualization" spelled the end of *Info-Santé* services provided *for* the Eastern Townships' residents, *by* the nurses located at the Sherbrooke Estrie *Centrale.* Until the advent of virtualization all calls originating from Townships' callers were answered within the region, this, however, is no longer the case. The distinct advantage for both callers and nurses of shared "local knowledge" of services, institutional and community memories, and local geography became less available.

In June 2008, a single access number, 811, was established to allow the Québec population access to an *Info-Santé* nurse anywhere in the province. The service continues to evolve, with the addition of *Info-Social*, the social service component of the virtualization process now in effect in the Estrie Region after 4:30 p.m.; the caller is now able to choose *Info-Santé* or *Info-Social* with the push of button. Within the not-too-distant future, this service with be available province-wide, on a 24/7 basis. At the time of this writing, local CSSS social

service personnel handle weekday calls between 8:30 a.m. and 4:30 p.m. (Info-Santé Centrale Estrie, *Rapport annuel 2008-2009*, 2009).

Info-Santé, as a provincial service, now handles about 2,400,000 calls per year; in the fiscal year 2008-2009, the *Info-Santé – Centrale-Estrie* responded to 113,379 calls (Info-Santé Central Estrie, *Rapport annuel 2008-2009*, 2009). Numbers of calls are dramatically affected by local, provincial, national or global health concerns such as the recent H1N1 influenza pandemic, during which average weekly calls answered by the *Centrale-Estrie* jumped from 400 to 1600 (Info-Santé, 2009).

The Centrale

The Sherbrooke *Info-Santé Centrale* has evolved since its inception in the fall of 1995. At the present time, it is one of 17 such centers serving the province of Québec. Two of these, located in the province's north are not as yet connected to the 811 access number, which, as stated above, has been in effect since June, 2008, replacing more than one hundred local *Info-Santé* numbers.

The Sherbrooke *Centrale* currently employs 27 nurses, 12 full-time and 15 part-time. Many part-time nurses work full-time but do not officially hold full-time positions. This deployment of nurses is typical of the search for efficiency within the health care system (Armstrong and Armstrong, 2009). Full time nursing positions offer benefits such as sick days and statutory holidays that are not available to part time nurses. Part time nurses, then, are required to "fill the gaps" in the work schedule. Such arrangements are beneficial for management but

lead to insecurity for the nurses themselves and can be disruptive to nurses' family/social lives.

Most nurses work 8-hour shifts, though some nurses choose the option to work 12 hour shifts on weekends, thus decreasing their work weekends to one-in-three, as compared to the usual work routine of one weekend in two, still practiced by the majority of the *Centrale*'s nurses. Shifts are staggered to try to match peak times for calls and accommodate meal times for the staff. Staffing shortages are common for a variety of reasons; not least among them the "just-in-time" staffing methods that can lead to shortages should just one nurse be ill. Ideally, day and evening shifts are each staffed by six nurses and night shift by one nurse at the Sherbrooke *Centrale*.

Before the advent of "virtualization," calls received by the *Centrale* in Sherbrooke were limited to those originating from the 05-Estrie region. Since the inception of the service's "virtualization" in 2007, the *Centrale* responds to overflow calls originating from anywhere in the province. At the outset, this meant that calls waiting on hold for more than 4 minutes were automatically dispatched to the next available nurse, anywhere in the province. This practice has recently been changed in response to the H1N1 pandemic in the fall of 2009, when, in an effort to quickly respond to the rapid increase in the volume of calls, the system began to automatically distribute calls after a wait time of only 15 seconds within the caller's region. Monitors of the *Info-Santé* system, both at the local and provincial levels, saw an increase in the efficiency of the system, as measured by a dramatic decrease in the percentage of "calls lost" (callers hanging up while waiting for a response) with this practice and have chosen, at least for

the present time, to maintain this 15 second distribution delay rather than return to the previous practice (personal communication with Marie Camirand, ASI par Interim – Interim Assistant to the Program Director, Info-Santé, January 12, 2010).

It is important to note that all calls to the *Info-Santé* line are audio recorded. This system, while purportedly to allow for possible retracing of calls for legal reasons, has the effect of "monitoring the nurse along with the patient" and is used by managers to "acquire greater control over the distribution and pacing of the work and (can be used) to justify staff cutbacks" as noted by previous research on health technologies (Choinière, 1993, as cited in Armstrong and Armstrong, 2009: 156). Indeed, monitoring of the entire system is constant, with detailed statistics being amassed on a daily basis on the number of calls, the region of origin of the calls, the reason for the call, if and what referral information was given, etc., all meticulously coded as part of the *Info-Santé* nurses' functions and carried out, for the most part, as a taken-for-granted practice while completing the callers' "*fiche*" or electronic record (Appendices H, I, J) . Callers' complete names, birthdates, phone numbers and postal codes are required by the MSSS as part of the electronic record and therefore are, necessarily, recorded along with the telephone interaction between nurse and caller. All calls originating from individual callers are collected in the electronic record and can be accessed by nurses or administrators of *Info-Santé*. At this juncture, access to electronic records and the associated audio recordings are limited to the region answering the call. However, the feasibility of province-wide access to the electronic record data base is currently under discussion. We can therefore

understand *Info-Santé* as an example of Foucault's notion of governmentality, and indeed, as an example of biomedicalization as both are put forth by Clarke et al. (2003: 165) and as these have been explicated in detail in Chapter 3 of this document.

This researcher has worked as a nurse in this center since April, 1996. For the most part, my work has been full time, though I have taken a two-year partial leave for study and a 9 month full time leave to teach, over the course of those years. I am the fourth most senior nurse in the center and the only Anglophone nurse, though 8 other nurses are able to respond to English-speaking callers. Most of my calls are conducted in French (about 95%), though that percentage has varied with the advent of virtualization, since I am able to "treat" English language calls from other centers which may not have adequate resources for English speakers.

The physical space

Each divided workstation is equipped with a telephone and a computer, emergency measures and most-used documentation. Most workstations are closed on 3 walls with a windowed opening in one. The fourth "wall" is open to allow for easy access to the bulk of the off-line resources which is located along one wall of the large, rectangular room and is shared by the nurses as needed. The openings also allow for consultation between and among nurses, allowing for a sharing of expertise and shared decision-making for more complex calls. More and more resources are becoming available on-line, reducing the need for "hard

copy" reference books which are expensive and become quickly dated. The key working tools are then, the telephone and accompanying headset, the electronic versions of many medical and pharmaceutical resources and, primarily, the *Info-Santé* on-line protocols, developed and continuously updated by a centralized agency comprised of nurses and verified by doctors and other health professionals located in the Québec City region. The *Info-Santé* on-line site is also "virtually connected" to the public health agency (*Santé Publique*) and thus, is, at least in theory if not in practice, automatically informed of any evolving public health issue.

Caller satisfaction studies have shown satisfaction rates above 90% (Hagan, 2001). Whether such rates would be found if similar studies were done today is an area for further research. Success of the service does, however, depend on continual updating of relevant information from the various health network partners. As one might expect, this is an ongoing challenge, particularly in light of rapidly developing public health situations.

Research into the appropriateness of telephone service interventions and references has shown positive results, indicating that nurses' evaluations tend to err on the side of caution (Marklund et al, 2007 as cited in Leppänen, 2009; Hogenbirk and Pong, 2004 as cited in Goodwin, 2007).

The Sherbrooke *Info-Santé Centrale* provides a unique site for the exploration of ideas about the intersection of nursing, technology and health service provision. Sociological notions of the clinical gaze, professionalism, power-knowledge/experience, the clinical encounter, discourse analysis, and the ideological underpinnings of the *virage ambulatoire* and its consequences within

the health care system are all open to investigation within both the walls and the virtual world of the *centrale.* The setting provides an ideal opportunity to observe the assessment of the disembodied patient/caller, the limitations imposed by the very technologies that underlie the service, the telephone and the *Répertoire des protocols infirmiers Info-Santé pour l'intervention téléphonique* (Info-Santé nursing protocols for telephone intervention), and the ideologies underpinning the service itself.

Conclusion

Info-Santé is not the family practitioner at the other end of the telephone line as in days gone by. It does, however, replicate some of the same information and referral features, in addition to a multitude of services that the family general practitioner of yore could not possibly have imagined. The 24/7 service offered by specially trained nurses provides many with an important and timely intervention in an era where family doctors, health services, and basic, general knowledge of health issues are unavailable, difficult to access or lacking easy interpretation.

The ease with which an *Info-Santé* call can be placed thus responds to many of the new health care "consumer" needs in the Eastern Townships and throughout the province. Despite this, many questions remain. Among these, it is imperative to ask: What is the role of the *Info-Santé* nurse? What is the role of *Info-Santé* within the Québec health care system? How is the sociological notion of the "clinical gaze" constructed in the absence of a physical presence of the "patient"? What are the notions held by *Info-Santé* nurses concerning their

practice and themselves as nurses in this non-traditional nursing specialty? These questions are the subject and substance of the chapters that follow.

Chapter 5 - Info-Santé – The Role

Introduction

An understanding of the *Info-Santé* experience necessarily calls for an exploration of the role of the *Info-Santé* nurse. As this chapter will demonstrate, this role is multi-faceted and calls for a multiplicity of talents, skills and knowledge. To begin the exploration, this chapter aims to contextualize the role in providing a detailed account of the daily routines particular to *Info-Santé* nursing as represented in this particular *Centrale.* Next, the role of the *Info-Santé* nurse is examined at both the micro and macro levels, in an attempt to understand how the nurses themselves see their role as *Info-Santé* nurses and to explore their perceptions of the role of the service itself within the health care system. In so doing, the particularity of the role, as compared to more traditional nursing roles is made explicit.

Settling in

Each work shift begins with saying hello. As the nurse arrives for her or his shift, she makes the tour of the room, speaking with nurses not on line, and giving a sign of hello with a smile or a quick wave to those who are on line; "On line" meaning in conversation with a patient, a caller, a client. Nurses, thus, scan the room upon arrival to see who is working, and where. Depending on the shift, "regulars," those nurses who hold permanent positions, have their preferred "stations" where they always sit to work. Departure from the usual seating

arrangement will elicit comments and queries. The response will be discussed if the nurse is not on line – it will be deferred if she is on line, or others will share the information, for those already working will surely know the answer.[13] Since the claim to one's "station" is typically justified on the basis of regular occupancy, those with full-time positions think of particular cubicles as their private space. It remains, however, that the space is shared by nurses from other shifts. Nurses who work less frequently than full-time, or do not have a fixed shift, are obliged to work at the less desirable stations, thus the necessity of everyone's "settling in" process described below in detail at the beginning of each shift.

Eight cubicles, each enclosed on three sides form the outer perimeter of one large room, the main section of the *Info-Santé Centrale*. Two additional cubicles are located in a much smaller room on the opposite side of the corridor from this large office. This smaller room is located next to the management office. Two additional *Info-Santé* work spaces are located in the room beside the main office, should these be required (Appendix E). These are used primarily for training purposes but may be pressed into regular service should the occasion arise, as was the case during the H1N1 pandemic in the fall of 2009.

Once a work station is chosen, ambient temperature and lighting may need to be adjusted by switching on or off the fan, opening or closing the window or

[13] Many nurses are impatient when interrupted while on line. The concentration required while speaking with a client, while trying to "hear" the client, is easily broken by outside interference, be that a wave of greeting, chatter in the room, the noise of a floor cleaner – anything that breaks concentration on the conversation between the nurse and the caller.

adjusting the air conditioning/heating system, turning on or off a desk or overhead light, all depending on the time of day and the individual preferences of the nurse. This done, the nurse will usually proceed to choose a chair that is to her liking. There are a number of different styles of chairs, all meant to be ergo-dynamic, according the criteria of the time in which they were made. Once chosen, the chair needs to be adjusted to the most suitable seat height and angle, arm rest height, back rest angle. All of these have been monitored and suggested by workplace ergonomic "specialists," who tour the office about once a year or whenever new chairs arrive, with a view to reducing workplace stress and strain injuries. Next, the keyboard rest needs to be adjusted; again height and angle are taken into consideration. Footrests are chosen according to the nurse's comfort and individual tastes. A number of nurses personalize their space with photographs of their children, grandchildren or pets. For those who do not have a regular cubicle, these photographs are carried with them, to be unpacked and repacked at the beginning and end of each shift.

The telephone and accompanying headset are next on the list. Wireless headsets are specific to each work station, thus they do not belong to anyone in particular. In the fall of 2009 during the H1N1 crisis, nurses were provided with the option of having their own wired headset or of using the wireless set particular to each work station. Nurses who prefer wired headsets now each have their own which, as a matter of the nurse's choice, are kept in labelled boxes on a shelf within the main office or with the nurse's personal belongings in a locked cloakroom containing open shelves divided and labelled with each nurse's name. Wireless headsets allow for movement in and around the room, and into the

corridor. These headsets have only one earpiece, the other ear is exposed to the ambient noise. Those with trouble concentrating, or who are more easily distracted, are more likely to work with a wired headset with two earpieces. Their movement thus is necessarily limited to the length of the wire. The headset must be removed for any movement about the room. It is sometimes, some would say often, the case that headsets are missing pieces, or are not to the nurse's preference. A hunt for the desired components then ensues. Once the headset has been found and adjusted to the individual, the login process begins.

The nurse must log into both the computer and the telephone system. *Windows* is the operating system used and a password is required to login. Once *Windows* opens, the nurse must proceed to open the *Info-Santé* program. It too has its own, separate password to allow access to the various programs available within the main *Info-Santé* program. Alerts issued by the *Santé Publique* - Public Health are located on the opening "page" of the *Info-Santé* program and an additional warning system is in place that flashes to draw the nurse's attention should a new alert be issued over the course of the shift. Access to various other relevant Ministerial publications and medical references are also available on the opening page.

Additional programs are accessible from within the main *Info-Santé* program once the "chart" has been opened at the outset of a call. These consist of the *Répertoire des Ressources* – which allows nurses to search for a wide variety of resources according to the caller's needs and geographical location. For instance, the caller may be seeking information concerning the nearest available walk-in clinic and its operating hours.

This program's mapping system, similar to other well-known public mapping systems, allows for more precise locating of a specific resource in the caller's locality. Its detailed information on each resource provides operating hours, services offered, wheel chair and public transit accessibility and other pertinent contact and resource-specific information.

A second increasingly used program is the *Module de Garde* – On-Call Module. This program is still underdeveloped in many areas of the province, but is intended to allow *Info-Santé* nurses to contact on-call doctors or nurses for clients who have been specifically registered by their own clinics (*GMF*s – family medicine groups) as needing 24/7 access. These clients tend to be "vulnerable" recipients of long-term care facilities, residential or palliative care, although some short-term clients are similarly registered, for example in the immediate post-hospitalization period when receiving particular nursing interventions at home. Individual clinics are responsible for keeping the on-call information up to date, including any unexpected changes to contact numbers.

Telephone login requires yet another numerical password. The system records the time that the nurse logs in and out, as well as the times that she is available to receive calls, is "on line" with a caller, is using the "not ready" button – usually while completing the electronic record after the caller has hung up, is on her break or is otherwise unavailable. Nurses disconnect completely from the telephone system for lunch or supper breaks. At any given time, mangers can access a program which allows them to see how many nurses are on line in any given area of the province and how many are "not ready." Thus, as mentioned in a previous chapter, we see managers monitor both the nurse and the patient in an

effort to exert control over work practices and sometimes to justify staff cutbacks (Armstrong and Armstrong, 2009). *Info-Santé* managers carefully monitor peak times for calls. Staffing and breaks for staff are adjusted accordingly.

Paper for notes and a pen or pencil are also required for daily use. Each station is equipped with a calculator, a calendar, a binder with frequently used information and a CPS – compendium of pharmaceuticals – which describes medications, their dosages, common side effects, etc. in detail, though this is now also available in an electronic version for each nurse who is logged onto the system. Should any of these materials be missing, the nurse will seek these out before beginning to take calls.

As the above suggests, the physical work environment is frequently a source of frustration. *Info-Santé* occupies the south wing on the top fifth floor, with the Information Technology Department occupying the north wing, in the former *Hôpital Saint-Vincent-de-Paul*, an institution which opened in 1909. A rehabilitation center and a residence for the elderly occupy the remainder of the building. Although the space has undergone extensive renovations over the ensuing years, the most recent prior to *Info-Santé*'*s* arrival at this site in January 2008, the locale shows its age in a variety of ways: the elevator frequently breaks down; a foot-long crack in the ceiling recently allowed melting ice water, built up on the roof, to leak down into one station in the largest of the three main offices – rendering the station inoperative until the roof can be fixed in the spring or summer; the heating and air-conditioning systems are precarious and difficult to regulate. The lighting is deemed to be less than satisfactory by many. Sound control measures are problematic with many nurses speaking at the same time on

line, some with voices naturally louder than others, some needing to be raised to accommodate a client who is hard-of-hearing. Given that the locale is occupied 24/7 by *Info-Santé* and that the nurses are limited by the nature of their work to the immediate physical spaces, nurses experience these environmental discomforts as stressors. The same can be said for any of the necessary equipment: computers, chairs, telephone headsets, and so on, should any of these be lacking, broken, or in some other way perceived as not up to par. When asked the question: "What measures could be taken to improve the *Info-Santé* service?" a number of nurses thought first of these local environmental challenges, illustrating the primacy of these concerns:

> *"Personally, I think that the environment must be adequate ...the level of noise from other nurses ... our desks, the arrangement of the office, the ventilation system ...the lighting and all that, I mean, our physical milieu, the big machine on the roof that when it stops it sounds like an earthquake ...I think it decreases our concentration ...I think there is a lot of work to do to make the environment really adequate."– BM*

> *"I would like to have my own workspace. You know, at least the full time people, to have one place, our place. You know, you arrive and well, I take a space and there's never anything there that conforms to my needs, I have to look for things, these are irritants, okay?"– BS*

"One thing that certainly negatively affects my work is the noise. When we work with someone who talks loud, it disrupts my concentration. The locale could be better arranged, it would help."– JB

These nurses articulate the importance that the physical work environment holds for them as individuals, for their abilities to perform their caller evaluations adequately and safely and thus, to assure the quality of the service as a whole.

Calling - Part I

Now settled into her work station or cubicle, the work begins with the nurse lifting her finger on the "*pas prêt* – not ready" button and a call "descends" from the wait queue and "rings" at her telephone. If the nurse is wearing a wireless headset, the ring also occurs in her headset, allowing her to hear the ring and respond to the call with the touch of a button located on the headset even if she is not at her desk.

As the call "descends," the call display will indicate the caller's number, region of origin – indicated by a number 01 – 16 according to the MSSS designation for various health regions, and "an" for "*anglais* – English" or "fr" for "*français* – French" according to the option chosen by the caller from the opening message. [14] As noted earlier, all calls are audio-recorded. Auditory recording of the call starts immediately and automatically as the nurse begins the call.

[14] This information may not be available if the caller has ID block or if the call is transferred from among the various institutions in the province. A fault with the system that seems to be unable to be addressed from a technical point of view is that the "*an*" used to indicate English calls

"Good Morning, *Info-S*anté. My name is ----------I am a nurse. How may I help you?" the caller usually responds with "I'm calling for some information" - "*c'est pour un renseignement*" and they begin to relate their story; alternatively, "I just want to verify ...", "I need some advice ...", "Do I need to see a doctor?" may be the caller's opening comment or question. Occasionally, the caller will begin by jumping directly into their story, without any preliminary comment. This is interpreted by the nurses as rudeness, a lack of recognition of the nurse as a social actor, or an indication of a heightened state of anxiety or frustration on the part of the caller. These calls often require the nurse to "cool off" or soothe the caller before the evaluation process can begin in earnest. This soothing of the caller is an indication of the "emotional labour," (Hochschild, 1983; Wharton, 2009), performed by *Info-Santé* nurses.

As the nurse picks up the call, she opens the *Info-Santé* program to create an electronic, written record of the call. This will become part of the caller's "chart," so to speak, a collection of calls kept electronically under each specific caller's name, birthdate, postal code and telephone number.[15] Thus, as she listens

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disappears or is transformed to "*fr*" if the call "descends" to the nurse, but she is unable to take the call immediately and pushes her "*pas prêt*" button to return the call to the queue. This results in English calls going to the next available nurse, and not necessarily a nurse who can speak the language, causing frustration for both the caller and the nurse, who must then transfer the call to a colleague or send the call back into a specific wait queue for English callers.

[15] These identifying details are supposed to be collected at the beginning of each call, according to norms established by the Ministry. However, many nurses deviate from this norm, feeling that such a bureaucratic beginning interferes with the nurse/patient interaction about to take place. The collection, then, of caller identification is often deferred to later in the exchange. This deviation

to the caller, she is typing what the caller is telling her into the record in its "data collection" section. As she listens to and writes the caller's story, using the caller's own words for specific questions and descriptions and in as much detail as possible, she is assessing the symptoms and information given. Is this person's situation urgent? This is the first possibility to be eliminated. What is the most likely problem causing the symptoms being described? Questions arise as the caller relates symptoms, for instance: how old is the person experiencing the symptoms? When did the symptoms begin? What, if anything, preceded the problem? Has anything been done thus far to relieve the symptoms? What has been done and how successful were these attempts? Any previous consultations related to the current problem are recorded, including as many details as possible concerning the resource consulted, when the consultation took place, what types of tests or treatments were undertaken, how the patient responded to these and any diagnosis given.

As the nurse narrows in on the reason for the call, she uses keyword searches to access various protocols adapted to physical symptoms from within the *Info-Santé* program.

These protocols are often subdivided into age-specific protocols, and are further divided into several sections. The first provides a brief description of the disease or problem, giving a general overview and a number of possibilities for the causes of the symptoms; the second involves interventions – that is, actions that are deemed adequate responses to the problem. Most protocols also include a

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from prescribed Ministerial norms can be interpreted as a form of resistance on the part of the nurses.

section on suggestions for further care or consideration and finally, a section on prevention is included. The relevance of each of these sections depends on the call, and may or may not be related to the caller/client. Each protocol also includes a "*surveillance*" section. This section lists a set of symptoms that require immediate medical attention – immediate in this sense is a delay of 2 hours or less – and a non-urgent section for situations/symptoms requiring follow up within an unspecified delay, anywhere from two hours or more. The nurse may access as many protocols as needed for each call. These protocols, developed by a specialized team of doctors and nurses working under contract for a company responsible to the Ministry of Health, are meant to be the framework for decision-making for the *Info-Santé* nurse. At times the information in one protocol contradicts the information in another, equally relevant protocol. This is but one instance where the nurse's own experience and clinical judgement is needed to evaluate how to "treat" the client and is evidence of the privileging of the nurse's "voice of experience" over and above the "voice of science," as represented by the *Info-Santé* protocols and as put forth by Atkinson (1995: 4-5).

Other studies in telenursing (Larsen, 2005; Leppänen, 2010; Snelgrove, 2009; Goodwin, 2007) have noted similar findings with nurses seeking autonomy in resisting the standardized computer protocols or in venturing beyond the protocols on the basis of their personal experience when their "silent knowledge is at odds with the advice they have to give" (Leppänen, 2010: 24). Indeed, Snelgrove (2009: 362) reports that computer clinical assessment system (CAS) used in NHS Direct "lacks flexibility" and that "scientific rationality" is insufficient in dealing with the "multiplicity of client problems that arise, rather

that nurses' use of experiential knowledge and judgement is viewed as invaluable in their practice."

One wall of the *Info-Santé* office is filled with reference books on wide variety of medical, nursing, pharmaceutical or resource information. From my observations and my history within the site, it was apparent that these are accessed on numerous occasions throughout the day by the nurses for more detailed information than is contained in the protocols, or for which no protocol exists. A filing cabinet containing similar information is also handy for such instances.

A section of the record called "precisions" is used to precisely describe what advice was given to the client by the *Info-Santé* nurse in terms of addressing the current problem as well as what symptoms to watch for over time that may necessitate further evaluation and/or consultation. In some cases, nurses are permitted to "copy and paste" directly from the relevant protocol to save time, but only the information actually given to the caller must be copied or typed into this section. In the case of the recent H1N1 pandemic in the fall of 2009, directives were received from the Ministry of Health not to use this section in the interests of expediency. At the time of this writing, this directive is still in place. Given that time constraints are much less now than at the time of the pandemic, some nurses will record information in this section if a case is deemed problematic in some way – the nurse feels that some sort of legal repercussion could result and feels a need to protect herself, or that the call is likely to require some further

intervention. [16] Precision of the information recorded in this section is deemed very useful to the nurse giving follow up care should the caller be required to call back for further assistance.

All calls are coded as part of the "charting" protocol according to the "reason" for the call. For example, someone calling to inquire only about the availability of walk-in clinics in their geographic area would be given the numerical code for "Resources." Many codes, though, are "system specific," that is, specific numerical codes are associated with each body system and the selected code would be the one most related to the symptoms at the source of the call; for instance, vomiting would be given the code related to the gastrointestinal system, chest pain to the code for the cardiovascular system (Appendix H). The format of the electronic record allows for only two codes per call. Only the first code is used for statistical purposes by local administrators and the Ministry. Coding at times presents a problem for nurses, since the descriptors available for each code are limiting, given the scope of health problems encountered. Group discussions among the nurses are sometimes taken up with regard to coding problems for health problems or inquiries that do not easily "fit" into any of the available categories, according to the descriptors provided within the program. Thus, there is an element of subjectivity to the coding in this section.

Another element that is numerically coded is the "action" taken by the nurse. Codes differ should the nurse provide "listening and support" as a service

[16] The *Info-Santé fiche d'appel* is a legal document equivalent to the patient's chart in hospital or clinic settings. While there has not been a precedent to date at this *Centrale* of a legal repercussion per se, the *fiche d'appel* has been used to confirm caller's claims; for instance, that medical advice had been sought for a child under Child Protection, *Centre jeunesse de l'Estrie*.

versus providing a "health plan," a "psychosocial plan," or a "referral," as some examples. Again, only two codes can be used and only the first one recorded is used for statistical purposes (Appendix I).

A third code is used for "follow up." This category records the type of referral, if any, recommended by the nurse and the time delay suggested for the referral to take place. Only the *type* of referral is coded, for example: no referral, referral to a clinic, a hospital, a dentist, and so on, each having its own distinct numerical code. Again, only two possibilities are allowed for, with the first one recorded given priority for statistical purposes (Appendix J). A time delay for the consultation is also included in this section of the chart, but is not numerically coded.

Finally, the type of caller is recorded and coded. Was the caller calling for himself? If not, what is the relationship of the caller to the patient/client? Each category of caller has its own numerical code associated with it (Appendix I). It is frequently the case that the caller is seeking information for her/his child, spouse or another family member, but it may also be that the caller is a neighbour, a babysitter, a residence for the elderly, a home for pregnant teens, the police – many possibilities are allowed for, or may be specified by the nurse under the category "other," which has, as one might expect, its own numerical code.

User information, as it is called, is recorded in a separate section of the chart and is accessed by clicking a "button" called *usager*, most frequently by searching for the user by his/her date of birth. If the caller's information is already in the system, meaning they have called in the past, or someone has called on their behalf, the nurse checks to see that the information is up to date and clicks a

button *relier à l'appel* – related to the call. This registers the current call with the caller's previous records. Should the caller be new to the system, a new registry is created with the caller's full name, birthdate, postal code, telephone number and language. In this section, one may choose the relevant language from a drop down list that includes about 15 languages. [17]

To complete the "chart," the nurse "signs off" by choosing the category of call received from a list of possibilities. Generally, the call is an "*Info-Santé* general" call. Separate categories include: home care, vulnerable clients, suicide prevention line - *JEVI*, *Urgence Détresse* (social service emergency), and *Info-Social* among others. These are all duly coded using the numerical codes associated with them (Appendix I). Thus managers can track how many calls are being received from, for example, residences for the elderly. Statistics for many of these calls are also recorded in paper form on a clipboard kept in the main section of the *Info-Santé* office, allowing mangers a quick view of these types of calls and providing a double check on the electronic version counts, as these often differ due to nurses' forgetting to record the appropriate code in one or another of the two sites.

Beginning and end times of the call are also recorded on the sign-off section. These times are automatically recorded by the program but can be adjusted manually by the nurse completing the chart, should this be required.

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[17] Nurses do not as a habit choose a language other than that in which the call was conducted, leading to misleading information concerning minority language groups using the service. At the present time in this particular "*Centrale*," nurses provide service only in French or English. Although, two nurses are able to communicate in limited Spanish, should the occasion arise.

Nurses also record the language that the call was conducted in – choices here are limited to English and French and this information is used to determine the percentages of English and French calls to the service. Finally, the nurse signs off using her password and closes the chart. Should her password be incorrectly typed, a drop down list of all potential system users appears from which she must choose her name and retype her password.

Calling – Part II

What, then, is the role of the *Info-Santé* nurse? As described above, collecting and coding information on calls received to the service, the nurse appears as a surveillance agent of the state. While this is surely one part of the role, the *Info-Santé* nurse's role is much more complex and demanding than the above description would suggest. A separate chapter will deal with how the nurse goes about evaluating the problem which has spurred the call to 811. The notion of the disembodied clinical gaze will be examined in detail, as the *Info-Santé* nurses relate how they "hear" the caller, and how this hearing necessarily takes place in the absence of a physical body. The remainder of this chapter will describe how the nurses themselves see their role as *Info-Santé* nurses and the role of *Info-Santé* as a health service within the health care system. Such descriptions provide vivid depictions of the visions these nurses have constructed of themselves and their perceived place in the health care system in general and the nursing world in particular.

In both focus groups and in the individual interviews conducted with *Info-Santé* nurses, a number of answers to this question concerning their role dominated. The role is seen as "helping," "listening," "orienting," "palliative"; it is one where "clinical judgement," "teaching," "prevention," "support," "reinforcement," "evaluation," are all deemed by the nurses themselves as critical to the practice (focus group and interview data). One might ask: do these elements of the role "nurse" differ from those of nurses who work in a more traditional setting, such as a hospital, or a clinic? If so, what is it that sets the *Info-Santé* nurse apart from the particular image held by the public, other health care professionals and nurses themselves? In seeking to answer these questions, we must raise yet another: what is a "*Real Nurse"*?

The notion of a "*Real Nurse"* appears as an *ideal type* (Weber, 1988). The "*Real Nurse"* is the traditional nurse who has before her/him „the patient' as an actual physical presence. The "*Real Nurse"* has at her/his disposal the sum total of the senses. The nurse is supposed to be a "hands-on" practictioner in the traditional view of „nurse' (Armstrong & Armstrong, 2009: 157). The nurse's practice is understood by many to be that of techniques: measuring blood pressure, inserting and maintaining intravenous catheters, changing dressings, giving medication, monitoring and using various medical technologies such as intravenous pumps and cardiac monitors, to name but a few. While all nursing programs teach the necessity of seeing the patient as a social being and not as someone to be "worked on," such holistic views of the patient are lacking in the ideal type of "*Real Nurse."* Interestingly enough, the focus in most "specialty" areas of nursing is *not* communication or human relations with the patient

(Henderson, 1994). Indeed, those nurses who are at the top of the prestige hierarchy, as constituted by nurses themselves, the Intensive Care Unit - ICU, Emergency - ER, Cardiovascular and Thoracic surgery - CVT, the Operating Room - OR and Recovery Room nurses, are those who are seen as the most accomplished at the physical *techniques* of nursing. These, for most nurses, are the embodiment of the "*Real Nurse."* This image of the nurse is the prevailing image too in movies and television series. These techniques, in and of themselves, require of the nurse an understanding of the bodily processes and the medical and technological knowledge that inform those processes, in order that they be adequately and safely carried out. This fact, though certainly understood and acknowledged by nurses, is not necessarily made available to the public through popular images of the nurse on medical televison series, which more often than not, portray the nurse as an unthinking "doer" of acts or techniques, as the doctor's handmaiden, or as a background "extra."

> *"Sometimes my friends ask me: „Don't you have the impression that you're losing your techniques, going to work sitting down? You're sitting on a chair and talking on the telephone. Don't you have the impression that you're losing contact with the floors?' That's the worry of the young nurses – even the girls who are not nurses will sometimes ask me if I am really a nurse." – LI*

> *"I have the example of my father who always asks me when I am going to become a nurse." – PV*

> *"Well I can't say that I am proud to work here. When someone asks me where I work, I don't say that I work at* Info-Santé*, I say, at the CLSC...the perception that I have is the people think it is degrading, well, not degrading, but that it is not being a nurse, not being a REAL nurse. It is sure that when you work in intensive care and you say that you work in intensive care, it seems that it is worthwhile."(emphasis is the speaker's) -FJ*

The *Info-Santé* nurse, in contrast to this *ideal type,* has a "caller" at the end of a phone line, instead of a "patient." The absence of a physical presence affects and distorts the definition of "nurse," especially as defined by those *not* of *Info-Santé* – e.g. other nurses, other health professionals, and perhaps, although seemingly less so, the callers themselves. As we have seen above, *Info-Santé* nurses themselves struggle with this "identity crisis" since recognition by others is integral to self-definiton. Snelgrove (2009) also noted nursing identity issues at NHS Direct as nurses seek to defend their status as nurses (as opposed to call-centre workers).

Since the telephone and, necessarily, the voice, are the intermediaries to the nurse/caller exchange, the *Info-Santé* nurse is as *disembodied* to the caller as the caller is to the nurse. The *Info-Santé* nurse is *disembodied* too to other nurses, and to *Info-Santé* partners – with the voice as the only link to these other constituencies. What stands out in the data is that the *technique* of listening, is not one that is seen by *Info-Santé* nurses as valued among other nurses outside the

Info-Santé realm. Nurses are accustomed to a lack of recognition by other health professionals but generally are respected among other nurses. This lack of recognition by peers then, is especially grating for *Info-Santé* nurses. I suggest that this lack of peer recognition occurs because *Info-Santé* nursing does not fit the learned "ideal type" of "*Real Nurse"* that values physical techniques and hands-on care and privileges sight over "hearing" and "listening" to the "patient."

Interestingly, what the data show is that the role of the *Info-Santé* nurse is, in some ways at least, more "holistic" than that of the "*Real Nurse"* who, defined here as an ideal type, is focused on physical techniques. Their role can be seen in many instances as complementary, to that of the floor [hospital] nurse, but for *Info-Santé* nurses, it is much more. In answer to the question: how do you perceive your role as an *Info-Santé* nurse? the following responses are insightful:

> *"I think we have multiple roles ...a big role is teaching which I never had time to do on the units [in the hospital]. I don't remember ever having done teaching with a patient, we never had the time. Also educating the population and lots of prevention too ...that's how I see it ...teaching, prevention, educating, lots of reassuring and giving ...our expertise to help them [the callers] to evaluate their situation. There's a lot of evaluation, it's clear." - LC*

> *"Well, it's really a teaching role, a helping role ...to help the population be as autonomous as possible ...to encourage them to take themselves in hand. Sometimes it is curative, but mostly it is teaching: to help people*

to be autonomous as long as possible. [That's the] difference with when I worked on the floors [in hospitals] ...you know, on the floors we „patch' them, we're there to 'patch' them because no prevention was done." - GL

"*I see my role as someone who directs the client, who above all does a lot of teaching, gives a lot of information. I believe we have a role to educate the population to help them to take charge of themselves in the measures they can apply themselves to help themselves to heal." – JB*

"When you work in a structured environment like the Emergency and someone comes in with a burn, you know what to do. You have all your little medication and all your little creams ...but at 11 o'clock at night, when they call and all the pharmacies are closed – what do they do with a burn? I find it very validating to have the protocols there ...all the things that are applicable in the home environment ..." – BO

"... [it is] also a teaching role, of education because with the hospitals and all the reorganization ...it falls more and more frequently to us to do the post-op teaching or the teaching before tests." – ME

" ...we are accessible too. Because there are not too many resources like that, that are accessible and free." - PA

These nurses are keenly aware of the prominence of their teaching role in addressing the caller's immediate need, in relation to prevention and, therefore, in assisting the callers in remaining autonomous, in the manner described by Mirowsky and Ross (2003) as "learned effectiveness." It is clear that the service is perceived by these nurses as filling an important role within the health care system, with *Info-Santé* nurses taking up the role of post-operative teaching and offering accessibility to information.

Info-Santé itself is understood, by the nurses and the health care system, as a *first-line service*, thus is the *porte d'entrée du système* – the front door to the system. Despite this, there is a strong sense among the nurses that their role is not well understood or appreciated by other health professionals. Indeed, the data suggest that *Info-Santé* nurses see themselves as undervalued and underappreciated by other nurses, other health professionals, by the health institutions that employ them and by other partner institutions. [18] Typically, when the question was posed as to how other nurses outside *Info-Santé* and other health

[18] A "recognition party," to mark *Info-Santé* nurses' contribution to the provincial efforts to contain the H1N1 virus, thrown by the institution at the "conclusion" of the H1N1 pandemic in the fall of 2009, saw the nurses themselves setting up the tables and plates, heating the hors d'oeuvres and washing up after the party. While the gesture of the party and the token gifts, a tote bag, key chain and neck strap all bearing the institution's logo, were unprecedented and appreciated by the nurses – it is hard to imagine this behaviour being expected of or accepted by any other professional group at a party being held in its honour. While nurses were appreciative of this institutional attempt at recognition, this paradox did not go unnoticed. The fact that the institution did not appreciate the irony is evidence of "the place" of nurses within the institutional hierarchy. It speaks too to nurses' own complicity in maintaining the status quo.

professionals see the role of the *Info-Santé* nurse, nurses either laughed wrly or groaned.

> *"I don't think they [other professionals] know it [the role of the* Info-Santé *nurse] ...for them, we are just people who answer the telephone ...we are sitting down, [the work] is not tiring. They do not know the complexity of the work. I don't think it is well perceived ...not even by our employer ...who does not want to set particular criteria for the postings for* Info-Santé*. Then, [as we have seen] nurses come and go saying ,,I did not know it was like that – it is too hard.'" -BM*

> *"[the role is perceived] badly ...I had to go as a patient to emergency and I heard the doctors laughing amongst themselves about the nurses at* Info-Santé*, about their role ...I think we would benefit from some marketing [strategies] amongst health professionals for them to know our role. As events of recent months have shown, it is not any Joe Blow who can come to work at* Info-Santé*. It has to be someone with clinical judgement. From the start, I would put in place criteria [for the postings for* Info-Santé *nurses]." –PH*

> *"I have the impression that others think everything is ,,toutcuit' – [ready to eat] – that people call us for very precise reasons ...that everything is well framed and written in the protocols and we only have to follow*

what is written – it is far from that ...it is the competencies that it [the job] demands [that are not well understood by others]."– BN

As the above quotations illustrate, management's misconception of the role of the *Info-Santé* nurse is seen as explicit in the job descriptions for postings to the service. These misconceptions are also held by the nurses' union which has to date argued for the unfettered mobility of nurses within the institution, which comprises a CLSC and a number of long-term care facilities. Job descriptions' criteria for *Info-Santé* postings are not perceived by the service's nurses to be as rigorous as they should be, resulting in many nurses with little or inappropriate nursing backgrounds being hired only to find the demands of the role too exacting. The quotes above refer to an extended period of time in 2009 which saw a number of nurses coming to *Info-Santé*, primarily from the long-term care facilities within the institution, and therefore union-protected, and leaving the service during their orientation period of three weeks or shortly thereafter. *Info-Santé* nurses themselves train or "orient" new nurses to the service. This orientation process is demanding on the nurses, and is thus generally shared amongst several veteran nurses. As a consequence, nurses who "come and go" are considered a burden, exacting extraordinary amounts of energy and effort on the part of the "orientor(s)," only to leave, making the time and energy invested in their training seem wasted. Couple this with the reality that new nurses must then be sought out and trained to fill the vacant postings and we can see the seemingly unending cycle that brings forth comments such as those above. In addition, while this training is taking place, positions are going unfilled, requiring the nurses to

work short-staffed until someone else is hired and trained. Generally, a nurse is not considered fully functional in the job until she/he has been working at the service for six months.

> *"Most of the people I worked with in Emergency before coming to* Info-Santé *saw* Info-Santé *as useless in the sense that [they think] we aren't doing much by not seeing the person and we're sending everyone to the emergency room. Other [health professionals] think that all we do it sit and read protocols and that it is not complicated. They do not think about all the evaluating, the questioning, the physiopathological knowledge that it takes to read the right protocol."–PC*

> *"[the role is seen] like a nurse who wasn't able to get a job elsewhere. It's degrading ...when people come to* Info-Santé *they realize that it is difficult, that it really takes a lot of clinical judgement but from the outside it is not well seen, it is[seen] like someone who knows nothing and sends everyone to consult at emergency."– AL*

> *"[for many] we are no longer nurses, we are telephone operators." - FJ*

> *"[it is seen] like we are sitting on our asses ...that we don't do much ...and because we do not intervene directly with the patient [physically] it is less valorizing. Anyway, personally, I don't think it is very well seen. I think it is changing slowly because the population uses it [*Info-Santé*]*

more and more and because more professionals are starting to refer patients ...but it is not the most valorized ...I think that a nurse in emergency or in intensive care is more appreciated than the nurse who works at Info-Santé*."– LC*

"Ah, I think I will have an answer similar to many others. I don't think we are that well perceived, unfortunately, amongst our peers ...there is a lot of prejudice, eh?...It is a funny (sic) role for a nurse, it's not like, say, a school nurse that you can see or imagine what she does. I wouldn't say it is devalorized but it calls into question, what is a nurse?" - BS

"I used to work in Emergency as we would often have the occasion to say „Well, Info-Santé *...'- we perceived the role of* Info-Santé *as those who send everyone to the emergency room. And it is still seen like that ...I don't have the impression that nursing personnel outside Info-Santé consider it as important work; in inverted commas „a sitting job, answering the telephone.'" – BO*

As the above attest, the role of *Info-Santé* is not well understood, nor does it appear that the service is appreciated, particularly by those doctors and nurses who work in the emergency rooms. It seems, then, that as one nurse suggested above, there needs to be some "marketing" done to demystify the service within the institution and among its various partners. Similar identity issues were noted in Snelgrove's (2009) study.

Info-Santé is mandated by the Ministry of Health to inform, refer and direct callers and this, according to the notion that *Info-Santé* is a "front-line service" (*Cadre de Référence,* 1994; 2007). The media frequently distribute information to the public *before Info-Santé* has been informed by the Ministry through its regional representative, the *Agence de la santé et des services sociaux*, the *Santé Publique* – Public Health Department or other partner institutions. This bypassing of "insider/partner" information on the part of official institutions' representatives provokes frustration among *Info-Santé* nurses and contributes to this sense of undervaluing, and lack of appreciation. Furthermore, this lack of attention to informing *Info-Santé* of developing situations undermines the integrity of the service as callers aware of media reports call in for verification only to be told that the service has received no information to be able to confirm or deny media reports. [19]

> *"I said before that we are a front-line service. But those who are higher than us, the Public Health Department, the Ministry, the partners like the CLSC, the CHUS, maybe Health Canada, well, sometime situations arise ... we need to be prioritized when it comes to receiving information – and not only to receive the information rapidly but in enough detail.*

[19] This problem, evident during the H1N1 pandemic in particular, seemed to originate with the Minister of Health himself, Dr. Yves Bolduc, as he frequently could be found sharing information with the media which had not yet been "cleared" for release to health partners such as *Info-Santé*, by the local *Agence de la santé et des services sociaux* which adminsters and oversees health services in the *Estrie*.

[sometimes] people know more listening to the television than when they call us, even though on the television they are told to call Info-Santé for more information, but we don't have more information so it is very frustrating. It is also very frustrating to we have to keep repeating two lines, because two lines of information is all we received in a communiqué. I think we have to promote Info-Santé within the health care system." –BN

"Like in the case, for example, of listeriosis, a big public declaration that goes out in the media – the reaction has to be faster than that of the media. We can say that the media is capable of publicizing [information] right away. It takes two seconds. While it takes the Public Health a weekend to get the information to us. For the problem with the contaminated water in Lennoxville it took three days [for Info-Santé *to get the notice]. There is a kind of* laissez aller – let it go. *We work in partnership with them [the Public Health] but the partnership is not complete. We are missing a part of the information that we are unable to divulge [to the population] until we get the notice from the Public Health, sadly, even if we know it. It is the fact that it just does not fit together." –BBM*

"....A lack of rapid information – I am thinking of the Public Health when I see in the news that something has happened, like this morning, an H1N1 death and once again, we were not informed. I find that, yes,

we are supposed to advise but when we don't have the information about what is going on and the population informs us ....it is a lack of professionalism when we are not kept informed. They [the health partners] refer the population to us but they don't keep us informed. So [to improve Info-Santé*] keep us up-to-date more rapidly and inform us more completely of the situation [in question]. Like with the H1N1 – we should be up to date if we are to reassure the public and keep the panic down ...it is a communication problem." -PV*

During the course of this study, many made reference to *Info-Santé* being a kind of "catch-all," in their words *la poubelle* (literally the garbage bin) – where all kinds of information and services which no one quite knows what to do with, or can't be bothered with, are "dumped." Data indicate that there are striking contradictions in the front-line service role of *Info-Santé* as perceived by the nurses working there and the practice of the service's partners within the health care system in relation to that role, primarily, it would seem on the level of communication.

The role of the *Info-Santé* nurse is multi-faceted. In relation to callers, the nurse's role is understood primarily as a teaching role, with the goal of aiding the caller in dealing effectively with the immediate problem at hand and equipping the caller with information and strategies for future use in prevention and autonomous care. In order to adequately address the teaching needs of the caller, the evaluation component of the nurses' role is paramount. These aspects of the role provide the nurses with satisfaction and a sense of usefulness in contributing

positively to the well-being of the population. Frustration arises primarily from the misconceptions of the role by others, whether these be other nurses and health professionals, family members and friends, or at the institutional and health partnership level. A key component of these misconceptions arises from the non-traditional aspect of the role. Frustration, too, arises from not having information or the authority to release information in a timely fashion, that is, when callers seek it.

Chapter 6 - The Disembodied Clinical Gaze

Introduction

This chapter will explore the notion of the clinical gaze in the absence of a physical presence of "patient." I begin with the theorectial perspective that is key to the overall enterprise. I follow this with an exploration of the critical elements needed to exercise this disembodied nursing practice. Data obtained from both junior and senior focus groups and from interviews are presented to illustrate the elements deemed critical from the perpectives of those who implement the gaze as matters of everyday practice.

Theoretical Perspective

Foucault's notion of the clinical gaze is a key concept in sociological literature. As an integrated theory of power, Foucault's work has given us an analysis of the concepts of power/knowledge and governmentality and has given rise to the emergence of a sociology of the body as an analytic foundation for medical sociology (Turner in Peterson and Bunton, 1997). Understood as well as a contributon to social control theory, these concepts are important for the trajectory of the clinical gaze as analyzed herein.

Atkinson reminds us that "...the clinical gaze is shaped by language and is socially organized" (1995: 5). Atkinson's fieldwork analyzes the language used by haematologists in order to gain insight into the "doctor-doctor" interaction that serves to "construct and reconstruct patients as objects of discourse" (ibid: ix).

The interactions he presents are, for the most part, not within the patient's hearing. His interest is the "rhetoric of the clinic" and how this "shapes membership, produces and reproduces medical knowledge and, particularly, how the "voice of science," as represented by the haematologists, contrasts with the clinician's "voice of experience'" (ibid: 4). Indeed, he thinks "of medical work in terms of rhetorical skills" which he calls "ethnopoetics" (ibid: 4).

Atkinson argues for a notion of the "social production" of medical knowledge, with an emphasis on this production as „work,' embedded within a social and technical division of labour (ibid: 45). For Atkinson, "the socialized competence of practitioners" is a "matter of apprenticeship" (ibid: 47). It is important to note, as Atkinson tells us, that for Friedson (1988), the "clinical mentality" arises from the "production and reproduction of clinical knowledge or opinion grounded in characteristic modes of perception and legitimation" (ibid: 47). Thus, medical "knowledge is justified primarily in terms of the personal knowledge of the physician and his/her professional experience." (ibid: 47). Atkinson takes Friedson's formulation one step further, suggesting that the "individual practitioner's clinical judgement is resistant to the *uniform* exercise of knowledge and skills" (ibid: 48; emphasis mine). This resistance is also noted in the nurses' use of clinical skills versus the *Info-Santé* protocols and was noted too by Snelgrove (2009), Larsen (2004) and Leppänen (2009) in their work with telenursing services.

The notion is that a "disembodied body" – a body divorced from the body of the patient – can be "thought of as a series of representations which are inspected, interpreted and reported by various different, specialized personnel" so

that the "body can be read at different sites – not just at the bedside – and subsequently is reassembled as "The Case" by means of a narrative reconstruction during such medical practices as ward "rounds" and Morbidity and Mortality "rounds" – informal and formal gatherings designed to teach apprentices to the profession" (ibid: 89). This "disembodied body," as Atkinson calls it, is first and foremost the product of the physical exam, the "objective," and empirical findings of amassed tests "done to" the actual physical body and the narrative that connects these.

The above, then, offer valuable insights in the context of this current study of *Info-Santé* nurses and "the work," as Atkinson would call it, of the disembodied clinical gaze. This chapter aims to describe the ways *Info-Santé* nurses engage the clinical gaze with the body in absentia – a notion this researcher has chosen to call the *disembodied clinical gaze*. That is, through the descriptions offered, we come to understand how it is that the clinical gaze can be learned and practised in the absence of a physical body and, most frequently, in the absence of the objective, empirical measurements readily available to those in a traditional clinic.

Gazing Without Seeing

For the *Info-Santé* nurse, the clinical gaze itself is disembodied. Hearing is the only sense that the nurse has at her/his disposal and that sense is mediated through the telephone.

"We use the telephone as a tool, as a stethoscope [that, for example] we can use to listen to a child's breathing." – AI

The voice thus, can be understood as these nurses' field of action for the health consultation. It is the conduit for the delivery of symptoms and information, for their evaluation and interpretation, and for exchange of information and teaching.

What, then, does the voice offer as the means to uncovering and evaluating the caller's motivation for placing the call to 811? Does the nurse's "voice of experience" as a clinician, contrast with the "voice of science" as represented by the *Info-Santé* protocols? If so, how are these two voices negotiated in the context of the telephone consultation? How do the nurses tease out the callers' verbal representation of their physical or emotional problem in order to best evaluate the reason for the call? How are the techniques, the strategies of learning to hear the caller, acquired by *Info-Santé* nurses? What, indeed, do the nurses "listen for" as they "listen to" the caller? The following are sequential excerpts from the focus group conducted with the more senior *Info-Santé* nurses as they attempt to articulate how they go about "seeing" the caller's problem.

"I often use mental imagery ...I try to see the client. When he tells me: „I have a sore toe.' [I ask] „Where exactly, beside the nail?' ...it seems that I can see the toe. I try to use a mental image; it helps me to ask the right questions to do my evaluation." –JS

"It's always in relation to your previous experience ...you know, she starts to describe it, that her toe is red on the side and you have already seen ingrown toenails so I think it is always in relation with your previous experience ...that's how you're able to [„sæ' the problem]." – BO

These nurses' responses are powerful illustrations of the "work" of the *Info-Santé* nurse. Here, the ability to "see" the problem is clearly understood by these nurses as clinical "knowledge" linked to experience, similar to what Atkinson reports above. These, then, operate in a tandem with each other, with clinical experiences continually adding to the nurse's knowledge base. Possessing "experience" allows the nurse to "ask the right questions" in order to conduct an "evaluation" of the caller's needs.[20] The disembodied clinical gaze is such that the *Info-Santé* nurse is required to solicit the caller's cooperation in "seeing" the problem that prompts the call to 811. In this sense, the caller can be understood as an extension of the nurse whose "work" it is to guide the caller in "seeing" for her/him.

[20] In subsequent excerpts we will see that the nurses learn from each other's experiences as well, to the extent that these are shared – or overheard. Participant observation demonstrated that it is common for nurses to "borrow" from each other, adapting their practices, suggestions for care, signs to watch for, and the like, through explicit or accidental sharing of experience. The nurses, while remarking frequently on the distraction caused by other voices in the locale and the necessarily one-sided hearings of other nurse-caller interactions, frequently purposely listen to these and learn from them. Thus, it is that "experience" is not just an individual, but also is a collective, entity in this milieu. The social construct of the problem is not limited to any particular Info-Santé nurse, rather, it arises from a shared body of knowledge which in the course of the workday engenders solidarity in Durkheim's sense of the term in *The Division of Labour in Society* (1983).

"I see the caller very well in my head. Often, I will say to my caller, „You are my eyes, so you are going to tell me what this wound looks like, how long it is' ...and I will describe everything that I want to know to have a good image of the wound." –PH

From this we glean the importance of "asking the right questions" of the caller. This "seeing" is necessarily mediated not only by the experiences, knowledge, and sociocultural location of the nurse, but also those of the caller. The *Info-Santé* nurse must search for a common, shared set of measures and understandings with the caller, in order to clarify the image being constructed and arrive at a working hypothesis of the caller's need.

*"Sometimes, I try to make comparisons, let's say, a swelling– [the caller will say] „I have a **big** swollen bump ...' and I will say, „How big? Big like a pea? Like an orange?' You know you have to have an idea of the size, so I often use objects that are easily identifiable and neutral, like a pea ..." –ME – emphasis is that of the speaker*

In the following excerpts, again from the senior focus group, we learn what the nurses are "listening for" in order to conduct the clinical evaluation necessary for triaging the caller.

"I am very sensitive to the voice. Very, very sensitive ...she has pain in her back so I see a back, I try to get them to say exactly where they have

back pain – ...[I tell them] „Try to situate your pain' because if they say it is just under the shoulder blade or just above the buttocks, it is not the same thing, eh? So it is the image ..." - PH

"I don't know, they call and say they have a headache but you hear 56 noises in the background ...there are lots of elements ...the context, the sounds , lots of imagery, the timber of the voice ...the respiration, the sighs, the emotion ..." –BS

"Sometimes what will influence you a lot is the tone of the voice that they use to speak with you ...sometimes they will have a voice that is very, very insecure, you notice that they speak quickly ...that they need reassurance and you can sense that you need to disarm the bomb first and you say „What does your child have? Go slowly.' And then they will start to describe as they should, or when the child has just fallen, and my god, their hearts are broken and you feel it when they speak because their voice is trembling ... so you say „Cry, Madame, it will do you good.' And they cry and then they are calmer and you can have them describe the symptoms. Before that [crying] they are just not able to speak, they are choking and the words just don't come out." –RD

"It is the speed of the voice too, the tone ..." – BJ

"First of all [the voice will tell you] if the caller is listening to what we are saying because sometimes you ask a question and they respond to something else ...or sometimes they don't follow our conversations. Sometimes you have to bring them back, or sometimes you start to say something and they cut you off." –DM

"But the tone of voice really can tell us is someone is suffering, or if he has respiratory problems with shortness of breathe ...it can help us determine the age of the person, their sex – although sometimes it is hard to tell ...[if the caller is a man or a woman]" – [the group laughs in agreement at this last comment]. –BO

For these nurses, the voice itself speaks. Nurses listen to the voice and all its qualities (timber, tone, speed, among others) to help them to see the caller, to augment the words the caller speaks in order to gain the most complete image possible of the caller and the problem requiring evaluation. Ostwald (1964) too considered voice qualities such as these important to the overall evaluation of the patient.

As nurse BS hints at above, these elements of the voice as well as the context, the call's background noises, can serve to put the nurse on guard. She will be able to hear inconsistencies between what is said, how it is said, and whatever other information she can glean from the sounds available to her. Consider as evidence of this, the following excerpts from the same focus group.

"I remember situations where the person says, ,,I am suffering,' and we know that when they arrive at emergency they will have a big smile – I turn this back on them saying, ,,Generally when someone is in pain like you're describing, they will have difficulty to finish their sentences' – I'm not shy to say this to them. Maybe it is just their tolerance for pain, but for me, an intense pain is 7/10 and the person tells me they have a 9/10 but she is talking to me with the same rapidity of speech that I am using now ... I have doubts, but that is what she is telling me, so I say, 'Let's give it a couple of hours,' we bargain together and I will try to get them to reflect: ,,Generally with an intense pain, you don't have much control, your body will cause you to be short of breath' ... I will get them to reflect even if I am not in agreement with what they tell me." –BN –[21]

"Concerning the intensity of the voice, I said before that I do not judge the person but still I have a ***clinical*** *judgement. I am able to make the distinction between a little 9 and a big 6. The person who says it [the pain] is just 6 on 10 with a tone of pain in his voice, for me it's not the same as the person who speaks easily to me and says they have a pain that is 9 on 10. Do you see what I mean? Naturally in my way of evaluating, it is sure that at the end of two hours I will probably send them to emergency if nothing has happened with what I recommend for them to do. But my person with the 6 on 10, I would not recommend him*

[21] The speaker is referring to a subjective pain scale frequently used by health professionals to help to assess pain. Patients are asked to rate their pain intensity on a scale of 1 to 10, with 1 being very little discomfort and 10 being the worst pain the person has ever experienced.

to do anything, my big 6, he will go directly [to emergency]. You know, it is the intensity of the voice for me." –GL – emphasis is that of the speaker

In these statements, we see that these senior nurses typically give more credence to the voice and its seemingly unfiltered qualities than to the caller's actual words. Inconsistencies between the caller's qualities of voice and his or her words, though, present the nurse with a dilemma. From both ethical and legal standpoints, the nurse is "forced" to take the caller's claims seriously. She can, however, point to the discrepancy as does nurse BN above, and as she says, "get them to reflect" on their state of being. Using the two-hour window of delay allowed for by the *Info-Santé* protocols for an urgent consultation, the nurse will "bargain" with the caller, usually suggesting easily applied interventions that the person can carry out to ease their pain at home within that timeframe. The caller is instructed that if there is no relief or decrease in the pain by the end of the two-hour period, he/she should then proceed to the emergency room.

"For me, the tone of voice has a great impact because right away, we can sense things. You can sense worry, sadness, you can sense when she is questioning herself. When she calls and says, „It is just an information that I want' – well, you know that it is just a type of informational call, as opposed to, „Hey, I am sick, I vomited and I don't feel well at all.' The voice is different. The voice gives you a lot." –RD

"And we can sense when our answer satisfies them. Honestly, we can feel it right away, that we have dedramatized the situation for them because they saw themselves waiting in the emergency." –DM

"Exactly, the voice is important." –RD

"The voice is important and it can raise questions for you too. „Ifeel that you're worried' [you say], but she has not formulated that; or „I have the impression that you don't understand, is there something that you want me to clarify?' The hesitations, the silences, the sighs, and the noises – you sometimes wonder, „Is she listening? Is her child distracting her? Is she receptive, available [to what you are saying]?' For me, with my values, when you are speaking on the phone, when I am speaking on the phone ... I am not doing the dishes at the same time, nor am I on the toilet – sometimes you hear them flush the toilet. For me it is a question of respect." –BN

"Yes, it is an aggression when suddenly they turn on the faucet and they are running a bath, or suddenly you hear them get out of their bath. You know they're doing other things and you say to yourself, „They're not listening very much.'" –DM

"For me, it is mostly the noise of the TV – it just gets to me and I ask them to decrease the volume." –RD

"For me, it is when you hear ... you know, they are asking questions of a sexual nature and you hear people in the background laughing and you say to yourself, ,,Is this [call] a joke?'" –DM

The above illustrate not only the importance that the voice holds for these *Info-Santé* nurses but also the extent to which ambient noises contribute to and inform the nurses' perceptions of the caller, the reason for the call, the importance that the call has for the caller and, most critically, the urgency of the problem which prompted the call. How are these elements of listening learned?

"Well, it is important to validate [your perception] ...you have to reformulate [what they are saying] ...these are the tools that perhaps with experience and maybe with the way we are oriented – you have to validate, to reformulate, ,,Is this really what you are telling me?' or ,,Is this what is happening?' – so for me, it is a tool, validating, reformulating what they are saying." –BN

"Or, [you say] ,,If I understand well ...'" –PH

"Yes, that is what we should do ... it is with experience ... I depend on my experience with the voice ... we rely heavily on our instinct, our

experience and the information we collect [to evaluate the caller's problem]." –BN

"There is something more I would like to add concerning the evaluation of a person without seeing them. The way it is at Info-Santé*, it is a team – so that even if the person who takes the call, who collects the information – well, we always have the possibility, except on nights, to go and validate our hypothesis, our perceptions, our ideas with another person. Sometimes this is difficult, because we only have what the other nurse is telling us – we are missing the voice and the voice is important. I mean, like, was the caller stressed? I can give the nurse my opinion on the ABCs of the elements that she is relating to me but I am missing elements too [without the voice] and so I will say to the nurse „With what you are telling me, I would do ...' but it was not me who spoke with them, so I will say, „Rely on your feeling, if you have the sense that you are worried, that the person needs to go to the hospital, well, rely on your feeling.'" –BN*

These senior nurses attribute their abilities to "hear" all these elements to their "experience" and "instinct." These two elements are understood as being in relation to both previous clinical nursing or personal experience and also, to experience and instincts with their interpretations of the voice, gained over time listening to many callers at *Info-Santé*. In BN's response above, the notion of a collective image of the caller and his or her problem is raised, an image formed

collectively by the nurses consulting together. This technique is used in "treating" more difficult calls in which the level of ambiguity of the information collected is such that the nurse receiving the call seeks input from her colleagues to assist with her decision making. We see too the primacy given to the voice and its connection with physical symptoms, relayed by way of words, over and above the words themselves used by the caller to describe physical symptoms. BN's comment makes clear that the immediate contact with the caller, via the voice, is a key element in the *Info-Santé* triage decision making.

Are there differences, then, to be found between this group of senior nurses and the junior nurses with less than two years experience at *Info-Santé* in their abilities to form mental images of the caller and his or her problem? Or in the ability to grasp the importance of the voice? Or in being able to "hear" the caller? Let us turn to comments brought forth in the junior focus group in order to address these questions:

> *"I always form a mental image of what is happening. If there are pimples on cheek, there is a face, a cheek. It is always a different person, each time [that I see]." –AB*

> *"Me, too, it comes from asking questions ...and you look at yourself too – watch and see when you are taking calls, we look at our own bodies. Today I saw a nurse looking at her leg; the call was about a problem with a leg." – CD*

"Once, I drew on my hand during a call, for example, to make the image clearer." –AB

"To visualize, you make ...the image by posing questions." –CD

And what signs are attended to during the course of the call? As the following sequential excerpts illustrate, some of the same concerns that were articulated by the more senior nurses arise too with this junior group. The reliability of the caller is one such problem. Indeed, it appears as one of the major difficulties facing the *Info-Santé* nurse, surfacing again and again over the course of the focus groups and later in the interviews.

"If it is [a call about] pain and she is telling me jokes ...if she has a pain 10 on 10 ...it is a sign that we will [sometimes] hear. And we don't have the choice but to rely on the 10 on 10 that she tells us, but it is sure that it is hard to believe if the girl is speaking and breathing normally, is making jokes,[or] if the person with the 10 on 10 went to work today."- CD

"The signs that don't lie – [are] the respirations, simply put. When they are in pain, the voice will stop [speaking] when they change positions. Or they will cry on the phone, the baby who is screaming in the background ...it is the [totality of] sounds that we hear." –DE

"Sometimes, they tell me that the baby is very lethargic. But what do I hear in the background? I hear the baby gurgling and cooing ...so for me, he is not lethargic – lethargic is like a rag doll. You have to pay attention to the sounds in the background." –DM

Once again, from the above we note that the nurses seek to hear consistency from the voice, the background sounds, and the speech of the caller. As was the case with the more senior group of nurses, background noises are deemed essential to completing the image of the caller, adding a plethora of information beyond the caller's words. The context that these ambient sounds provide contributes much to the nurse's ability to "hear" and thus, to "see" the caller. More evidence of the attention that the junior nurses afford these sounds is apparent in the following passages.

"The breathing, the boyfriend you hear who is swearing – sometimes you have images of what is going on in the house. There are many things we pay attention to. We form our image ...the young mother who calls and you hear the guy in the background „[Explicative] aren't you going to hang up the phone?'" –AB

"You are alert to all kinds of signs: maltreatment, the breathing, the wheezing, the secretions ...first it is [important to assess] the breathing, the respirations. Once [you judge that] things are safe, then you do your

information collecting. But your clinical judgement, it is everything, you [need first to] see if it [the call] is urgent." –BP

The above illustrate the setting of priorities by the nurses in the course of their evaluation of the call. The need to establish the urgency of the call is first and foremost in the minds of the *Info-Santé* nurses. In this, ambient sounds heard via the telephone can alert the nurse to a social context of, for example, maltreatment that would not necessarily be available to the nurse in a clinic. The urgency of the call then, is not limited to the urgency of a particular symptom, but to the overall image gained by the nurse using the totality of the information gleaned through "hearing" and, clearly, through the interpretation, or clinical judgement, based on what is heard.

The importance of experience, knowledge and instinct are also brought to the fore, as we see with the comments below from the same junior group. "Experience" is not limited to the nurse's previous physical contact with various health problems. For instance, especially for newcomers to the service, the ability to transmit information, techniques or concepts clearly to callers without the benefit of visual cues as aids is frequently perceived as problematic. Effective methods for the transmission of such information, symptoms or techniques is learned through repeated attempts over time and thus constitutes another aspect of what these nurses take to be "experience." The quote below, taken from the junior focus group, is a rich example of this struggle for clarity.

*"There are lots of little things that are going to affect your judgement. Sometimes it is not so simple, like „*tirage*' – how do you explain „*tirage*' to a mother? – that it [the skin]goes in below the ribs, between the ribs, by the clavicle and the shoulders ...it is a bit like wrapping food in space ...[to try to explain some things to callers over the phone]." –CF*

The notion of instinct, a sixth sense, or a "feeling" is brought forth in many of the comments from both the senior and junior groups. This sense is not taken lightly by the nurses and indeed, informs their practice and decision-making in many instances. Snelgrove (2009) notes that intuition based on experience played a role in NHS Direct nurses' decision-making as well.

"With experience, we develop a sixth sense. Yes, I find that with experience we develop a sixth sense ...it is like at the hospital, I go out of a room and sometimes I am not too sure, so I go back in half an hour to check. We develop this on the phone too. I find it amazing because we don't see the people." –BP

The last comment by the nurse above, illustrates her acknowledgement of such a sixth sense in more traditional nursing settings. She expresses her amazement that this same sense is made available over time in the absence of seeing, with only the voice and other auditory input as guides. Others express the same sense as guiding their interventions, as illustrated below.

"You have to figure out if the person is reliable. Sometimes a child has a fever of 40.4°[C], but you don't send them, because you know the mother is reliable, so you can tell her what to do. But sometimes people call and you send them, because you have the sense that they are not reliable. She can give you the answers but you have a sense, it rings an alarm that it is not reliable [what she says]." –DB

At the center of the *Info-Santé* practice is the importance of a wide knowledge base, without which the nurse is unable to evaluate the seriousness of the caller's need and cannot address solutions to appropriately guide the caller's actions. Indeed, Holmstöm and Höglund (2007: 1866) describe telenursing as a "highly skilled, knowledge-intensive work."

"When you know yourself what is normal, you can demystify what is not [for the caller]. That's why it is important to have a wide base of general knowledge to do this work. It helps you to do your work." – AB

"You also have to know what is normal for that person. You always have to verify, for instance, if someone says they say they are going frequently to the toilet, and they usually go three times a day and now they are going four times a day. It can be more normal for one person versus another who has the same symptoms. It is an important element to help us." –DB

So what then, does the group perceive that the voice gives them to enrich their evaluation of the call? Let's see what the junior group has to say:

> *"I think that the voice is surely our guide. It gives us our base; it situates us in the context [of the call]. It is like the context of the situation." –AB*

> *"[We hear] anxiety, the breathing ...or the trouble to talk because of too much pain. The voice will cut and you can see (sic) that they are in pain. And often, these people will tell you [that their pain is] 7 or 8. These people will not say 10." –CD*

This last quote above illustrates the nurse's perception that people who are in intense pain are likely to understate that pain on the subjective pain scale previously described. However, the nurse is able to more accurately assess the pain through the qualities of the breathing and the voice, which, for her, are more precise indicators of the caller's status than the subjective scale used to measure pain.

The junior group though, is not in complete agreement with the importance to be afforded to the voice.

> *"Sometimes the voice gives us more information [than the words spoken], sometimes it doesn't. Most of the time, it does not. What is more important is what comes from the questions we ask ...The voice – is*

a tool that helps you to give a service that is of a better quality. It is one element, but you can't base your intervention on that." – CF

"You can't base it on that but it can colour your consultation a lot." – BM

"It gives you an indication, it gives you a context, you take note of the voice and take it into account but it is not that upon which you base your judgement." – CF

"Sometimes, it is because it is contradictory [the voice and the speech]. And you have no choice but to rely on what they say. Like the example of the pain 10 on 10, you have no choice but to rely on what they say ...but you write in your notes: „No trembling of the voice.'"- CD

These younger, more junior, nurses have learned to recognize the importance of the voice and the dilemma that the contradictions between the caller's voice and speech present for their evaluation and their decision-making with regards to follow-up care. There seems, though, to be less of a tendency to give the voice primacy than was the case with the more senior nurses. The junior nurses argue with each other, in the above passages, for and against the primacy of the voice. Interestingly, we also hear less explicit talk of "experience" with this group than we did with the more senior group. Explicit acknowledgement of the

link between experience and knowledge is also missing in this younger group's speech.

In the interviews, however, this link was often raised. Asked what the nurse considered to be the particular difficulties of *Info-Santé* nursing, this junior nurse provides important insights.

> *"You have to have a wide base of knowledge. This is difficult because when we work on a surgical floor, we only work with [for example] surgical patients, or cardiac patients. At* Info-Santé*, we need to have a lot of general knowledge: babies, breastfeeding, cardiology ...so it is difficult, especially for me. I do not have a lot of experience. I am not a nurse with experience – I have not seen that much yet. I was on a float team[22] but I don't have 20 years of experience behind me. It is a problem at the beginning, you have to get your knowledge up to date in the areas that you know less ...and keep them up to date to be able to adequately respond to the callers' needs. It is not always easy." –LC*

Nurse LC above, makes explicit her understanding of the critical linkage of personal clinical experience with nursing/medical knowledge, much in the same way as Atkinson reports that "knowledge is justified primarily in terms of the personal knowledge of the physician and his or her professional experience"

[22] A „float team' is a team of nurses who „float' from one hospital unit to another based on staffing needs. This type of nursing exposes the nurse to many different types of patient problems but does not allow him/her to develop a complete sense of competency in any one area. Nor does it necessarily, as this nurse relates, prepare the nurse for the wide variety of caller needs at *Info-Santé.*

(1995: 47). Indeed, this is a common thread in the professional and nursing literature (Allen and Cloves, 2005; Traynor, 2010; Leppänen, 2009; Larsen, 2005; Snelgrove, 2009) and is often used to justify breaking from the computer protocols to give advice that is not sanctioned, and this, in spite of the constant surveillance through monitored calls (Leppänen, 2009; Larsen, 2005; Snelgrove, 2009). Personal cultural knowledge too, particularly concerning the care of children, plays a role in decision-making (Larsen, 2005).

Over the course of the interviews, many of the same notions raised in the focus groups repeated themselves. The mental image of the caller and his/her problem begins with what a senior nurse calls "the physical exam." She goes on to speak of the voice and its qualities, the ambient sounds that affect her judgement, returning to the physical exam in the last sequence.

> "*I always start by asking the person's age, his illnesses and if he takes medication ...so already, I have a small physical image. I ask a lot of questions in relation to the physical exam, which was one of my strengths in the past. So it is my way of visualizing the person, by way of these questions."*

> *"[I pay particular attention to] the pauses, the people who speak and pause ...the trembling of a voice or to those who blow off the questions, don't answer them, or swear ...these things give me an idea ...[for example] if I have [a caller with] a child who falls and I am convinced that he can stay at home without consulting if he has good surveillance*

every two hours, but sometimes I doubt the parents ...because from what I hear, the tone of voice, the father who swears in the background ... it can happen that I will send the mother to consult because I doubt the [adequacy of] surveillance that the child will have."

"[to create a visual image] it is mostly the physical exam that permits me to visualize a caller and to pay attention to what, when the person is before us, we would call the non-verbal. At Info-Santé *it is the verbal that is not said but which we hear in the background or that we divine from the trembling of the voice that pushes us to ask more questions." - PC*

In the above, previous nursing expertise with physical examinations of patients is reformulated by way of questions to help the *Info-Santé* nurse in forming her image of the caller in the absence of a physical body before her. We see too the recognition of non-verbal cues from the voice and the background as vital to the evaluation and the choice of subsequent interventions. Yet again, the reliability of the caller is an issue; in this instance, ambient sounds have raised the nurse's doubts in the parents' ability to assure adequate surveillance of their child following a trauma. Reliability, then, has two senses for these nurses: first, the words of the caller must be deemed reliable, that is, there must be consistency or, at the very least, a lack of contradiction, in the words and the sounds that are available to the nurse such that the nurse can trust what the caller is saying. Second, what the nurse hears must convince her that the caller is capable of

carrying out her suggestions for care without increasing the health risk of the problem at hand. This second feature is what is often referred to in medial parlance as *compliance* wherein both willingness and ability to comply are necessary components. The notion of reliability is seen by nurses as one of the major difficulties of nursing at *Info-Santé*. One nurse expresses it thus:

> *"Contradictory responses are the most difficult. People tell us, „Ihave bumps all over my body, I am red all over' ... [and] you realize [from further questioning] that it is only on their hands and feet, but [they will say] ‚all over my body' ...or they say, „It is a terrible pain,' but they then say, ‚I can tolerate the pain well.' These contradictory responses [are problematic] and the fact that we can't see either, that is a big barrier, but you get used to listening carefully and you have to use your brain to make the images and to try to understand exactly [what the caller is describing]. - LI*

Credibility (or reliability as these nurses refer to it) is an issue in other research findings (Snelgrove, 2009; Leppänen, 2009). Being able to trust callers' information is viewed as critical since nurses build their mental images from this information. Trust, though, is bidirectional with the caller having to trust the knowledge and expertise of the nurse.

Clearly, when one's visual information is limited as in the case of the *Info-Santé* nurse, the information given by the caller must be as precise as possible in

order that the nurse can "see" precisely and thus evaluate the problem. A junior nurse likens the learning to evaluate the caller to the world of a blind person.

> *"It is really impressive. You develop senses ...a lot like a blind person does with his environment. For the blind person it is his physical environment itself but for us it is the sounds, the symptoms, a breath that is a bit wheezy and things like that; for the [medical] history taking, it is very important." – AI*

> *"How do we **learn** to do this?I think we **develop** it. A little like the blind person who comes to define his environment, it is the same. We see the [computer] screen but beyond the screen we see the image of the person, his environment and I think this becomes refined as we take more and more calls. In the beginning [when first arriving at* Info-Santé*], we treat the call as a call, but little by little we develop an assurance with the information we give and the protocols, the knowledge that we pass on, and we start being able to speak and think at the same time. I think it is at the levels of neurons, that we start to form bridges, eh? Because these are things that develop over time, the longer I am at* Info-Santé*, the more I have the impression that I am developing senses and capacities. And I notice that I carry it into the streets: I hear someone cough and . . . these [mental] gymnastics that we perform everyday, even without realizing it, at times I will realize that I am analyzing people that I hear in the streets." –AI – emphasis is that of the speaker*

This last comment is an extraordinarily powerful description of what it is like to learn "the work" of an *Info-Santé* nurse, to learn to appreciate the complexities of the disembodied clinical gaze and to put what is learned into practice - a practice that becomes taken-for-granted, and so well-incorporated by its practionners that it is carried with them outside the work site and into the world at large.

> *"How do we learn this? On the job, like it or not, it is with experience. There are things that just come by themselves and there are things that are innate too. Some people just have an ability with interpersonal communication ...you have to learn to adapt to each person. It is really by trial and error, you become more confident, you refine your intervention, you refine your listening. The interventions that you have at the beginning serve as tools for you later on." –PA*

Conclusion

Nursing in the absence of a visible, physically available "patient" is both a challenge and an art. These nurses have generously shared their experiences in becoming adept at the practice and in so doing, have provided rich descriptions of what they take to be the critical elements necessary to the successful execution of that practice. While noticeable differences arose between junior and senior focus groups in the primacy given to the voice over and above the words spoken and of the explicit linkages between experience and knowledge, these difference tended

to disappear in the interviews. Nurses pointed to the importance of the voice and ambient sounds combined with *Info-Santé* experience and general nursing knowledge in the development of a "sixth sense" or "instinct" which they deem as critical in particular decision-making situations.

While knowledge and experience in nursing's application are essential attributes for the *Info-Santé* nurse, it is these combined with the refinement of listening skills that allow the novice to the service to develop and master the intricacies of the disembodied clinical gaze. To instruct the novice to the richness of the voice and all that it has to offer is to call upon the nurse to reformulate the skills and knowledge of her craft in the absence of a physical body. It is to necessarily privilege hearing over seeing. The voice and its accompanying ambient sounds inform the disembodied clinical gaze, uniting the practioners of this gaze as members of a uniquely specialized nursing service.

Chapter 7 - The Voice, the Social and Info-Santé Culture

Introduction

The *Info-Santé* encounter is a disembodied experience for both the nurse and the caller. Since the gaze is limited in important ways, we note that both the caller and the nurse use the body, relying on their respective body experiences and the use of language to relate these experiences, to connect with each other and to transmit information. The encounter, however, does not take place in a social vacuum. Both nurse and caller are necessarily socially and culturally situated and thus bring to the exchange expectations, experiences and expressions representative of their respective social realities. Professional nursing values also have a role in these exchanges. Is it possible, then, for *Info-Santé* to be seen or experienced as value neutral? That is, is it possible for the social, moral, religious values of the nurses and/or those of the callers to have no effect on the exchange and/or interpretation of the exchange? Does the absence of physical characteristics, upon which many prejudices are based, preclude the absence of prejudice in its totality? This chapter seeks to illustrate the nurses' perspectives and interpretations of a number of social characteristics manifested through the voice. In so doing, it will show that the social is ever-present in the exchanges between caller and nurse. The chapter will also raise issues concerning the place of *Info-Santé* within the health care system and the limitations placed on the nurses by the system's current structure.

The Voice and Education

Education is one such social characteristic. How is the caller's education made evident to the nurse via the telephone? What criteria does the nurse use to assess this social characteristic? How, if at all, does the nurse's interpretation of the caller's education affect the interaction? These are just some of the questions which inspired an investigation into this social trait. A caller's education is made manifest primarily through her or his use of language. In this, there is a distinction in the callers' use of medical terminology and their general use of vocabulary; clearly, one might be well educated but lack familiarity with medical terminology. The following accounts from the senior nurses' focus group provide a glimpse into this aspect of the *Info-Santé* encounter.

> *"At the level of [the caller's] education, we will know and we'll adjust ... she will say something and you know you can't use a big word, you have to choose your vocabulary [to fit with the client]." –BS*

> *"... [sometimes] we have to use more common language." – PH*

> *"It is that sometimes we have prejudices against the type of client ...all that, the language, the education, the timber of the voice and we have to try not to take notice because it can bias our judgement." –BO*

The last speaker acknowledges that prejudices exist and that these must be set aside or limited for the sake of a being able to deliver a quality service. The nurses adapt the language that they use with the caller, according to the caller's own vocabulary. As with any interaction whose purpose is the exchange of information or teaching, there is a need to ensure that callers understand the information that is being transmitted to them. Thus, nurses use the callers' vocabulary as a starting point to guide the level of complexity of the interaction. We note similar findings from the junior focus group:

> *"The vocabulary, the knowledge, the schooling, these are all the things you have in your head while you're speaking with someone ...[you say to yourself] „Well, [if] he speaks like this, his education is not the same.' ...his description, the words he uses ...someone will say something is „red and swollen,' another will not use those words ....it is the basic [component] of communication, you have to put yourself a bit at the level of the person. For sure with some people, I just can't put myself at their level, like when someone is too drunk to speak coherently." –DB*

> *"[For example], even the difference between an ecchymosis and a hematoma – it can be difficult for some people [to understand]." –JN*

In this last example, it is clear that the speaker is concerned with the caller's ability to discern the distinctions raised by the medical terminology being employed. It is less clear that the nurse is able to help the caller to make the

distinction using various descriptive techniques. This focus on medical terminology seems to have been more pronounced in the more junior group of nurses. It could be interpreted that their focus on such terminology is a result of their more recent interactions with their professors and educational institutions. The use of medical terminology in day-to-day exchanges with patients, however, can be misleading for both the nurse and the caller, if the meanings of such terms are not well understood or are misused by the caller. This finding is consistent with that of Leppänen (2010) who noted cautious use of medical terminology by callers and their simple acceptance of nurses' corrections in instances of misused terminology. The distinctions must be made clear to callers in words or descriptions that they can comprehend in order for the telephone evaluation to be effective. The more senior group of nurses seemed to implicitly understand this, so while some did raise the issue, for the senior group, the problem seemed to concentrate more on what one might call moral issues, rather than vocabulary issues in terms of education, in and of themselves. Although, these too, can be understood as matters of education if one is to understand moral comfort with various medical or often more specifically sexual terms, as matters of education.

> *"For example ... [the woman who called] ...she was telling me about „thepussy' of her little 2-year-old daughter and I said, „Areyou talking about her genital organs?' and she said, „Ifind it less vulgar to say pussy.'" –PH*

Nurses vocalized their ease in treating calls from those who are most like them. Thus, sociological notions of the group membership are prominent in the data, even when these are not specifically sought out. Asked what type of caller she found herself most at ease with, one nurse answered:

> *"Well, it is sure that it is mostly with the people who have a certain education. It is always easier for me if they have a certain education." – LC*

The question had been intended to determine if nurses were more at ease with, for example, cardiac patients as opposed to those with mental health problems, or calls concerning babies as opposed to those concerning the elderly. These types of distinctions did come out with many of the nurses but evidently, as one might expect with the use of open-ended questions, departures from the expected often provide rich insights. On the other hand, being "too much" like the nurse also causes a reaction:

> *"We all have our „little black bugs' that will make us feel aggressive, right? For me it can also be someone who says, „Iam a nurse,' or „I work in the healthcare field,' [right away] I feel that I am in a competition, that I have to be twice as good." –BN*

This comment brings to mind previously addressed sociological notions that medical knowledge is power (Foucault, 1975; Friedson, 1988; Peterson and

Bunton, 1997). The nurse feels that her status is open to challenge in that she shares more medical knowledge with this particular caller than with most. For the same reason, the general feeling from this type of comment seems to arise out of the sense of privilege that comes with the caller's announcing "I am a nurse"; that is, it is interpreted by the *Info-Santé* nurse as: "I share your knowledge therefore you must deal with me differently that you would with others" and demonstrates attempts to invert the power asymmetry inherent in the nurse-caller interaction. Leppänen (2009: 20) noted similar reactions of nurses to power/knowledge challenges by what she refers to as "professional" callers.

In general, those seeking a privileged status for whatever reason are cause for discomfort and negative comments among nurses at the call's conclusion. This notion came out in a number of ways over the course of the interviews and was evident during participant observation. Nurses vocalized their understanding that they are "supposed" to treat everyone the same: all callers are to be considered of equal status, of equal importance. Indeed, the standardized protocols themselves promote "objectivity," an excess of which demeans individual subjects, minority cultures, and neglects the reality of the caller's lived experience. Thus, the reality, as we have seen and will see from the speakers themselves, is that this ideal type of objectivity is neither realistic, nor desirable if nurses are to "see" each caller as an individual, with individual needs.

The Voice and Social Status

I tried to examine this phenomenon with a number of questions addressing socioeconomic status directly. What I found was that the nurses generally tended to take a defensive stance in response to the interview questions, seemingly reluctant to acknowledge distinctions they might make in response to differences in social class. Asked the question: "What are the effects of socio-economic status on the kinds of service requested or received by the callers?" The response below is representative of the nurses' difficulties in dealing with social inequalities:

> *"It is sure that there is a barrier sometimes in the calls from people on social assistance who ...ah, it is a judgement and I hate that ...who want all services free .. ,,I don't have money for my teeth,' ...it is a problem, no money, but these people, well, sometimes they don't want to be on social assistance, they want to get off it. She has a problem with her teeth and she wants them to be pulled, she has to go to the dentist, but she has no money. [With] social assistance, well, it all goes on the card. It is the category [of poor people] just above that [not on social assistance but poor] who have a need but don't have the means. If they were on social assistance it would be alright, but because they want to get out [of poverty], they are limited because, well, even when they are on social assistance, I tell you sometimes there are people who will say, ,,Ihave a fever and I'm going to the hospital, I going to take the ambulance,' and we have to advise them that the ambulance is not free, you know, unless*

it is really an emergency. It is possible that they will be obliged to pay. But I think that the category of people who just want to get out of poverty by themselves, who could be on social assistance but want to do it on their own, I find it is difficult. Always you try to find the best solution for someone who does not have the means but it is not easy. Things like the ‚morning after' pill or an aloe gel for their burn, there is no money because these things were not foreseen in their budget." –AL

Again, we note the nurse's acknowledgement that she is making judgements, generalizations about the poor, and is aware that this is not something she is "supposed to do." We note the distinctions between categories of the poor, as described by this particular nurse, in the above example. There are those on social assistance for whom, according to this speaker, all services are expected to be freely available and who are perceived as not wanting to better their status. The second group are those on social assistance who do not want to be recipients of the service but find themselves in a position where they have no choice. Lastly, there are those who are poor enough to be on social assistance but choose to be independent of social assistance. This nurse's categorization of these three groups and her moral evaluation of these were consistent across all interviewees. It would appear that these nurses have successfully incorporated Western notions of the Protestant ethic in regard to social status (Weber, 1988). In addressing this moral interpretation, it comes out that this last group is one which, though the nurse seems to find honourable, is also a group for which solutions are more difficult. These are the callers without an economic safety net. For those on social

assistance, and for whom the accompanying free services are seen as subject to abuse, there is the sense that they will be taken care of, that the services are there for them to use, or abuse, as the case maybe. The remainder of the poor do not have the luxury of this fall back system. They must find the means to get by on their own. This frequently increases the pressure on *Info-Santé* nurses to assist them in finding their own solutions.

This same nurse was asked if she thought that the elderly might find themselves in similar situations. She answered that she had not yet seen this situation with the elderly, but that she imagined it could be the case. She added,

> *"And it could happen with the middle class too. The dad who just lost his job, or just quit because he had a fight [with the boss] and doesn't have employment insurance, yes, I think this situation could happen to all classes in society." – AL*

Asked if she sought to know the socioeconomic status of the caller, this same nurse interpreted my question literally, replying:

> *"No, but if the person says, „Ican't, I have no money. Do you have another trick?' I think that the information that we give, it is information for anyone regardless of their category. If they don't have the means, well, we have to figure out alternatives. But no, I don't ask questions about their socioeconomic status. Everyone has a right to the same answers and if it doesn't work, we find other alternatives." –AL*

Despite the literal interpretation of the question above and the generally defensive stance taken by most of the nurses in response to the question, nurses made it clear throughout the focus groups and interviews that they regularly pick up on the callers' socioeconomic status by less direct means and seek alternative solutions to help callers to deal with their problem. Asked the question: "What are you able to discern from the voice of the caller?" the junior nurses voiced the following sequential comments in their focus group:

"The social class ..." - CD

"Mostly in the language used, yes." –GH

"Or the place they are calling from too sometimes. We hear wind in the telephone, and we know they are outside. When it is a cellular [phone] the line is less clear. [If they are calling] from a phone booth, they have less money [they may say] „Ilost 50 cents waiting for you.'" - SL

"There's the social milieu of the person, the language ...the person calls and it's 'Yeah, my baby won't stop shitting and puking everywhere' – right away, you're not going to use the same terms. You have to use more common words, you have to adapt ...sometimes, I am going to say „bum' because 'anus' is not even in there in their vocabulary." - KD

"Yes, but sometimes you have, for example, the elderly person, who is not comfortable using some words and she won't even dare to say it and you have to guess and have her confirm it. You see that the person comes from a prudish background, you see that it is an elderly person." –SL

"The elderly are often more vague with their terms." - GH

"Yes, the young too, the language they will use ...if you use scientific words, they will hang up." - KD

The first four speakers demonstrate their having picked up on clues to social class from the voice and more specifically from the language used by the caller. In the interviews, too, we note that the nurses make explicit connections with the callers' vocabulary, particularly the use of slang, vulgarity and swearing, and their educational status and social class. These last two social traits, educational status and social class, are indeed understood as interchangeable in most of the nurses' comments. For example, this nurse's comments in her interview:

"People who are less well-off will be a bit more stuck ...for instance, they will have difficulty to see a little farther, to think a bit more [in depth]. But I don't think, at least I don't [pause] first, it is not something that I look at [socioeconomic status] except from the point of view of resources ...because for me if you are very rich or very poor, for me you

are equal ...because if it is a doctor who calls me for advice, I will give the same answer as I would to the person who sweeps the streets. Unless it is someone who has more of a facility to understand ...it is mostly at the level of language, sometimes you have to speak more commonly to the person who has less education." –BM

From the analysis of the data, it was evident that the linkages of vocabulary and these social traits were more easily talked about in response to general questions, rather than those that specifically addressed socioeconomic status, which as stated above, seemed to render the nurses defensive. Waitzkin (1991) found that doctors tended to avoid dealing with patient's social problems, but many of these *Info-Santé* nurses express a willingness to adapt their self-care suggestions and/or referrals to meet the caller's social needs, within the limits of constraints often imposed by resources of the health and social service system itself. In this sense, the nurses are making use of "background knowledge" and melding it with the "foreground knowledge" which, as May (1992) suggested, gives meaning to nursing work and is indicative of a more holistic concept of nursing.

The above quotes also lead us to discern the nurses' perception that use of language, or its avoidance, is often generational; that is, that generational mores affect the ease with which callers use specific terms for the body and its functions. This avoidance is most notable with regard to sexual terms, sexual body parts and sexual functioning, and seem to be more pronounced, as the nurses tell us, with the elderly and the young (adolescents and young adults). The use of language,

then, provides access to a number of social traits and categories and does not necessarily, for these nurses, always denote social class as illustrated in three of the examples above. This vagueness of language presents its own difficulties for the nurses, the quotes above suggest, as they try to conduct the evaluation of the caller's problem. We will encounter other such comments concerning "generational" differences later in the chapter.

The Voice, Languages and Cultural Values

The particular linguistic realities of Quebec also are omnipresent in the *Info-Santé Centrale.* Among the 27 full and part-time nurses at the Estrie *Centrale*, only nine nurses were "coded" to take calls in both English and French at the time of this study, and this despite the designation of this *Centrale* as one of four within the province to treat English-language calls. The remaining nurses lack sufficient English second-language skills to be able to "treat" calls in English. This "coding" is the result of administrative programming of particular codes ascribed electronically to the individual nurse's sign-on code. Thus, when the nurse "signs-on" electronically to the telephone distribution system at the beginning of each shift, the pre-installed codes indicating the individual nurse's abilities to "treat" different types of calls, including language distinctions, are automatically initiated. Such coding of language distinctions, however, does not necessarily eliminate linguistic difficulties encountered by the nurses, as we shall see. Accents, for example, are considered problematic in general, as are regional accents and expressions.

"Since we are virtualized, we have the accents from the other regions ... sometimes, I ask myself, ‚Is he speaking to me in French or in another language?' And expressions, you know, when you [have a call from] the lower Saint Lawrence ...there are regions that have expressions and accents that are difficult to understand." –RD

"I don't know if there is a side to language because I answer [calls] in English. I am not a native anglophone. I think though that I have a [sufficient] level of English ...I have had an evaluation that says that I am functional [in English] but for me it is still a barrier ...a barrier in the sense that there are always terms that I have mastered less well and that I try to validate with other expressions." –BN

"Linguistic barriers, sometimes we have them. There are many ethnicities, more and more all the time, and sometimes the accents are very strong, and there are words used sometimes, other than English." - JN

Within the *Centrale*, comments are often made among the nurses concerning the necessity of using English. Having to express oneself and to conduct an evaluation in a second language is perceived as an added strain for the nurses. During the H1N1 "crisis" in the fall of 2009, the number of calls from English-speakers rose dramatically, as did the overall number of calls. Nurses

could be heard to complain that, “It seems all I did today was answer calls in English,” or “Yesterday, I took so many calls in English, I was so tired when I got home – I was wiped out” (participant observation notes). The same is true of those with foreign accents.

The nurses’ normative social values are frequently confronted during calls. As the following conversation from the senior focus group illustrates, nurses’ notions of the equality of women and accepted gender roles in Quebec society are among such values explicitly addressed:

> *“One thing that really gets me – we’re still speaking of the voice – is when the man calls for the woman and you say, „Can I please speak to your wife?’, [and he replies] „Why? I am capable of answering for her.’ But when you ask questions, he turns to her for the answer and repeats it to you and you say to yourself, „This guy is controlling’ ... the North African who calls for babies ... the wife does not speak on the phone, she is mute. I think these calls confront us directly [our values]. I would never let my husband decide that he would call for me, or that he would do this or that, that he would tell me what to do - not me – I just can’t take this attitude – it really gets to me.” –PH*

> *“Yeah, but you have to see the men of the generation who are now 70-80 years old, it is always their wives who call for them ... because the men aren’t used to it [seeking medical advice]. They don’t know what to say,*

they don't know how to say it. So, it is not just cultural, it is generational too, you see, it is how they were raised." –BN

"Well, yeah, it is the mentality. It's as though the men of that generation are shy to call, but if you ask to speak to them, they are able to describe ...I don't have any trouble with these men, it is more the young men, who want to control their girlfriends [that I have trouble with]. The ones I have the most trouble with are, I don't know if I should say this, but it's with the idiots. You know, they don't understand at all [they'll say] „Yeah, well listen here, I want something concrete.' You know, they are full of slang, full of stupidity. I give the information, but I am less kind. With others, like the elderly, I am patient with them or with the young mother who just gave birth, who has a little baby who is not doing well, I have patience; but with the idiots, my call won't last very long." - RD

The three quotes above occurred sequentially in the more senior focus group. We have demonstrated the recognition of cultural and generational differences in gender roles, how these are manifested in the call, and how these are perceived or interpreted by the nurses. Health care is seen as the woman's domain, particularly amongst older generations of Quebeckers. Thus, it is seen as typical for the Quebec wife to call for her 70 or 80 year-old husband. In contrast, the North African husband who calls for his wife is perceived as controlling. Indeed, "talking through a third party" often places nurses in an ethical dilemma as they seek to meet the needs of the patient (Holmström and Höglund, 2007: 1867).

Newcomers to Quebec and North America in general are subject to established gender roles of the host society as well. Thus, well-known patterns of public and private spheres often find immigrant women at a disadvantage linguistically, being less likely to quickly learn the host society's language if spending their days at home with young children. This can be seen as one alternate explanation for their husbands' calls to *Info-Santé*, as opposed to the interpretation offered by the speaker PH above. It is apparent from the above, that a multicultural society places particular ethical demands on nurses as they struggle to avoid violating cultural norms and values of their callers while seeking to do what is best for the person in need.

The Voice and the Health Care System

While some callers are constrained by their social circumstances in their ability to respond to health problems, this limitation is further exacerbated by conditions in the health care system itself. In this, nurse and caller alike are united in their frustration. The quotes below offer rich insights.

> *"Aggressivity, you're going to feel that a lot. The guy who calls you for a toothache and you don't have any solutions [no clinics are open] and you tell him to go to emergency, that they can give him something for the pain and he starts swearing at you. It is not always ,,chic' – you can tell that it is a social milieu where there is no money. ... [they say] ,I am on*

foot' – [and you say] „Call a friend' - you can't take them by the hand to emergency, they have to figure things out on their own." –BM

"Even with the voice, you can sense that they want to go [to emergency] but they are really stuck: „Well, I just don't have the money' and finally it is up to us to try to find a solution for them – for some everything is their due – you know the ones [who say] „Iam on welfare, and I have no money, so ...' and then there is the young mother who really has no money." - KD

"I find that often it is the people less well-off, I am not generalizing (sic) -but I find that often, we could say that we have to fix all their problems. Often I find that they expect more than others, they hope that we will be able to solve everything, find them transport, that we will give them a diagnosis, you know, I find that they are more demanding. If we tell them that they need to consult [a doctor], then [they say]: „I can't, I don't have the money, I don't have a ride,' well my job stops there. I find that people from a less favourable milieu are more demanding. I have the impression that I am unable to meet their expectations; what they expect from me, I am unable to do anything about. And they are frustrated but at the same time, I can't do everything. At the end of the day, there is a limit to what I can do for them. But they always seem to want more; these people take more energy [to deal with]." –LC

The comment made by KD above portrays the speaker's moral distinction made between those on welfare, who, according to this speaker, expect everything from the State and those who are poor but do not hold this expectation. While the nurses note the frustration of the caller, it is clear from the LC's comments above that these types of calls engender frustration on the part of the nurses as well. If nursing is to be understood at least in part as a helping profession, to have demands or expectations from callers that are considered outside the bounds of the role of the *Info-Santé* nurse is felt as a frustration on the part of the nurse. However, within the bounds of the role of the *Info-Santé* nurse, referral of many of such social dilemmas to appropriate agencies is expected, both by the caller and as the legitimate task of the nurse. Thus, the nurse may decide to transfer the caller to a social worker or suggest a number of community resources that may be of assistance. Problems arise, however, given the fact that many social or medical resources are not available on a 24/7 basis, or that these may not be able to respond to the need in the timely manner required, which necessarily places limits on the nurse's ability to respond to the caller's need. Frustration with the lack of availability of services to which the nurse can readily refer the caller is a daily feature of the practice of *Info-Santé* nursing, challenging their nursing *care* as well as their *ethical* values and creating dissatisfaction with the job for many of the nurses. Similar findings were found by Holmström and Höglund (2007) in their study of Swedish telenursing where burnout often resulted from these very same issues.

Frustration may be in large part responsible for the nurses' apparent lack of sympathy with the plight of the callers. What appears as complete dependency

on public services by the callers and their lack of alternative resources, their limited social capital, reappears in some of these nurses' interpretations as an unwillingness to act on their own behalf. Frustration is experienced by callers too, as evidenced by the comments above is common as they attempt to address their needs and find themselves caught between personal and health or social resources.

These problems raise policy questions related to the creation of dependent populations within a social welfare system, bringing to mind, yet again, well entrenched Westernized ideals of independence and self-reliance and the all-too-often apparent contradictions between the two positions. It also raises questions of the role of *Info-Santé* within the health care system. Educating callers in matters of health is a key role of the *Info-Santé* service and provides for opportunities for callers to develop their own skills and adopt both habits and attitudes that allow them to have more control over their lives. Mirowsky and Ross (2003) call this "learned effectiveness." Policies then which seek to increase educational attainment have the power to decrease health inequalities; *Info-Santé* seeks to equip callers with self-care strategies and health information that have the potential to create such "learned effectiveness."

Conclusion

As is evident above, callers' use of language is indicative of a number of social characteristics. The linkage between education and social class is clear. There are also distinctions in linguistics concerning accents, for example, foreign

and regional, and ethnic. Use of language according to generational standards is also raised by the nurses.

The personal and professional values of the nurses are brought to the fore, particularly in the quotes concerning gender roles and gender equality as well as those concerning social class and ethnicities. The nurses are, for the most part, francophone, native Quebeckers. One nurse immigrated from France and was married at one time to an African; two are married to or in long-term relationships with immigrants from Haiti and Africa. All the nurses taking part in each of the focus groups and those interviewed are Caucasian, Catholic, and francophone. Values expressed then are generally understood as those typical of the majority group - middle-class Quebec values. The culture of this particular *Info-Santé Centrale* arises partially from these values. The ways in which this culture would be affected by the addition of nurses from other ethnic groups or differing social backgrounds would be interesting to study and may indeed be available in other *Info-Santé* centres.

Nursing is social. The *Info-Santé* nurse's day can be understood as a series of social yet disembodied encounters, mediated by the telephone and therefore, by the lack of physical contact between the participants of the exchange. Nurses' relations to callers, then, are dependent on the voice and the social characteristics of the callers that are made available through the voice and the ambient sounds transmitted through the telephone. As we have seen, these nurses have learned to "hear" the social in the voice in order to adapt their interventions to the individual caller's needs. The interpretation of these social characteristics of the callers is itself mediated by the social characteristics of the nurses: their culture, language,

religion, sex, education, personal histories and nursing experiences. As we have seen, the social does not disappear in the absence of physical presence; rather it remains omnipresent in its manifestations through the voice.

Chapter 8 - Conclusion

Structural characteristics of health care in Canadian society are changing rapidly, with many service delivery transformations over the last twenty years, and likely many more to come. In large part, these transformations have been in response to fiscal constraints imposed by provincial governments on the health care system as a result of federal government cutbacks to the provinces for health and social services in the early to mid 1990s (CIHI, 2009). In Quebec, this response has become known as the *virage ambulatoire*, the shift to ambulatory care. This *virage* saw the closure of a number of active, acute care hospitals in the province in general, and in the Eastern Townships (Estrie 05 Region) in particular and the continuing practice of early discharge of hospital patients following surgeries, births, and medical treatments. It provoked the restructuring of many other kinds of health services, "downloading," if you will, these to an inadequate supply of home care nurses and to individual patients and their families.

The telephone nursing consultation service, *Info-Santé,* was established as part of these fiscally motivated transformations. Its mandate as a front-line service is to evaluate, advise and refer its callers to appropriate resources within the system, thus reducing unnecessary visits to emergency departments, and/or to provide callers with self-care techniques.

Info-Santé has become an increasingly utilized service within the health care system as its mandate continually expands to include 24/7 response capabilities for registered clients in long-term care facilities and family medicine

groups (GMFs), among others (*Info-Santé Centrale Estrie, Rapport Annuel 2008-2009, 2009)*. It serves as a vital link for the *Santé Publique* and various other members of the health care network. *Info-Santé* provides a vast array of front-line services that are easily accessible by anyone with access to a telephone. It is universally accessible, requires no specialized equipment, and is free at the point of service.

Despite *Info-Santé's* key role within the Quebec's health care system, until now very little research has been done to examine the advent of this nursing service and its particularities from the perspective of its nurses. The purpose of this research was to explore *Info-Santé* nurses' perceptions of the place of *Info-Santé* within the health care system as an integral component of the *virage ambulatoire* (the shift to ambulatory care) and to examine the particularities of *Info-Santé* as a "disembodied" nursing practice arising from the implementation of a relatively new health technology. Through their thoughts and experiences these nurses provided rich data from which I uncovered the interplay of various key aspects of the nursing evaluative process as performed by these nurses in the absence of a physical patient.

Research Findings

"Disembodied" Clinical Gaze

Having explored *Info-Santé* from its inception to the intricacies of its practice, this research expands upon Foucault's sociological notion of the clinical

gaze. Qualitative research methods and strategies were chosen to allow for a detailed exploration of the clinical gaze and its practice in a clinical setting that is becoming increasingly commonplace both nationally and internationally. Primarily by way of the extended case study method and employing grounded theory to inform the study's structure and analysis, I have presented findings that speak to an alternate version of the clinical gaze - one in which the body, as object of the gaze, is available only acoustically.

The voice and its accompanying nuances inform this "disembodied" gaze and provide both verbal and non-verbal cues and clues to the nurse in her/his evaluations. The voice is taken to include timber, tone, pauses, speed, and sighs, among other qualities, all judged by the nurses as critical components of the evaluative process. Indeed, during the *Info-Santé* nurse's telephone evaluation the voice and its various qualities are often afforded primacy over and above the credence given the caller's words, particularly if these tend to contradict each other. The voice and accompanying ambient sounds provide the experienced listener with a vast array of pertinent health and social information that have profound effects on the nurse's decision-making process.

Richly apparent in the data presented herein is the importance of apprenticeship for the "socialized competence of practitioners" as noted by Atkinson (1995: 47). This apprenticeship, in turn, gives rise to a *situated* knowledge adapted to the particular practice of "gazing without seeing," and constituting a unique form of nursing knowledge which melds traditional nursing ways of knowing through touch and sight in the physical presence of the patient with the practice-specific knowledge required to aurally evaluate callers' health

and social needs. The practical application and particularity of this knowledge gives meaning to the (care) work of *Info-Santé* nurses and creates a sense of membership that binds its practitioners together.

"Real Nurse"

Info-Santé presents the population and nurses alike with a revolutionary form of nursing. In this regard and in contrast to direct hands-on patient care, a paradigm shift was required to absorb the notion of nursing in the absence of a physical body. That is, as a disembodied practice, *Info-Santé* is an extra-traditional nursing service, calling for the redefinition of "nurse" by its practitioners, its health system partners and by the public at large. From the data we have witnessed the contrast between these parties' perceptions of an "ideal type," what the participants refer to as a "Real Nurse," and an *Info-Santé* nurse. A critical aspect of this comparison is that it results in identity and recognition issues for the nurses themselves and for the service as a whole.

The paradigm shift mentioned above is ongoing. The data support the idea that 15 years following *Info-Santé's* implementation in the Eastern Townships, the "fit" of the service within the Quebec health care system continues to be awkward and at times problematic,[23] bringing to mind Abbott's (1988) notion of interprofessional jurisdictional disputes, herein reformulated as *inter-service* disputes. These notions of *ideal type* and *inter-service* disputes interact and affect the perceptions held by other health care professionals of *Info-Santé* nursing and

[23] For example, the difficulties in communication among the Ministry, the *Santé Publique* and *Info-Santé* referred to at the time of the H1N1 "crisis."

the service's role within the health care system as well as the professional self-identities of *Info-Santé* nurses as these all continue to undergo transformation. As members of the health care network, *Info-Santé* nurses have a strong sense of membership in a nursing enterprise that remains misunderstood and underappreciated by other health network partners. In fact, it is the perceived lack of appreciation for their work by their peers and partners that unites *Info-Santé* nurses, provides them with a strong sense of solidarity, and contributes to an *Info-Santé* nursing culture.

Power and autonomy

The interrelatedness of knowledge, power and practice is a critical element of analysis in this study which demonstrates the nurses' awareness of their professional power and its limits within the practice of their work, both in terms of patient interaction and within the health care network itself. The explicit acknowledgement of experience, its vital connection to knowledge accumulation and its counterpart which these nurses refer to as a sixth sense or instinct, is one of the key findings of this study and adds to the evidence already accumulated in this vein (Snelgrove, 2009).

Nurses' autonomy within *Info-Santé* is limited by the structure of its practice and its protocols, but we have seen evidence too of resistance, and of power, particularly in nurses' clinical decision-making. There is also evidence of a high degree of professional discretion available in a setting, such as telephone nursing, that is available only to nurses and their callers. This aspect too is noted in other findings (Leppänen, 2010).

Nurses' disclosures demonstrate the power asymmetry inherent in their interactions with callers. In this regard, the service's surveillance and gatekeeping functions are taken on by and operate through the nurses' interactions with and directives to callers. The nurses make use of callers' social categories, particularly social class and education, to adapt information suggestions for care. Consistent with findings reported in Leppänen (2010), the nurses interviewed in this study reported displaying more power over patients they deemed to be difficult, that is demanding or aggressive callers, or those who challenged their professional competence or control.

Concluding thoughts

This study has explored the richly nuanced world of the *Info-Santé* nurse. The techniques and strategies developed by the nurses over time to "see" the caller are well articulated by the nurses themselves and are keenly insightful as sociological data, exposing as they do cultural, social, moral, political and economic cues which necessarily but often unconsciously act to guide the telephone intervention. This research enriches the bodies of knowledge that inform the sociologies of knowledge, professions, health and the body.

In its examination of how these practitioners' ways of knowing are informed through previous nursing and personal experiences, and transformed through experience gained during the continual application of the practice of telephone nursing, this work contributes to sociological understandings of situated knowledge and what it means to see this knowledge in practice. It reminds us of the connection of knowledge and power as the nurses both exert power through

their practice and react to the limits of their power within the caller/nurse interaction, under the surveillance of service managers and agents of the Ministry of Health, through manifestations of the division of labour as a nursing service within the health care system, and within vital channels of communication among health care partners.

This research contributes a new and unique perspective to our understandings of the clinical gaze, as tele-technology has impacted the practice of that gaze. In this regard, *Info-Santé* is an insightful example of *biopower*, understood as a reformulation of power/knowledge which acts to extend the clinical gaze to discipline populations (Foucault, 1978). A critical dimension of biomedicalization and the "self-surveillant" society is the diffuse operation of power; *Info-Santé* contributes to this diffusion primarily through its informational and educational roles. This study increases awareness of this particular nursing service and its place within the health care system - all the while, reminding readers of the over-arching surveillance methods of the state and the practical effects of policy decision-making.

Buroway (2009) extols the virtues of the extended case study method, and indeed, I have found that this method is most applicable to this study. As explicated by Buroway, the extended case study method and the "reflective science" that is brought to the method, allows for the extension of the ethnography to wider society's macrostructures and patterns within the broader historical context. That is, though this study is situated within this particular *Info-Santé Centrale*, its findings can also be extended and thus understood as a response to state political and economic concerns evident in Quebec and in many

other jurisdictions both nationally and internationally. Among these concerns are state attempts to control ever-increasing health care costs. *Info-Santé* seeks to orient callers to appropriate health care centres or to self-care strategies, reducing both inappropriate use of ambulance services and consultations to emergency rooms thus helping to ensure adequate and timely emergency care for those most in need of such services.

Info-Santé assures 24/7 accessibility to health care information, education, and evaluation of health needs. In these ways, it acts to partially address structural constraints within Quebec's health care system which are exacerbated by shortages in health care personnel, particularly family doctors, and increasingly limited accessibility to timely general medical services for those without family doctors. It is hoped that these data will also raise awareness of some of the difficulties encountered by *Info-Santé* in its relations with the Ministry of Health and Social Services – the MSSS, the *Santé Publique*, various other health network partners and last, but certainly not least, the interaction of these with the media.

The unique skills and situated knowledge of *Info-Santé* nurses merit greater recognition. This research contributes to a greater understanding of the service's functions and needs within the system in order to improve the public's health. Such recognition would likely positively affect professional identity issues identified in this research and would work to increase *Info-Santé* nurses' satisfaction with their jobs, to improve the attraction and retention of nurses to the service and to advance recognition of the service's role within the system as a network partner.

FORMULE DE CONSENTEMENT ET DÉCLARATION D'INFORMATION À L'INTENTION DES PARTICIPANTS

Titre de la recherche: *Info-Santé : Une étude de cas d'un service de soins de santé désincarnés*
Titre original: *Info-Santé : A Case Study of a Disembodied Health Care Service*
Chercheuse: Norma J. Husk, candidate au doctorat, Département de sociologie, Université McGill
Coordonnées: norma.husk@mail.mcgill.ca
Supervision facultaire: Prof. Jennifer Fishman, Ph. D. Professeure adjointe, Unité d'éthique biomédicale, Université McGill, 3647, rue Peel, Montréal, Québec H3A 1X1. Tél. (514)398-7403; Jennifer.fishman@mcgill.ca

But de la recherche

Vous êtes invité à participer à une étude sur les soins de santé et leur promotion dans l'exercice de la profession d'infirmière pour Info-Santé. Comme service de première ligne, Info-Santé occupe un rôle stratégique dans le contexte du système de soins de santé. Je cherche à comprendre les difficultés particulières, s'il en est, que vous rencontrez dans votre rôle d'infirmière pour Info-Santé et dans l'évaluation au téléphone du patient appelant.

Rôle du participant

Votre participation est volontaire. Si vous choisissez de participer, ce groupe de discussion explorera vos impressions quant aux aspects social et culturel du rôle de l'infirmière dans le système de soins de santé; un des sujets abordés sera l'apprentissage des techniques d'évaluation et de représentation de l'usager par l'infirmière qui intervient au téléphone. Bien que la durée de la séance du groupe de discussion puisse varier, celle-ci prendra tout au plus une (1) heure. **Votre participation à cette recherche est entièrement volontaire. Vous pouvez choisir de ne pas répondre à certaines questions ou de vous retirer du groupe de discussion en tout temps.**

Confidentialité

Un enregistrement audionumérique de la séance de groupe sera réalisé. L'information recueillie au cours de la séance du groupe de discussion ne sera accessible qu'à mon superviseur et moi, D^{r} Fishman et Norma Husk respectivement. En aucun cas vos commentaires ne seront mis à la disposition d'Info-Santé ou d'administrateurs. Comme d'autres participants seront présents lors de la séance du groupe de discussion, la capacité de la chercheuse à assurer l'entière confidentialité de la séance de groupe est limitée. Vous pouvez choisir de ne pas répondre à une ou à plusieurs questions, ou choisir de vous retirer de cette étude en tout temps en communiquant avec moi (coordonnées ci-dessus). Certaines citations directes tirées de vos commentaires pourraient être utilisées. Cependant, l'information rapportée sera publiée de façon à ne pas divulguer votre identité. Aucun nom réel ne sera utilisé.

Risques et avantages

Certaines participantes pourraient se sentir comme si leurs compétences sont évaluées au cours de la séance du groupe de discussion. L'objectif de l'étude n'est cependant pas d'évaluer vos compétences professionnelles, mais bien de recueillir vos impressions. Si pour quelque raison vous vous sentiez mal à l'aise, il vous sera possible de mettre fin à votre participation à tout moment, et ce, sans contraintes ni conséquences. Le seul inconvénient sera le temps requis pour la participation.

Le participant ne tirera pas un avantage direct ou personnel de sa participation. Votre participation pourrait contribuer au savoir relatif au service à l'étude (en l'occurrence Info-Santé) et à ses particularités dans le contexte de la littérature sociologique.

Diffusion des résultats

L'information recueillie sera analysée et présentée dans mon mémoire de doctorat. Il est possible que cette information soit présentée dans des publications universitaires comme dans des articles de revue, un livre ou lors d'une conférence.

Droits des sujets de recherche d'un établissement de santé

Si vous voulez formuler une plainte en lien avec votre participation à cette recherche, vous pouvez contacter la personne responsable du traitement des

plaintes au CSSS-IUGS, monsieur Germain Lambert au 819-562-9121, poste 40204.

Approbation par le comité d'éthique de la recherche

Ce projet de recherche a été évalué et accepté par le comité d'éthique de la recherche des centres de santé et de services sociaux de l'Estrie. Pour tout problème éthique concernant le fonctionnement de ce projet ou les conditions dans lesquelles votre participation se déroule, nous vous prions de discuter avec le responsable de cette étude. Si vous n'avez obtenu une réponse satisfaisante à vos préoccupations, veuillez communiquer avec la présidente du comité d'éthique au secrétariat en composant le 819-562-9121, poste 47101.

Consentement éclairé

Déclaration du participant

Je soussigné(e) déclare que l'on m'a expliqué la nature et le déroulement du projet de recherche, que j'ai pris connaissance du formulaire de consentement et que l'on m'en a remis un exemplaire, que j'ai eu l'occasion de poser des questions auxquelles on a répondu à ma satisfaction, et que l'on m'a accordé un temps de réflexion. Je reconnais avoir été informé(e) de façon suffisante sur la nature, les bénéfices et les risques liés à ma participation à ce projet de recherche. Ceci étant, j'accepte librement et volontairement de participer à ce projet de recherche.

Nom du sujet :_____(en caractères d'imprimerie S.V.P.)

Signature du sujet : _____

Date de la signature :_____

Déclaration de la chercheuse

Je soussigné(e) certifie avoir expliqué au signataire intéressé les termes du présent formulaire, avoir répondu aux questions qu'il m'a posées à cet égard; lui avoir clairement indiqué qu'il reste, à tout moment, libre de mettre un terme à sa participation au projet de recherche décrit ci-dessus.

Nom de la personne obtenant le consentement :_____
____

(en caractères d'imprimerie S.V.P.)

Signature de la personne obtenant le consentement :

_____

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Rôle du participant

Votre participation est volontaire. Si vous choisissez de participer, je vous interviewerai une fois. L'entrevue portera sur vos impressions quant aux aspects social et culturel du rôle de l'infirmière dans le système de soins de santé; un des sujets abordés sera l'apprentissage des techniques d'évaluation et de représentation de l'usager par l'infirmière qui intervient au téléphone. Bien que la durée de l'entrevue puisse varier, celle-ci prendra tout au plus une (1) heure.
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Confidentialité

L'anonymat de l'information obtenue dans le cadre de cette étude sera parfaitement conservé. Vous pouvez choisir de ne pas répondre à une ou plusieurs questions, ou choisir de vous retirer de cette étude en tout temps en communiquant avec moi (coordonnées ci-dessus). Certaines citations directes tirées de vos commentaires pourraient être utilisées. Cependant, l'information rapportée sera publiée de façon à ne pas divulguer votre identité. Des pseudonymes seront utilisés dans l'éventualité d'une publication. L'information recueillie au cours de l'entrevue ne sera accessible qu'au D^{r} Fishman et à Mme Husk. Aucune autre personne au service d'Info-Santé n'aura accès aux données recueillies. L'information tirée de l'entrevue ne sera transmise à aucun des administrateurs d'Info-Santé, ni diffusée dans le réseau CSSS-IUGS.

Risques et avantages

Certaines participantes pourraient se sentir comme si leurs compétences sont évaluées au cours de l'entrevue. L'objectif de l'étude n'est cependant pas d'évaluer vos compétences professionnelles, mais bien de recueillir vos impressions. Si pour quelque raison vous vous sentiez mal à l'aise, il vous sera possible de mettre fin à votre participation à tout moment, et ce, sans contraintes ni conséquences. Le seul inconvénient sera le temps requis pour la participation.

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L'information recueillie sera analysée et présentée dans mon mémoire de doctorat. Il est possible que cette information soit présentée dans des publications universitaires comme dans des articles de revue, un livre ou lors d'une conférence.

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Consentement éclairé

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Nom de la personne obtenant le consentement :
_____ (en caractères d'imprimerie S.V.P.)

Signature de la personne obtenant le consentement :

_____

Date de la signature :_____

Questions à l'intention de groupes de discussion

1. Comment décririez-vous votre rôle à titre d'infirmière d'Info-Santé?
2. Dans quelle mesure y a-t-il un accent sur l'enseignement dans le cadre de votre rôle d'infirmière d'Info-Santé?
3. Quelle importance revêt l'enseignement fait dans le contexte d'Info-Santé par comparaison avec l'enseignement fait à titre d'infirmière dans des postes précédents?
4. Comment votre rôle d'infirmière pour Info-Santé diffère-t-il des postes d'infirmière que vous avez occupés auparavant?
5. Comment votre rôle d'infirmière pour Info-Santé ressemble-t-il aux postes d'infirmière que vous avez occupés auparavant?
6. Selon vous, comment d'autres infirmières (extérieures à Info-Santé) perçoivent-elles votre rôle?
7. Que pensez-vous de ces impressions?
8. Selon vous, quelles sont les difficultés particulières de ce poste?
9. Comment faites-vous pour vous représenter mentalement l'appelant et son problème?
10. Portez-vous une attention particulière à certains signes durant l'appel? Quels sont-ils?
11. Que vous révèle la voix de l'appelant au sujet de celui-ci?
12. Est-ce que la voix de l'appelant vous donne plus d'information quant à la raison de son appel? Veuillez expliquer.

13. Ce que vous entendez est-il toujours confirmé par ce que l'appelant vous rapporte? Veuillez expliquer.
14. Dans quelle mesure votre impression de l'appelant est-elle modelée par l'information de base que vous obtenez à son sujet? Par la raison de l'appel?

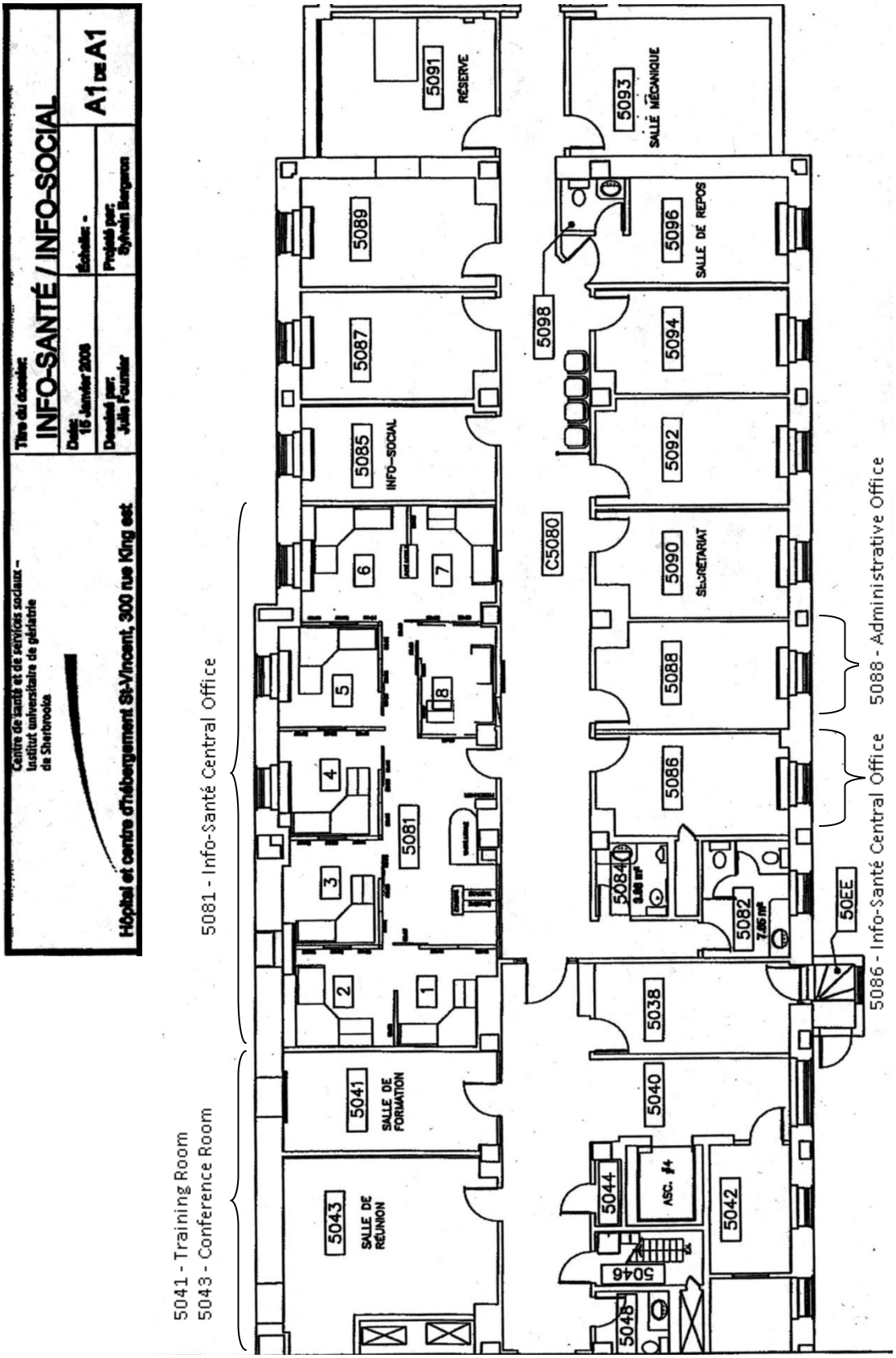
Guide d'entrevue – Info-Santé

1. Comment est-ce-que vous voyez votre rôle comme infirmier (ière) en Info-Santé?
2. Comment est-ce-que vous croyez que d'autres infirmiers (ières) et autres professionnels de la santé perçoivent votre rôle?
3. Comment est-ce-que vous croyez que votre rôle soit vu par la population?
4. Qu'est-ce-que vous voyez comme des défis particulier de ce rôle d'infirmier (ière) en Info-Santé?
5. Comment est-ce-que vous voyez le rôle d'Info-Santé comme service dans le système de santé?
6. Qu'est-ce-que, selon vous, pourrait être mis en place pour améliorer le fonctionnement du service Info-Santé? (il y en a des améliorations à faire)
7. Qu'est-ce-que vous trouvez le côté plus frustrant du nursing en Info-Santé?
8. Qu'est-ce-que vous trouvez le côté plus valorisant du nursing en Info-Santé?
9. Combien de temps est-ce-que vous prévoyez rester travailler en Info-Santé?
10. Quels types d'appelant vous mettent le plus à l'aise? Pourquoi?
11. Quels types d'appelant vous mettent le plus mal à l'aise? Pourquoi?
12. Comment est-ce-que le statue d'économie de l'appelant affecte le type de service demandé et reçu par les appelants?

13. Est-ce-que vous juger le statue d'économie de l'appelant, et si oui, comment?
14. Comment est-ce-que vous construisez une image de l'appelant et sa raison d'appeler le service?
15. Est-ce-qu'il y a des éléments spécifiques que vous cherchez entendre pendant un appel? Pouvez-vous les préciser?
16. Comment est-ce-que vous avez appris de construire cet image de l'appelant?
17. Qu'est-ce-que vous nommeriez comme facteurs clés qui vous aident à construire cet image?
18. Qu'est-ce-que vous faites si vous ne pouvez pas répondre à une question de l'appelant?

Questions Démographique

1. Quel âge avez-vous?
2. Depuis combien de temps est-ce-que vous êtes infirmier (ière)?
3. Qu'est-ce-que c'est votre éducation en nursing?
4. Depuis combien de temps est-ce-que vous travaillez en Info-Santé?
5. Dans quels domains de nursing avez-vous travaillé avant de commencer à travailler en Info-Santé?


Centre de santé et de services sociaux – Institut universitaire de gériatrie de Sherbrooke
Hôpital et centre d'hébergement St-Vincent, 300 rue King est
Titre du dossier:
INFO-SANTÉ / INFO-SOCIAL
Date: 15 Janvier 2008
Échelle: -
A1 DE A1
Dessiné par: Julie Fournier
Projeté par: Sylvain Bergeron
5041 - Training Room
5043 - Conference Room
5081 - Info-Santé Central Office
5086 - Info-Santé Central Office
5088 - Administrative Office
5041
SALLE DE FORMATION
5043
SALLE DE RÉUNION
5081
INFO-SANTÉ
5085
INFO-SOCIAL
5087
5089
5091
RÉSERVE
5093
SALLE MÉCANIQUE
5096
SALLE DE REPOS
5094
5092
5090
SECRÉTARIAT
5088
5086
5084
5082
50EE
5038
5040
5042
5044
ASC. #4
5046
5048
C5080
5098

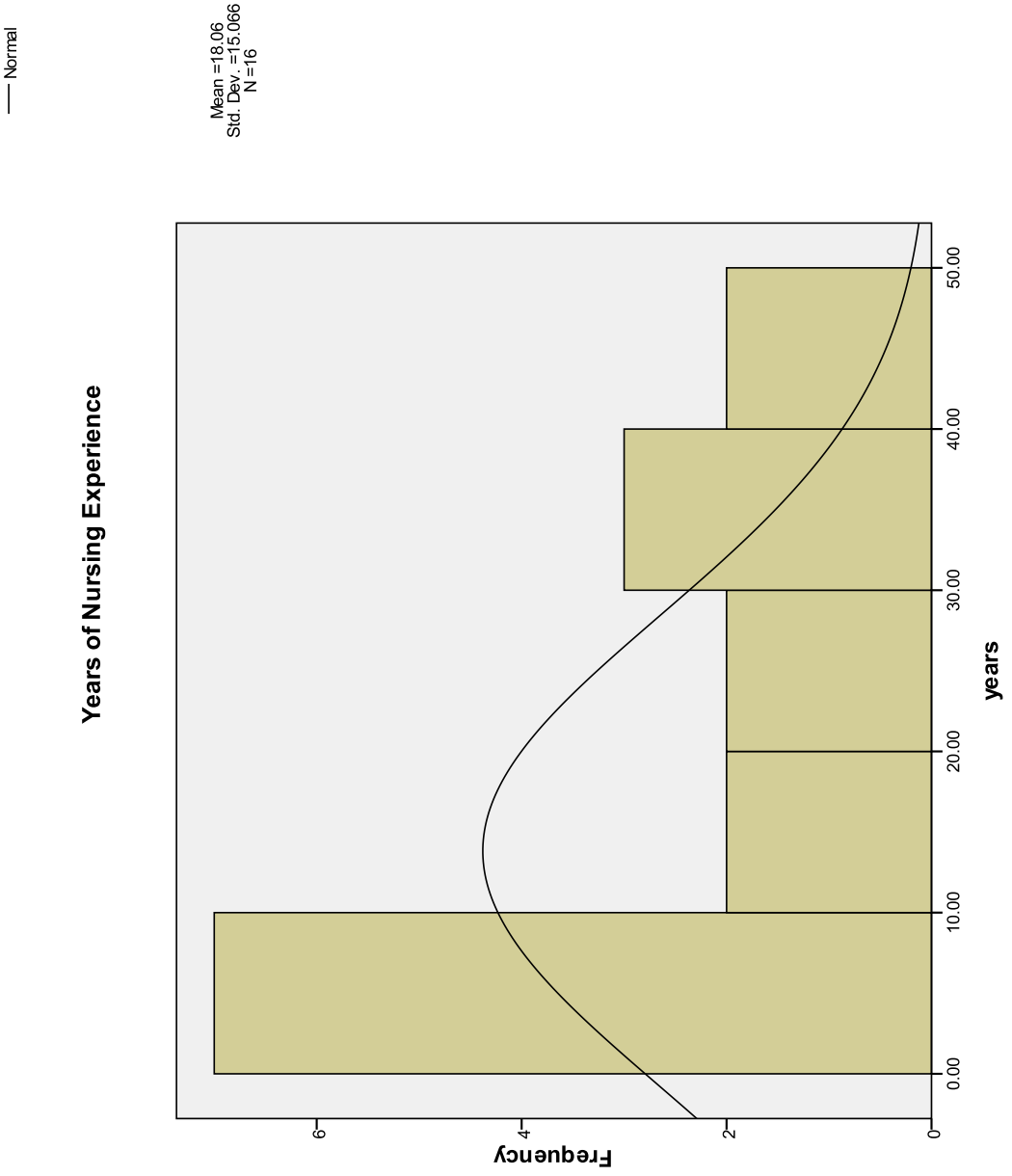

Years of Nursing Experience
Mean =18.06
Std. Dev. =15.066
N =16
Normal
Frequency
0
2
4
6
0.00
10.00
20.00
30.00
40.00
50.00
years

Table: Respondents' Demographics

Respondent	Age	Gender	Education	Years/nurse	Years/Info-S	Focus Group	Interview
001	35	Female	DEC	15	10	Senior	Yes
002	43	Female	DEC	23	14	Senior	Yes
003	44	Female	DEC	24	14	Senior	Yes
004	34	Female	DEC+	12	5	No	Yes
005	25	Female	DEC	3	1.5	Junior	Yes
006	27	Female	MScN+	7	1.0	Junior	Yes
007	59	Female	BScN	39	2.75	Senior	Yes
008	53	Female	DEC+	33	9	Senior	Yes
009	29	Male	BScN	2.5	1.25	Junior	Yes
010	36	Male	BScN	2.5	1.5	Junior	Yes
011	39	Female	BScN	17	0.75	Junior	Yes
012	24	Male	BScN	4	2	No	Yes
013	52	Female	DEC+	31	1.5	Senior	Yes
014	29	Female	DEC+	3.5	1	Junior	Yes
015	35	Male	DEC+	11	2	No	Yes
016	36	Female	DEC+	4.5	2.5	No	Yes
017	45	Female	MScN	23	1.5	No	Yes
018	62	Female	BScN	41	8	Senior	Yes
019	47	Female	DEC	25	5	Senior	Yes
020	61	Female	BScN	40	5	Senior	Yes
021	25	Female	MScN	2.5	0.25	Junior	No

Cadre Normatif Info-Santé

2800 Problèmes reliés à la sexualité
2900 Problèmes reliés à la vie de couple
3000 Problèmes reliés à la vie familiale
3400 Problèmes socio-économiques
3500 Problèmes reliés au travail
3600 Problèmes sociaux divers
3602 Demande d'information sur les ressources et services
3800 Vaccinations et immunisations préventives
3801 Réactions post vaccination
3900 Demande de placement
4000 Problèmes reliés à la victimisation
4200 Problèmes reliés à la toxicomanie
4500 Problèmes reliés à des agressions à caractère sexuel
4600 Demande d'information associée à une déficience intellectuelle
4700 Demande d'information associée à une déficience physique
4900 Problèmes de comportement
4950 Problèmes suicidaires
5000 Problèmes d'adaptation sociale, de développement et de croissance personnelle
5050 Problèmes de santé mentale non diagnostiqués
5110 Schizophrénie et autres problèmes psychotiques
5120 Troubles de l'humeur
5130 Troubles anxieux
5170 Troubles de la personnalité
5300 Problèmes reliés à la violence conjugale
5310 Problèmes reliés à la violence familiale
5700 Demande d'information-conseils sur le plan social
5750 Événements d'envergure
5751 SRAS (Syndrome respiratoire aigu sévère)
5752 Répercussion d'une guerre en cours
5753 Influenza d'origine aviaire (Grippe aviaire)
5754 Listériose
5755 Grippe A (H1N1)
5800 Demande d'information – conseils
5801 Alimentation
5802 Allaitement
5803 Auditif (manifestations ou symptômes du système)
5804 Cancer et phase terminale (manifestation ou symptômes)
5805 Cardiovasculaire (manifestations ou symptômes du système)
5806 Dentaire (Hygiène ou problèmes)
5807 Empoisonnements
5808 Endocrinien (manifestations ou symptômes du système)
5809 Examens, dépistages et investigations
5810 Gastro-intestinal (manifestations ou symptômes du système)
5811 Grossesse et situations périnatales
5812 Maladies infectieuse et parasitaires
5813 Médication
5814 Maladies transmises sexuellement (ITSS)
5815 Nerveux (manifestations ou symptômes du système)
5816 Ophtalmique (manifestations ou symptômes du système)
5817 Organes génitaux (manifestations ou symptômes du système)
5818 Ostéo-articulaire, des muscles et du tissu conjonctif
5819 Peau et tissus (manifestations ou symptômes du système)
5820 Planification des naissances
5821 Post-hospitalisation et post-opératoire

5822 Respiratoire (manifestations ou symptômes du système)
5823 Saines habitudes de vie
5824 Techniques de soins
5825 Thermorégulation
5826 Urinaire (manifestations ou symptômes du système)
5827 Lésions traumatiques
5828 Grippe
5829 Chaleur accablante
5830 Santé environnementale
5831 Soins palliatifs
5900 AUTRES RAISONS DE L'ACTIVITÉ PONCTUELLE

Rôle Action
6000 – Démarches pour l'usager
6009 – Signalement à la DPJ
7200 – Plan psychosocial (actions éducatives et préventives au)
7300 – Santé physique (actions éducatives et préventives en)
7400 – Affaires matérielles et autres (actions éducatives et préventives concernant les)
7500 – Santé au travail (actions éducatives et préventives sur la)
7700 – Caractères psychosocial (actions à)
7702 – Écoute et soutien (conseils et assistance)
7703 – Intervention en situation de crise
8200 – Santé mentale (Actions éducatives et préventives en)
9000 – Autres actions

Catégorie d'appelant
100 – Usager lui-même
110 – Ami, parent, voisin
120 – Médecin
130 – Infirmière
350 – Service de l'urgence d'en centre hospitalier
500 – Famille d'accueil
510 – Services de garde
520 – Résidence privée d'hébergement
540 – Services policiers
550 – Institutions scolaires
560 – Service relais téléphonique pour malentendant
570 – Organisme bénévole, communautaire ou socio-économique
580 – Agence de la santé et des services sociaux (incluant DSP)
590 – Services ambulanciers
900 – Autres

Centre d'activité
59267 – JEVI
60939 – Info-Santé Population générale
60941 – Info-Santé Réponse SAD
60942 – Info-Santé Réponse GMF
60943 – Info-Santé Réponse RI-RTF

Cadre normatif

Suites
100 – Aucune suite
200 – Référence à l'interne entre professionnel Info-Santé et Info-Social
300 – Référence à l'Externe (sans démarches)
301 – Centre Hospitalier (CHSGS) (sans démarches)
302 – Médecin de l'urgence d'un CH (non disponibilité d'autres ressources) (sans démarches)
303 – Centre jeunesse (sans démarches)
304 – CSSS (mission CLSC) (sans démarches)
305 – DSP (sans démarches)
309 – Médecin (excluant médecin de l'urgence 302, GMF, 312) (sans démarches)
310 – Professionnel en pratique privée (sans démarches)
311 – Ressources communautaire (sans démarches)
312 – GMF (sans démarches)
314 – Autres ressources externes (sans démarches)
316 – Centre anti-poison (sans démarches)
317 – Services ambulanciers (sans démarches)
318 – Service policiers (sans démarches)
319 – Ligne d'écoute (sans démarches)
320 – Pharmacien (sans démarches)
321– Dentiste (sans démarches)
324 – Clinique psychiatrique (sans démarches)
331 – Clinique de grippe/SNT ambulatoire (sans démarches)
350 – Référence à l'Externe (avec démarches)
351 – Centre Hospitalier (CHSGS) (avec démarches)
352 – Médecin de l'urgence d'un CH (non disponibilité d'autres ressources) (avec démarches)
353 – Centre jeunesse (avec démarches)
354 – CSSS (mission CLSC) (avec démarches)
355 – DSP (avec démarches)
359 – Médecin (excluant médecin de l'urgence 302, GMF, 312) (sans démarches)
361 – Ressources communautaire (avec démarches)
362 – GMF (avec démarches)
364 – Autres ressources externes (avec démarches)
367 – Services ambulanciers (avec démarches)
368 – Service policiers (avec démarches)
370 – Pharmacien (avec démarches)
371 – Intervenant psychosocial (avec démarches)
372 – Médecin de garde (avec démarches)
373 – Infirmière de garde (avec démarches)
374 – Clinique psychiatrique (avec démarches)
375 – Centre de crise (avec démarches)
376 – Centre anti-poison (avec démarches)
377 – Inhalothérapeute de garde (avec démarches)
381 – Clinique de grippe/SNT ambulatoire (avec démarches)

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