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Zusammenfassung:

Der vorliegende Artikel beschäftigt sich mit arbeits- und berufsbezogenen Identitäten von Pflegepersonal in Deutschland, England, Estland und Frankreich. Die vorgestellten Ergebnisse sind eingebettet in das von der EU im 5. Forschungsrahmenprogramm geförderten Forschungsprojektes „FAME – Vocational Identity, Flexibility and Mobility in the European Labour Market" (Laufzeit von Februar 2000 bis Mai 2003). Ziel des Projektes war eine Untersuchung von arbeits- und berufsbezogenen Identitäten im Kontext von Veränderungen von Arbeitsprozessen und des Arbeitsumfeldes aufgrund von zunehmenden Anforderungen an Flexibilität und Mobilität von Arbeitskräften. Hierbei wird davon ausgegangen, dass auf den Arbeitskontext bezogene Identitäten eng verknüpft sind mit Arbeitseinstellung und wie der einzelne sich zu seiner Arbeit in Beziehung setzt und somit ganz entscheidend Einfluss auf Motivation, Leistungsbereitschaft und die Qualität von Arbeitsergebnissen haben.

Insgesamt wurden im Rahmen des Forschungsprojektes Prozesse der Herausbildung und Ausgestaltung von arbeits- und berufsbezogenen Identitäten in verschiedenen Beschäftigunszweigen in den Sektoren Metallverarbeitung, Gesundheitswesen, dem Telekommunikations und IT Sektor sowie Tourismus und Holzverarbeitung (letzterer nur im Estland) untersucht. Der folgende Beitrag behandelt die Rolle von Arbeitsidentitäten von Pflegepersonal vor dem Hintergrund verschiedener nationaler Kontexte.

Abstract:

This paper is looking at the formation of work-related identities of health care professionals in Estonia, France, Germany and the UK. The presented findings have been generated in the framework of the research project "FAME – Vocational Identity, Flexibility and Mobility in the European Labour Market" funded under the 5th EU framework programme for the research period from 02/00 to 05/03. The project investigated the role that work-related identities play when employees and workers are increasingly expected and required to adjust to changing work contexts and demands. As work identities are closely linked to an individual's concept of work and how he or she relates to his or her job, the work environment and the employer, they also have a strong influence upon an individual's work commitment, performance and the quality of work.

In total, processes of work-related identity formation were investigated in different occupations covering the following sectors: metal working industry/engineering, health care, telecommunications/IT, tourism and timber and furniture (the latter in Estonia only). This article focuses on identity formation processes in the nursing profession with its varying features when embedded in different national contexts.

1 Introduction

European workers and employees are increasingly exposed to demands for flexibility and mobility at work. They are challenged to deal with and adjust to continuous changes in the work context generated through technological innovations, competitive pressures, organisational restructuring, etc. Adjusting to these changes requires specific learning and work attitudes that enable the individual to actively engage in work processes in order to ensure his or her successful integration into the labour market.

The FAME research project[1] investigated the role that work-related identities play in these forms of adjustment that employees and workers are expected and required to make over time. Work identities develop through the interaction of personal characteristics, attitudes and values with work processes and contexts. An individual's concept of work and how he or she relates to his or her job, the work environment and the employer closely connects with his or her work commitment, performance and quality of work. The project investigated the role of work identities in different occupations in the metal working industry/engineering, health care, telecommunications/IT, tourism and timber and furniture (the latter in Estonia only). These sectors were selected as they represent different occupational and work traditions on the one hand, and different dynamics and challenges with regards to flexibility and mobility on the other hand. In addition, the project consortium consisted of partners from seven European countries (Czech Republic, Estonia, France, Germany, Greece, Spain and the UK) in order to achieve a Europe-wide assessment of the phenomenon.

This paper is looking at the formation of work-related identities of health care professionals in Europe. The analysis is based upon qualitative interviews and additional contextual background material from Estonia, France, Germany and the UK. The material has been generated in the framework of the FAME research project through semi-structured interviews with health care professionals with varying levels of qualification, specialisation, skill profiles and functional responsibilities. Across the four countries 92 nurses were interviewed as well as smaller numbers of midwives, doctors, radiographers, physiotherapists and personnel of human resources departments of health care providers. This article focuses on the nursing profession with its varying features when embedded in different national contexts. National contextual information may vary concerning its level of detail as the author personally only conducted interviews in Germany whereas material and data for the other countries were generated by the project partners.

2 Contextual information: national features and general trends in health care

In the research project the health care sector was chosen because it represents one of the traditional service sectors. The nursing profession as one of the core occupations in this sector has a long-standing occupational tradition with related identity patterns. During many centuries churches (nuns, district nurses), religious and charitable organisations and groups like the red cross developed specific health care services by

[1] The research project "FAME – Vocational Identity, Flexibility and Mobility in the European Labour Market" was funded under the 5th EU framework programme for the research period from 02/00 to 05/03.

building and running hospitals, care institutions for the elderly and other charitable and health care institutions. These historical roots over decades have influenced work profiles and have established a more or less universal image of what qualities and skills a 'good' nurse should possess.

Since the 1980s changing work requirements, new skills profiles and a strong tendency towards professionalism in providing quality health care are questioning and opposing this traditional image. Today, the provision of health care has become a growing sector due to demographic shifts. These shifts and an aging European society challenge nurses to become more flexible and mobile. Health care needs and provision today require a broader perspective looking at staffing and skills demands across countries, but also shifting the focus from simply providing care to prevention, counselling and the support of a patient-oriented self-help approach.

2.1 The nursing profession in national perspective

2.1.1 Estonia

Being a country in transition from a former state-controlled economy during Soviet times to a democratic society with open markets Estonia faces the challenge of redefining profiles, skills requirements and related occupational profiles of the nursing profession. The new political system and its aim for structural, organisational and educational reforms also had fundamental consequences for the labour market and the health care sector. Since the former planned system no longer determines the distribution of labour and human resources, employment and deployment upon demand have become a new, up to now unknown, mechanism of human resources policy, also in public hospitals. At the same time the entire health care sector has been challenged to implement new medical technology.

For the nursing profession the driving force for change during the 1990s were the foundation of private hospitals and the implementation of a new curriculum for the education and training of nurses. This means that nurses in Estonia not only had to deal with major changes in employment policy including employment insecurity, but they also had to adjust to new technological, organisational and educational demands. Today, nurses who trained during Soviet times have to undergo a retraining process and pass examinations according to the new curriculum to raise their status and market value as qualified staff.

The liberalisation policy allowed unions to actively shape working conditions by, for example, negotiating wages or initiating strikes. Also nurses started to become unionised and founded nurse associations in order to foster their status in the political dialogue. This seems to be important for the development of a new concept and profile of the nurse profession, because through associations nurses can now influence educational directions in cooperation with medical schools and government. Through this approach they can influence the establishment of new vocational standards. In addition, these associations also facilitate better information exchange within and beyond the health care sector.

The process of lobbying and the diversification of occupational paths and opportunities due to the possibility of employment in private hospitals lead to the creation of new occupational profiles of nurses at work and new training programmes. However, these developments do not automatically imply a general upgrading of the work-related and social status of nurses. Wages are still uneven

depending on the employment contract and the employing institution. For example, larger hospitals offer more complex and expensive services and they often turn out to be a more popular employer than small hospitals since they can offer higher wages. Private hospitals can offer a more modern and flexible work environment. Since most of them started from zero in the beginning of the 1990s they had the opportunity to create and implement an organisational culture which fosters new work concepts, occupational profiles and identities of nurses. These also go along with the emergence of a new set of values influenced by the demand for commercialisation of the health care sector. New organisational and work-related features of private hospitals include greater responsibility and independence of nurses, a stronger emphasis on the quality of care and working in small teams. But even in private hospitals a new partnership model regarding the communication and cooperation between doctors, nurses and patients still has a long way to go before becoming a daily work reality.

Public hospitals are still to a certain extent characterised by structural, organisational and habitual features of communist times. However, it is only state and communal hospitals that are authorised to accredit and award certificates for the nursing profession. This seems paradoxical, because it is the private hospitals that much more effectively implement a nursing profile that fulfils the requirements of the new curriculum, but they are excluded from the accreditation process and are only allowed to employ nurses certified by state hospitals.

With regards to continuous professional development nursing in Estonia has established itself as an independent discipline with the possibility of following an academic career in nursing. But the dominant opinion in society and of employers about what qualities and skills a 'good' nurse should possess still comes close to the rather traditional image. That is, nurses should in the first place be devoted to their profession as a mission, harking back to the original charitable mission under the supervision of doctors. In addition, safety and stability in respect to work and the workplace seem to be values of growing importance in an unstable economic environment.

2.1.2 Germany

The German health care system also underwent important structural reforms in the 1990s that affected the nursing profession by setting new standards for the financing and organisation of health care provision. After a period of expansion, specialisation and implementation of the latest technology during the 1980s the German health care system had to face a significant cost explosion that forced politicians to take action pushing the German government to restrict and control expenditures for health care services. As a result a major legislative reform was put in place in the mid 1990s that substantially changed the organisation of hospitals and other health care institutions. It implied that subsidies for public hospitals are now determined by medical case and outcome, unlike before when hospitals were given lump sum allowances per patient and hospital day.

Today, the number of hospital days is reduced to a minimum and all hospital processes and structures are subject to quality assessments and evaluation. Service providers are required to document every single intervention and prescription of treatment and have to justify why no cheaper treatment could be chosen. To reduce the costs for in-patient treatment a concept is favoured that supports patient's out-patient pre and post treatment instead. The length of stay per patient in hospitals is

reduced to an average of 6.3 days, a duration that in most cases does not allow for the completion of a successful healing process. Hospital wards organised as profit centres and the flattening of hospital hierarchies are also seen as solutions to achieve cost reductions. While each physical service and medical treatment has to be documented and justified to get reimbursed by the health insurance, social interaction and communication with patients suffer. Hospital staff often find themselves exposed to conflicting demands, the restrictions by health insurances on the one hand and patients' expectations on the other hand. With increasing competition between health care providers hospitals are forced to provide patient-friendly services to become more attractive to their customers. Customer orientation, high quality of care and economic efficiency are new criteria not only hospitals have to meet but also other health care institutions like residential care institutions for the elderly and domiciliary health care providers.

In the case of care institutions for elderly people and domiciliary health care services an additional statutory insurance was implemented in the mid 1990s. The objective of this supplementary care insurance (compulsory for every German employee) was to financially support elderly and people with special needs in a way that they could continue living as long as possible in their private homes with the support of domiciliary health care providers. As a new institutional structure the statutory medical service defines the level of care old people are entitled to receive by assessing the level of caring needs combined with the patient's ability to care for him- or herself. Based on this assessment the statutory medical service gives or refuses allowances for health care services and medical treatment. The statutory medical service also monitors the quality and performance of institutions and health care services, the infrastructure of institutions, the training of personnel, the organisation of work schedules, etc. For nurses working in care institutions for elderly people or domiciliary health care providers this means that they are requested to document every single activity while often working under severe time constraints and very tight financial resources. Still, these kinds of service ensure growing employment possibilities for nurses, because the additional insurance made new financial resources available thus encouraging the development of a new market for private and charitable domiciliary health care providers. The result was the creation of a large number of jobs in this area. This market is still growing while the need for jobs in hospitals slightly decreases. Although the stressful physical, psychological and interpersonal demands lead to a high turnover of staff, domiciliary health care services are expected to flourish in the future.

With the cutback of in-patient treatment and care more responsibility is transferred to the individual patient and principles of modern health care are designed to encourage the patient's capacity for self care. This approach also requires a new attitude and knowledge of nurses on how to best support patients in activating their self-healing potential.[2] On the patient's side, their demands also have changed. Patients today are much better informed about health issues and health care procedures. They show a more proactive attitude and have higher demands on the quality of care and treatment. For example, patients have become much more involved in making decisions regarding their medical treatment. This attitude of patients also demands better and more detailed information exchange bringing a new

[2] In the UK we could observe the same shift from a directive 'control' approach towards an 'empowering' approach to care that relies upon the establishment of trust, with a focus on support and development.

focus on consultation, giving guidance and counselling into the health care process. As a consequence nurses and other medical staff are increasingly challenged to meet these expectations and counselling methods have become an important aspect of the training of nurses. As a general trend, the professional profile has shifted form a hierarchical oriented structure towards a model that emphasises self-organisation and independent action of patients and nurses.

The legislative reform as the driving force for change forced all kinds of health care institutions to develop new work concepts and organisation to meet the new reality of extremely limited financial resources. Personnel being the major cost factor the reform also resulted in the deployment of a large number of nurses in hospitals and other health care institutions. Quality control has become a major focus and in order to ease nurses from the burden of an increasing amount of administrative work, a new professional profile, the ward secretary, has been introduced. Most hospitals today operate with a pool of highly mobile and flexible staff to meet peak work loads in different wards or to compensate for staff shortages. Working in health care more and more requires a high degree of flexibility.

The job profile is changing insofar as institutions and management increasingly put emphasis on efficiency, quality control and documentation. Market economy standards and financial constraints in hospitals and other health care institutions put pressure on staff. Work intensification, time constraints and, in particular, not having enough time to care for the individual patient are major issues. Human resources management of hospitals see nurses facing an increasing complexity at work. Information and communication technologies, coordination and the management of complex data processing combined with a new approach towards customer orientation redefine the traditional profile of health care services. On the other hand, skill requirements and patient-related core activities in nursing change slowly as many work processes are highly ritualised. Thus, innovation and the introduction of new approaches in health care are difficult to put into every day practice. In summary, the following general trends in health care can be observed in Germany:

Increase of administrative tasks

The amount of administrative work is increasing and can reach up to 2/3 of the total working time of nurses in hospitals. This results in having less and often not enough time to provide direct patient care. Most nurses feel that they are overqualified for performing administrative tasks and would rather prefer to concentrate on working directly with the patients.

Striving for efficiency and a new division of labour

We could observe, in some way, a mismatch between a modern approach of performing integrated, high quality health care (supported by theory and science) on the one hand, and severe time constraints and very demanding efficiency criteria on the other hand. In a way these two extremes illustrate the 'management perspective' in contrast to the 'professional perspective' of nurses. Budgetary restrictions recommend that in the future work processes will be dichotomised between simple tasks to be carried out by lower qualified assistants and coordinating/supervisory tasks carried out by higher qualified nurses. However, the increasing coordinating role of nurses would leave the direct interaction with the patient to the lower qualified nurse assistants. This type of division of labour contradicts the aim for providing integrated health care services of high quality.

Professionalism

Nurses increasingly show a more 'professional' work attitude that would overcome an idealised model of nurses, which had been dominating the image of the profession until maybe a decade ago[3]. The tendency towards professionalism goes in line with a rather recent attempt in Germany to establish nursing as an independent profession in a way that nurses are not just subordinated to medical doctors, but are seen as experts in their own field. In this regard opportunities for continuous professional development play a key role and an academic path to step up the career ladder has been introduced recently. Health care strives for equal partnership with medicine, especially now that nurses increasingly also take over responsibilities for the economic aspects of hospital organisation. Through nurse associations this approach could be strengthened, but due to the diversified German health care system, which is split into a variety of different institutional responsible bodies, it is difficult for nurses to form unified political bodies to negotiate with policy makers and the legislature. In contrast, the medical profession represented by doctors relies upon a strong political voice of their associations. Other factors contributing towards professionalism and changing role models in nursing in Germany are the increasing proportion of male nurses (currently approximately 15-20 per cent) and a more professional work attitude of recently trained nurses.

Vocational education and training

Initial education and training in the German health care system is designed like other VET programmes of the German dual system, but vocational schools for health care are not under the governance and regulations of the federal state like other vocational dual programmes. General guidelines exist regarding education and training for certified nurses, but each responsible body insists in introducing a specific approach and ethos to the apprentices regarding the way to provide health care services. In contrast to other European health care systems nurses in Germany specialise in three different educational paths: general nurse, nurse for the elderly and child nurse – a concept which is increasingly questioned. Today various discussions and some pilot projects on VET policies in health care favour a more unified educational path to increase flexibility and international competitiveness of German nurses.

2.1.3 France

According to a WHO assessment the French health care system is rated as one of the best in the world in terms of four basic criteria: the overall level of health attainment of the population; the degree of health inequalities between individuals; the health system's responsiveness towards change and patient satisfaction; and the distribution of the financial burden. The system seems to be well equipped to satisfy these criteria. Within this system, nurses form a well established occupational group, although like in most other countries they are lacking social recognition compared to the medical profession represented by doctors. This is noticeable, for example, in terms of the comparatively poor salaries for the increasing work load and responsibilities nurses have. With regards to the division of tasks, doctors primarily have functional

[3] This idealised model emphasis society's and patient's ideal of a nurse as the always friendly and smiling woman who is devoted and willing to perform a large variety of services on demand.

(medical) responsibilities whereas health care services and the daily work in hospital wards are mainly organised by senior nurses.

Nurses in France show a strong professional identity closely linked to the attachment to the ethics of the nurse profession.[4] This attitude fosters a high work morale combined with organisational structures of hospitals and job profiles that provide a rich learning environment and support learning processes. These seem to be important preconditions for the continuous integration of innovations in health care and the use of modern medical technology. Although the organisation and hierarchical structure of large institutions of the French health care system are characterised as heavy and complex, human resources management acknowledges a general acceptance and commitment of employees regarding innovation and continuous learning. Of course, the complexity of hospitals in France is linked to their respective size. Usually small clinics are private and more flexible in their organisation and structure.

Nurses working in the public sector (mostly in hospitals) are employed as civil servants with a high level of job security. Unionisation is relatively high for this category of employees. By contrast, there is no employment guarantee within the private sector. Although nurses are generally highly attached to their profession and the French health care system, an increasing inner-European and border mobility can be observed. Nurses' desire for higher salaries and better working conditions has created an interest in job opportunities outside of France. This is particularly the case for nurses working for the private sector. For example, some nurses in the Alsace region prefer to work in Switzerland where salaries are relatively higher than in France.

In summary, nursing in France is regarded as a profession of high status protected by unions and integrated into a strictly regulated system. Nurses generally are well qualified and flexibly respond to the necessities for continuous learning. In both segments of the sector, public and private, nurses show a strong identification with the quality of services provided to customers. However, like in most European countries important structural changes challenge work profiles and identities of nurses and other medical staff:

- Health care related technological innovations are encouraging the home-use of disposable medical equipment by patients. The emergence of out-patient treatment, auto-diagnostics and home care services has effectively decreased patient's short-term stays in hospitals. Concurrently, the need for long-term hospitalisation has increased due to partially or fully dependent patients. Reforms in hospitals take these structural changes into consideration by effectively combining increased efficiency (through quality control) with reduced costs for universal health care coverage.
- Within the new structure of health care management, 24 regional hospital authorities have been established for planning health care needs and allocating hospital's annual budgets. These authorities form contractual agreements with individual hospitals to define objectives and requirements. The aim is to create pools of excellence by merging hospitals and closing down, if necessary,

[4] Nurses in France are strongly attached to the ethics of their profession which is twofold: the "acte propre" relates to a nurse's caring mission with autonomy, responsibility and a high level of psychological and relational interactivity with the patients. The "acte prescript" relates to the medical mission characterising a nurse's daily work-related relational interactivity with doctors within hospitals or clinics.

hospitals with occupancy rates of less than 60 per cent. The budgeted funding is allocated according to a system of accreditation for the identified efficient hospitals.

- In order to track down health care spending and improve the functioning of the sector through computer-based technologies, each social security affiliate is given a smart card called "VITALE" linking him or her through a secured computer network with all kinds of health care providers: public hospitals, private clinics, general practitioners, specialised doctors, nurses, etc. As this card enables a direct electronic transfer of the patient's medical records and prescriptions to health care reimbursing funds, it is also used as an instrument for controlling health care spending. Through controlling expenditures it is ultimately also a tool to implement sanctions against hospitals and doctors if necessary.
- The introduction and implementation of the 35-hour-regime has significantly affected the work organisation in hospitals. Given that this regime has increased the work burden and involuntary time flexibility especially for nurses, it is at present under reconsideration to be further readapted.
- The *Service de Compensation et de Suppléance* ('pool for compensation and replacement') facilitates greater flexibility of health care professionals to compensate for staff shortages in hospitals. Being a voluntary system, the 'pool' recruits nurses on the basis of permanent work contracts. Mostly ordinary nurses are functionally and horizontally mobile on demand between different departments of public hospitals. In the light of different departmental needs of temporary work or replacement, the 'pool' distributes them between its members according to their profile and their pre-planned time for shift work (proposed two months in advance).
- An initiative for facilitating and increasing the internal mobility of nurses between different departments of hospitals is currently under discussion with the social partners (not subject to the usual formal constraint of job-transfer). Outside the *Service de Compensation et de Suppléance* the internal mobility of nurses is still limited to the units of the same department.

Although the above mentioned developments do considerably affect work structures and organisation, they do not seem to induce major dynamics or shifts within the French health care system to the extent that the nurse profession is undergoing a redefinition process. The health care system and the nursing profession in France seem to be well established and financially well equipped evoking a high level of satisfaction for the medical staff and the customer. Within the French health care system there exists an inter-professional exchange and high quality service provisions for all affiliates of the social system without any kind of discrimination and regardless whether they are public or private.

2.1.4 The UK

In the UK, flexibility in work organisation had been a major goal of employers in pursuing the NHS modernisation agenda from the mid-1990s (Department of Health, 1997). However, since the 2001 general election the emphasis is upon recruiting and retaining more staff making the approach to flexibility more employee-focused rather

than employer-centred. Significantly, there is less talk of driving through change and more attention is given to staff as if they are part of the solution rather than being the problem.

For example, UK hospital radiographers and physiotherapists tend to have strong occupational identities, and managers are well aware that in many hospitals recruitment and retention of these groups of staff are major concerns. Professionals in both groups increasingly move to other hospitals, particularly on completion of initial or further training or for promotion. In addition, personal circumstances and locational factors (high cost of housing; less attractive working and/or living environments) can combine such that for some posts hospitals receive very few applicants. Managers have had to come to terms with the possibilities of increased mobility for these professional groups and hospitals have used access to further training as a means to encourage applicants. The possibility for promotion as extended scope practitioners (promotion that involves continuing in practice rather than moving into management) is also seen as an aid to retention of staff.

Many hospitals are facing staff shortages and face challenges to retain the staff they have. This is true for all medical staff and also for nurses. Staff shortages have resulted in recruiting nurses from other European countries and overseas and introducing greater flexibility in work organisation. However, there are, of course, limits to the scope for flexibility in the medical profession, because the employment of medical staff is subject to national regulatory frameworks. Human resources policies react to the problems of recruitment and retention of professional staff by, for example, changing the skill mix between consultants and employees and making greater use of assistants. This was occurring within a context where there was an explicit attempt to put greater emphasis upon team working involving doctors, nurses and other medical staff such as physiotherapists or radiographers.

Managers' perspective on individual scope is that individuals are being given more autonomy and responsibility, in a context of increasing demand for services. Individual commitment has always been strongly identified with the occupation and the department or service. Some human resources staff are consciously trying to reshape the focus of commitment more towards the inter-departmental team so as to improve overall quality of service to the patient. However, there is also recognition that individuals and departments are under increasing pressure because of increasing demand for services (and in many places staff shortages).

2.2 Reflections

In all four countries the national health care systems have been challenged to deal with structural changes during the last decade. These structural changes have also affected health care professionals, particularly through adjustments in work organisation and HR policies. In Germany, the factor pushing for change is the financial burden of health care expenses that lead to reforming the economic framework and financing conditions of the health care system. These interventions have affected the organisational structures of hospitals and other health care providers, work profiles, health care provisions and to a certain extent the interaction between medical staff and the patient. The highly regulated French health care system seems to benefit from a strong potential for learning and openness for the implementation of technical innovations in the medical field by at the same time promoting rich learning environments and strong ethical professional conduct of employees. More flexibility is introduced through the private sector, institutionalised inter-professional exchange

and a more flexible allocation of nurses through the *Service de Compensation et de Suppléance*.

In the UK, the demand for high flexibility of staff has become less of an issue in the light of persisting problems of recruitment and retention of qualified medical staff. It seems that human resources policies play a key role for encouraging, recruiting and retaining health care professional. Improved working conditions, interdependency of staff, team work, further training and promotion are major tools to combat the problem of staff shortages that occur throughout the UK health care sector. Reforms of the Estonian health care system have been pushed forward through radical changes of the political and economic system during the past 10 years. In the Estonian case it may become most obvious how structural changes can affect work profiles and work-related identities of employees. Here, different national bodies are actively supporting the establishment of a new nursing profession that complies with the present economic and labour market demands. Major tools for promoting a new nursing profile have been the liberalisation of the health care sector by establishing private hospitals and the implementation of a new curriculum for the education and training of nurses. Concurrently, emerging nurse associations and unions advocate a new concept of nursing and give nurses a so far unknown public voice. These associations also play a key role for the development of a new sectoral structure. Here one has to consider the size of the country with a health care sector that is fairly manageable in terms of its quantity.

The following section will look into whether structural changes, as they have been exemplified for the four countries, also affect occupational identities of health care professionals and if so, how this manifests itself for different individuals or groups of employees. This question will be addressed from a subjective point of view; that is how the interviewees perceive and describe these changes affecting their work-related identities. The emphasis lies upon the individual-psychological dimension of occupational identities identifying different coping mechanisms and individual strategies when adjusting to changing working conditions and work requirements.

3 Health care professionals and their work-related identities

In order to examine processes of occupational identity formation the research project identified and worked with certain evaluation categories. For example, learning, training and skills development underline the socialisation processes that play a key role for identity formation. Most issues dealing with work environment, work organisation, flexibility and mobility closely relate to the interdependence between structural demands and individual responses. Status and external recognition, attitude towards work, commitment and interaction with others largely connect to the elements of work with which the individual identifies. These and other factors and how they interplay with occupational identity formation processes will be investigated in the following section. Some of these evaluation categories can overlap, be interdependent or conflict with each other.

3.1 Learning, training and skills development

3.1.1 Initial education and training

In most European countries the nursing profession relies upon a highly formalised education and training system. This is true for certified general nurses as well as for the further qualification to specialise in a particular field such as head nurse, intensive care specialist, surgical nurse, nurse instructor, etc. The duration of the initial formal vocational training for nurses varies. In France and Germany, for example, it consists of a three to four years learning period in an accredited nurse school. In France, the successful completion of the initial training leads to obtaining the "Nurse State Diploma" which is regarded as equivalent to a university degree, but still needs to be complemented by a one-year internship in order to become a registered nurse. In Germany, the nurse school attendance is complemented by regular hospital practice where nurse apprentices rotate between different wards and regularly assist in hospitals for some days in addition to completing several internships whereby each apprentice is attached to an instructor nurse. They have to assist nurses in their daily routine and document medical cases and health care procedures. In the light of establishing health care as an independent profession, increase its status and broaden the career perspectives for health care professionals all four countries have established an academic career path in nursing. In Germany, the academic degree accredits teachers and trainers for the nursing profession or specialists in hospital and health care management.

A special feature of the German system may be that there exist three independent formal education systems for an initial specialisation in nursing; that is general nurse, child nurse and nurse for the elderly. For the latter the initial training only recently has been formalised into a three-years training course. Until 1996, the formal requirement for entering the profession was a 7-weeks retraining course complemented by three months practice in a relevant institution. This means that for many years the professional field of caring for the elderly was based on occupational retraining and because of the relatively low entry requirements it was very popular for house wives or women who had been out of their job for a longer period. In 1996, the formal initial training was initially restructured into a two-year training course, which has recently been developed into a three-year course.

In its function of socialising the individual into a specific occupation and the related professional community the vocational education and training period provides a basis to attach the individual to a certain occupation. A main aspect of this function is to make the apprentice familiar with the work environment, the daily work tasks, the work profile, colleagues, the work organisation, etc. The Estonian example elucidates that the educational system and the curriculum can also play an instrumental role for establishing a specific model or concept of nursing. Today there exists a strict differentiation between nurses who trained during Soviet times and nurses who trained under the new curriculum. The training received determines professional status, employability and labour market value of nurses in Estonia today.

However, in our interviews it also became clear that the initial education and training only plays a minor role in establishing nurses' occupational identities, particularly in a more long-term perspective. One major reason is that nurse apprentices do not take full responsibility for their work. The level of autonomy and

responsibility plays an important role for health care professionals and was a central element of their identification with the work they were doing, in particular with relation to the direct interaction with patients. Interviewees stated that the moment they were assuming full responsibility for their actions, generally immediately after completion of their apprenticeship, they also regarded their occupational role very differently. This transition also marked the moment when they became a full member of the professional community, another key element for the manifestation of their occupational belonging and identity.

Most nurses' occupational identity is formed and developed over time. This means that work experience is a crucial factor. Continuous learning and training and becoming an expert are other key factors. The interviews with nurses for the elderly in Germany may reveal how relatively unimportant the initial vocational training can become for developing an occupational identity. The level of identifying with their work did not vary between the nurses who underwent a 7-weeks retraining course and the ones who trained under the new curriculum for a duration of three years. The interviewees stated that what actually matters is the work experience, the attitude towards work and the fact that all nurses were in practice given the same level of responsibility.

3.1.2 Learning, training and continuous professional development

In nursing, the dominant mode of learning is learning while working (training on the job, learning by doing, self-directed learning). Implicit knowledge and competencies are generally expected to grow with work experience. In addition, further qualification is important and instrumental for both employees and employers. For nurses further qualification through formal training predominantly plays a motivational role. Such training helps them to develop expertise, supports the process of becoming confident, facilitates the professional exchange with colleagues and balances the daily work routine with new options for broader learning. German interviewees confirmed that most of the courses were regarded as very useful in imparting valuable background knowledge and supporting daily work processes. In addition, further qualification facilitates horizontal mobility and, to a much lesser degree and depending on the specific training, also vertical mobility. In the UK, opportunities for learning and further training have become an important tool for managers in an attempt to retain and motivate professional staff.

In France, Germany and the UK, most hospitals and other health care providers offer a rich learning environment and a variety of training courses for skill enhancement and further qualification. These imply short courses on specific medical issues (of a duration of one or several days) and qualifying courses of one or more years generally leading to an additional certificate as head nurse, intensive care specialist, surgical nurse, instructor, etc. In Estonia it seems that it is the private hospitals that are better positioned to offer a rich learning environment to their employees than the public institutions. In France, the opportunities for further learning and training seem to be highly formalised and generally nurses have to leave the work environment in order to dedicate themselves full time to further education, whereas in Germany these courses are attended parallel to work commitments. In Germany, nurses stated that they had difficulties to attend short training courses, because in practice they do not have the time. Many courses are scheduled in a way that is incompatible with working hours or working shifts. Thus in reality most employees would need to offer their free time for course attendance, which proves to

be particularly difficult for those with family commitments. In contrast, the qualifying courses of longer duration are pursued in agreement with the employer who frees up the employee for course attendance. At the same time it binds the employee for a certain number of years to the employing institution that is paying for the course.

Although for the nursing profession the enhancement of competencies through further training significantly contributes towards developing an occupational identity, it is not systematically linked to career development and job promotion. As stated above, the predominant mode observed in nursing is internal horizontal mobility and not vertical mobility regardless of the level of qualification. Some hospital nurses may choose to change wards within the same hospital every 3 to 5 years, because it can be one way of gaining more expertise and fostering one's own professional development. This choice sometimes was regarded as an alternative option or strategy for nurses who do not wish to become head nurse. The opportunity for horizontal mobility and flexibility in hospitals was often mentioned as a positive aspect of the nursing profession and linked to the context of hospitals providing a rich learning environment. In this sense short courses and specialised training courses increase flexibility and horizontal mobility of staff, but since they are not systematically linked to career development, they are regarded as an individual choice rather than as a requirement for good work performance. This may be different in Estonia, where the kind of training received is linked to a nurse's professional status.

It was interesting to see that for most nurses team leading positions are not appealing, because they imply responsibilities for personnel, a higher stress level, predominantly administrative and organisational work (instead of working directly with the patient) and less flexibility regarding working hours. In Germany, for example, head nurses are required to be present during the day and thus lose allowances for working in shifts, a loss that would balance out any salary increase related to a higher level job position. Particularly for nurses who are wholly dedicated to working with the patients a team leading position that involves predominantly administrative and managerial duties was not regarded as being attractive. The major reason why nurses would move into such job positions is the fact that working and interacting directly with the patient can become physically and psychologically very demanding after a few years. Then a team leading position may provide one of the very few alternatives within the professional field.

The lack of possibilities for professional development and alternatives in a broader perspective was particularly stated to be a negative aspect of the nursing profession in Germany and Estonia. The only alternatives mentioned that nurses could pursue were in the field of providing training or further qualifications for nurses, for example, as an instructor or facilitator, or attending university courses in health care. In this sense the UK and France seem to offer a broader range of choices to nurses, where registered nurses can, for example, become independent practitioners by opening their own practice or work as counsellors in the field of health care prevention and counselling. The connection between the level of qualification and vertical mobility may be stronger in the UK though, where nurses generally are more flexible and mobile than in the other countries. UK nurses also seem to move much more in and out off the nursing profession regarding nursing also as a temporary or transitional work situation rather than a life-long occupation.

3.1.3 Skills development

Continuity and communalities seem to exist when it comes to identifying the key competencies nurses should have, that is very good interpersonal and communication skills, particularly with regards to working directly with the patient. Even with the 'empowering' approach to care that encourages the patient's capacity of self care that has provoked a shift from providing direct care to a stronger supportive and counselling role of nurses, the key role that communication and interpersonal skills play is again strengthened. However, these competencies are not strictly regarded as a professional approach, but are also always linked to the ideal of expressive caring as one of the qualities a nurse should have. Respondents in all countries seemed to be aware of the danger expressed by Benner (1992) that lists of required skills or behaviours related to the tasks to be performed in nursing can be apparently never ending, but still not get to the heart of professional practice. Often nurses feel overwhelmed with performing a variety of caring tasks that from a professional point of view do not form part of their responsibilities. It was also perceived that this reality contributes towards lowering their professional status, particularly in the light of other medical staff like doctors, for example, who are not expected to perform such roles.

This conflict addresses fundamental issues about the shape and direction of health care and the occupational identity of nurses. Many of those engaged in health care philosophy, policy and practice are trying to come to terms with changing ideas about relational and caring constructs. Ethics and values are therefore necessarily involved in judgements about service delivery and skill utilisation and development in health care. That is ideas about the skills and attitudes of staff required for effective and caring service delivery are inevitably connected to views about how the service should be delivered, and patients, professionals, managers and the general public all have views on that. Amidst this debate about effective delivery of health care, the newly qualified practitioner seeks to develop a stable work identity. In order to accomplish this, an individual has to move towards a position where he or she is happy that his or her personal values align sufficiently with the professional values broadly espoused by the community of practice to which he or she belongs.

For professionals working in health care there is broad agreement that, ideally at least, the job should be about more than just technical competence. Providing health care services is not just instrumental caring, but also contains a more explicit affective dimension that should reflect the respect for each individual patient. This concept often was a key motivational factor for choosing to become a nurse in the first place and formed a core element of the occupational identity of nurses.

However, Oakley (1993) draws attention to the paradox that the increasing technical competence associated with greater professionalisation may serve to distance practitioners from those for whom they care. In Germany, for example, the new emphasis on documentation, administration and assuming responsibilities for the economic aspects of health care has not only evoked an expansion of skill requirements for nurses, but also turns out to often dominate the daily work routine. These tasks are taking a lot of time away from the direct care and interaction with the patient and many nurses expressed concern about this shift of attention. Nurses also regarded the documentation of health care interventions as an additional work load and a burden, whereas especially younger nurses often saw it as a process that supports their daily work and helps them to reflect upon work performance and

quality of care. Physiotherapists in the UK pointed to the conflict that arises between the 'empowering' approach that is very time consuming with its focus on supporting and encouraging the patient versus the 'control' approach, where the practitioner is less patient-oriented and much more directive, but may be able to cope with large numbers of patients. And in Estonia, there was the almost plaintive cry that younger nurses do not *really* care like some of the older nurses do. In any case the policy response of emphasising more person-centred models of care has not always been in step with how to facilitate this in training and implement it in practice. Especially German nurses for the elderly criticised that interpersonal and communication skills are not sufficiently emphasised and developed during the apprenticeship training.

3.2 Work organisation and requirements: demands for flexibility and mobility

In all countries we could observe an increasing demand for nurses to be flexible with regards to changing work positions, wards and tasks. In most private and public health care institutions nurses are expected to be universally appointed according to staffing demands and staff shortages. It seems that in France and the UK nurses are well prepared to adjust to these demands. In Estonia, the need for a high level of functional and organisational flexibility of nurses has developed in the course of reorganising the entire health care sector. Particularly specialised nurses are often asked to relocate to other hospital wards on demand as their skills may be rare. High versatility is an important feature nurses in Estonia today have to develop.

German nurses seemed to be rather critical when it comes to the issue of flexibility. There still exist a considerable number of nurses who very early in their career discover a particular field of interest and decide to stay with the same ward and in the same position for their entire professional life. Thus, adjusting to demands for flexibility and horizontal mobility was still rather regarded as an individual choice than a must. However, the tendency towards merging wards to meet new efficiency criteria is becoming more and more common putting the aspect of free choice into a different perspective. Such a situation puts new requirements on nurses to become more flexible, particularly with regards to increasing their spectrum of work tasks, and it was stated that some nurses had difficulties adjusting to this situation. This new setting also requires very high flexibility with regards to being responsive towards a very complex social environment at work and varying personal demands from patients, colleagues, supervisors, families, etc.

With the *Service de Compensation et de Suppléance* France has introduced and established an interesting model to deal with the increasing demand for flexibility due to staff shortages. Being a voluntary institution the 'pool' recruits general, assistant and a few specialised nurses on the basis of permanent work contracts, who are functionally and horizontally mobile on demand between different departments of public hospitals. In the light of different departmental needs for temporary work or replacement, the 'pool' distributes them between its members according to their profile and pre-planned time for shift work. Through this structure the 'pool' is meant to balance peak work loads by optimally combining labour flexibility with reduced health care costs through increased efficiency. The 'pool' functions in effect as an internal 'temporary employment agency' whose employees are permanent workers, but who are assigned to different wards on a temporary basis.

It may be interesting to look briefly into what this work situation means for the occupational identity of these nurses. Nurses who join the 'pool' showed a strong dedication towards the nursing profession and were open to adjust to changing work

requirements. Through the daily demand for polyvalence and adaptability to different care situations and working conditions nurses learn to become highly flexible. Nurses who joined the 'pool' are much more attached to their profession than to a specific ward or hospital. They valued being more independent and free in their choice of work and being able to develop personal human capital of "know-how" based on polyvalence and transversality. Another advantage was seen in being able to choose and pre-plan the time of their work shifts. However, the general duration of less than two months for each assignment was regarded as having positive and negative effects. On the one hand, nurses were experiencing fewer conflicts and less tension and hence stress than when being permanently attached to a regular working team. To be more mobile and to continuously develop new kinds of relational interactivity was also seen as a positive factor. On the other hand, the short assignments make it impossible to develop lasting work-related relational interactivity within working teams and result in a lack of integration into work processes and the work environment as a whole. Constant temporary replacement also hinders the professional development and the ability to deepen one's knowledge in a particular domain.

On the interplay between flexibility and learning we could observe that on the one hand, nurses of all ages generally show a positive learner's attitude and the openness to innovation and being flexible, particularly in France. But on the other hand, it was often mentioned that there is also a large number of nurses, predominantly older nurses, who are reluctant to accept changes and innovations and who hold on to traditional work routines ("what was good then cannot be bad today"), particularly so in Germany and Estonia. Generally we could observe that a few years before retirement the incentives and motivation of employees for learning and accepting innovations is decreasing, not only in health care. However, sometimes it may also be the employer, who does not encourage learning processes anymore. In Germany, for example, there was a case of a 55-years old hospital nurse wanting to attend a training course, but was refused because the employer considered her being 'too old' for investing in further training.

With regards to mobility, there are only very few nurses in French public hospitals whose work situation requires spatial mobility; and also in Germany most nurses stay with the same employer for a very long time and geographical mobility is generally low. However, general staff turnover in Germany is considerably high, because of a) the high percentage of female nurses who go on maternity leave, sometimes for 10 years or more; b) the increasing number of young nurses who leave the profession; c) the high number of non-certified nurses caring for elderly people; and d) the high number of non-certified nurses working for domiciliary health care providers. Spatial mobility seemed to be more of an issue for nurses in the UK and Estonia.

Although generally nurses do not tend to change employers frequently, they also do not seem to develop a strong sense of commitment towards the employing institution. Strong commitment was rather expressed at the team level and the particular ward or division nurses are attached to. Since nurses' work profiles and core tasks are somewhat similar in any kind of health care institution, the nurses interviewed did not intend to change employers if the work environment was personally perceived as good. In Germany, also practical reasons restrict nurses' mobility between employers with increasing age, and that is the employer's increasing salary cost factor when recruiting older nurses (above the age of forty, for example). Newly qualified young nurses seem to be more eager to gain work experience with

different employers and in different work settings. Changing the employer or institution, even if it involved moving to another part of the country, was often regarded as an attractive option, particularly directly or shortly after completion of the initial training.

3.3 Attitude towards work

The focus on the enhancement of technical competences and striving for professionalism is noticeable in all countries and resulted in a fundamental conflict that significantly affects nurses' occupational identities across Europe. It is the conflict between a patient-oriented work ethos and an almost intrinsic motivation related to helping others versus work organisation and structures that increasingly allocate time and energy of medical staff to more technical, instrumental, administrative or coordinating tasks. This new profile is particularly being established in hospitals putting a lot of pressure on nurses. But since it is also related to a specific concept of caring and thus affecting the sector as a whole, it is also noticeable in other segments of the sector.

3.3.1 Motivation and job commitment

One major reason for choosing the nursing profession seems to be an intrinsic motivation that is typically related to helping or caring for others. In Germany and Estonia, for example, this attitude was subjectively often related to a personal experience in the family or family tradition of nursing. Other aspects mentioned were job security and the universality of the profession ("nurses are always needed"; "it is a profession that is needed everywhere"), the flexibility of working hours and a general medical interest. The high level of responsibility and independence at work combined with a certain kind of personal maturity and the acquisition of medical know-how also make the profession attractive.

Since the nursing profession is heavily gendered, it was important to many women that nursing is a job that is compatible with building a family and family life, particularly because it is easy to re-enter the job after a long pause of maternity leave. Some women would even come back to the profession after a pause of ten or fifteen years without being significantly disadvantaged against nurses who worked continuously. This is possible due to general staff shortages on the one hand, but also because the core qualities and tasks of nursing do not seem to change significantly over time. With regards to the day to day work activities nurses liked interacting with others, working in teams, working independently and having a high level of responsibility in their job. In Germany, the following aspects were mentioned as influencing work motivation and satisfaction:

<u>Motivating factors:</u>

- Working in a good team, good interaction with colleagues and mutual support;
- Good management based on mutual support and transparency for decision making;
- Having the possibility to expand on skills and competencies (rich learning environment), but at the same time no pressure for learning;
- A positive orientation towards role and responsibility;
- Recognition of competencies by others (patients, colleagues, friends);

- Sense of belonging to a professional community.

Discouraging factors:

- The work is physically and psychologically extremely demanding, particularly when pursued as a life-time profession;
- The daily work load is too much;
- Time pressure resulting in not having enough time for direct patient care;
- Low status of the profession within the medical field and in society.

The vast majority of the nurses interviewed stated that they liked their job. The intrinsic motivation for helping others and the mutual encouragement and recognition between colleagues and within the professional community seem to foster nurse's occupational identity. Particularly in France nurses are highly attached to their work and to the ethics of the nursing profession. However, in all countries nurses had to struggle to come to terms with the personal costs of caring, unconditional service and authenticity of feelings. This is perhaps most evident in the balance required of staff for their own psychological well-being of caring about their patients but, at the same time, not caring too much. To find the right balance is particularly difficult for newly qualified staff and pressure for high standards may even have a negative affect when practitioners feel that they do not live up to the model.

Demonstrating commitment through caring as well as exercising technical skills adds complexity to the performance of a role, but in addition it can make the role much more demanding. Morrison (1992) points out that those working in the caring professions have to deal with issues of emotional involvement, stress, work constraints and role uncertainty. This reinforces the importance in such circumstances of having mechanisms in place where individuals can talk these issues through with colleagues. Nurses expressed concern that in most institutions such mechanisms may be in place in theory, but they were not implemented in a way that would really support nurses in coping with demanding work processes. Thus the support through colleagues and the team becomes crucial and often the major source for work motivation and encouragement, particularly when dealing with extreme situations of psychological stress like the death of a young patient, for example.

Particularly in Germany it was striking that the majority of nurses encountered being burned-out and not being motivated any longer after having been in the profession for a certain period of time, on average 8 to 10 years. This experience constituted a major conflict between a high level of dedication often aligned with a personal ideal model of caring and a high level of job commitment and the inability of performing accordingly. This moment in most cases did also mean a fundamental crisis in a nurse's occupational identity that not only significantly affected their work performance, but also their personal life. It is interesting to see the different strategies nurses developed in order to cope with this situation. Possible strategies mentioned were to leave the profession, change the work attitude, or develop a specific strategy to balance professional and private life. In this situation a welcome option for women often was to start a family, which would correlate with the typical period of family building at the age of 26 to 30 years.

Through the interviews conducted the following personal strategies or coping mechanism to combat burn-out syndromes could be identified:

a) *Redefinition*
Develop a more distant approach to caring for patients; that is finding a new balance between providing unconditional service and 'not caring too much'. Some nurses also called this strategy "developing a more professional approach" and it was stated that generally young nurses are better trained to practice such an approach than the older generation of nurses. The latter found it particularly difficult to initiate such a change, because hardly any support was given from the employer's side and the daily work routine and time pressure also do not support learning and practising a different approach towards caring. Case I (annex) illustrates how this approach was pursued and put in practice on a nurse's own initiative.

b) *Retreat A – Long-term adjustment*
Some nurses experienced a high level of dissatisfaction, but did not reflect upon this situation too much and would just continue their daily work routine hoping that the situation may change due to an external change in work organisation or structure that may bring along some kind of motivation (for example new management, new colleagues, a new assignment, etc.). Some nurses could get by with this kind of conditional adjustment and work attitude for a very long period of time, sometimes ten years or more.

c) *Retreat B – Leave the profession*
There exists a considerable percentage of nurses who leave the profession, either on a permanent or a temporary basis. One option may be to work part-time like a large number of nurses in Germany do. Being a gendered profession, many women also go on maternity leave and/or seek employment in a neighbouring field like, for example, social work, working with children, health care counselling, etc.

d) *Horizontal Mobility*
Some nurses opted for frequently changing wards, departments, or employers, for example, changing from a public hospital to a private institution or working for a domiciliary health care provider. The choice may depend upon how strongly the nurse identifies with the hospital structure and environment. Some nurses felt that the hospital is where they belong professionally (this group would rather opt for being horizontally mobile between different wards within one particular hospital) whereas others experienced hospital structures as restricting them in their professional development. Case II illustrates this form of coping mechanism.

e) *Professional Development*
As mentioned above, further training plays a key motivational role and it was often during a period when nurses questioned basic elements of their occupational identity that they would opt for pursuing further training within the hospital context. In Germany, for example, the course to becoming a certified head nurse or an instructor takes about two years alongside work commitments thus reducing the number of working hours and the direct interaction with patients for the benefit of investing time and energy in learning. It was stated that the exchange and interaction with colleagues from different departments, who are pursuing the same course, would also be motivating and broaden professional horizons. In

addition, this choice fosters opportunities for continuous professional development and vertical mobility.

f) Vertical Mobility

In some cases nurses opted for pursuing further qualifications outside the hospital context, that is further studies at the university in a related field (public health, health care management) often combined with still working as a nurse part-time with a private or public employer. The advantages of this strategy were seen in being independent from the employer (compared to strategy e) and significantly broadening individual career perspectives, including outside the health care field. This choice implies an alienation from direct patient care, one of the core elements of the nursing profession. It was often the nurses who personally experienced the direct patient care as psychologically too demanding or hospital structures as restrictive who would opt for this strategy (illustrated through Case III).

3.3.2 Core elements of nurses' occupational identity

It seems that nurses generally do not develop a very strong corporate identity or attachment towards the employer, whereas the field of specialisation and the immediate (the team) and broader professional community (nurse association) are key elements of nurses' occupational identity. Another source of occupational identity steams from the direct interaction with patients and the profession itself, which was stated to have a clearly defined job profile. Placing the patient at the heart of the health care profession seems to be an attitude that evolves gradually over time with work experience. Especially apprentices and newly qualified nurses rather expressed a general interest in medicine as the key motivating factor for becoming or being a nurse. They did not so much have a strong patient orientation, but their primary interests were medicine, administration, or providing training. Nurses with the latter orientation were generally more interested in assuming coordinating and administrative positions. In contrast, nurses with a longer employment record used to put the patient and direct patient care in the centre of the occupational context. This group would probably prefer to be horizontally mobile and work directly with the patient instead of assuming administrative or managerial functions.

Interestingly, German nurses stated that a patient-oriented approach could be better pursued when working in elderly care institutions or with domiciliary health care providers than in hospitals. The first group pointed out that when caring for elderly people the mode of interacting with the patient ranked much higher than medical know-how. These nurses also valued the intensive relational interactivity with patients that sometimes can last for several years. Nurses who provide health care services for patients in their own homes encountered an even more intensive contact with the patient, because the whole institutional context is taken away, placing the direct interaction with the patient automatically in the centre of activities. It was mentioned that the situation of visiting and seeing the patient in his or her domestic environment often supports an approach of providing integrated care, because the nurse perceives the patient in a totality that emphasises their individuality as a person, and not as an anonymous sick person as is common in a typical hospital situation.

When looking at the situation of nurses in the four different countries it seems that the positive identification with their work derives from the daily activities related to the interaction with patients and direct patient care, which is linked to a certain set of values and work ethics. Nurses stress that they like the interactive and

interpersonal aspect of their work that brings out a personal satisfaction being associated with 'helping others', 'doing something useful', or 'feeling needed'. Health care staff assume a lot of responsibility in connection with their relative autonomy in direct patient care. This combination leads to a high level of commitment towards their work and the ethics of their profession.

If the above mentioned elements constitute the core elements of nurses' occupational identity, one can conclude that these are elements which are relatively independent from structural changes. However, as has been illustrated in chapter 1, changes in work organisation, division of tasks, demands for flexibility or mobility, structural reforms, medical innovations, etc. do considerably affect nurses' daily work routine, skills development and the time allocation with regards to different tasks including direct patient care. Nurses experience increased pressure and time constraints leading to a conflict between providing patient-oriented care and rationalisation. This conflict is affecting nurses' occupational identity in that trends towards professionalism also question some of the core values of an idealised model of nursing that also includes full personal dedication. This may in some cases be regarded as a relief, particularly for nurses who generally feel overwhelmed with a personally too demanding caring situation. Whatever the personal perception may be, the problem is that it is almost entirely left to each individual nurse to find the right balance between caring and efficiency demands. The individualised character of this process seems to constitute a considerable burden for all kind of medical staff. For the nurses interviewed finding this balance often proves to be extremely difficult as they are generally not getting enough support from their employers or other institutions. This is also true for dealing with psychological stress nurses expressed they do not feel sufficiently supported in their work context.

In addition, nurses' occupational identity is often questioned and becoming unstable due to a personal crisis that has been characterised as burn-out syndrome and that is quite a common phenomenon for caring professions. Thus, the need for changing strategies in redefining occupational identities of health care professionals is also inherent and intrinsic to the profession itself, and this feature is not so much dependent upon the structural context. It is interesting to see the different conflicts arising around this problem. For example, it was stated that younger nurses generally show a more 'professional approach' and are better prepared and trained to balance an idealised model of caring with a more distant caring approach. However, one problem in all countries was that especially apprentice and newly qualified nurses are increasingly leaving the profession within the first 3 years and are lacking the dedicated attitude and commitment towards direct patient care that is highly valued by patients and employers.

3.3.3 Status of the profession

In all four countries the low status of the nursing profession within the medical field, but also in society in general was regarded as problematic. The conflict nurses experience between the working demands combined with a high level of responsibility and the lack of recognition for their work seems to be a major factor negatively affecting their self-esteem and occupational identity. The reasons for nurses perceiving their work as being undervalued are several. One reason can be traced back to historical roots when nurses traditionally were assuming the role of providing charitable services as a mission linked to a religious context and often without remuneration. In this role they were subordinated to doctors with a diffuse job profile

assuming all sorts of charity and health care tasks and responsibilities. That the job profiles of nurses are lacking coherence and clear definition still remains an issue today, particularly in contrast to medical doctors, for example, who have clearly defined competencies and responsibilities. Despite the tendency towards equal partnership between all groups of medical staff it is often hospitals with well established hierarchies that still perpetuate the subordinated role of nurses towards doctors, although nurses' associations are increasingly lobbying for equal recognition of the professional status of nurses.

This struggle is unequally advanced in the different European countries. But even in France where the nursing profession has a comparatively well established status it does not institutionally form part of the medical profession, but is considered as a paramedical profession. In terms of the medical de-ontology and in comparison to the French "Ordre de Médecins" there is no equivalent like an "Odre d'infirmières". Rather the nursing profession is a cluster of different professional associations with no common and independent deontological authority. In all countries we could register a strong approach towards establishing nursing as a profession independent from doctors and acknowledging nurses as experts in their own field. This is pursued by, for example, establishing an academic career path for nursing or supporting nurses' associations in their function to lobby for clearly defined work profiles and equal partnership. However, these rather institutional mechanisms do not compensate for the significantly lower salaries nurses receive compared to medical doctors. Nurses across all countries expressed that the financial incentives and remuneration for nurses are not adequate and that their salaries do not compensate for the increasing responsibility and work burden. Maybe the emerging lack of interest among young people to pursue a nursing career, increasing staff shortages in all countries and problems of retention and recruitment of professional staff will ultimately improve working conditions and salaries of nurses on a long-term basis.

4 Conclusions

In all countries of investigation the health care sector has become more diversified during the last decade making public and private health care providers compete for customers and the provision of good quality services. With an aging European society it is mainly financial pressure that is pushing for new efficiency criteria, rationalisation and quality control. By supporting the decentralisation of health care services this process also demands a higher level of flexibility of health care professionals and redefines work profiles and responsibilities. These developments also question traditional hierarchies and occupational identities opening possibilities for equal partnership of all medical staff and a redefinition of the traditional nurse profile in particular. Being the mediator between the doctor and the patient nurses assume a key function that increasingly requires a good balance between technical and social skills. Both types of skills are at the same time becoming more complex and are amplified by incorporating administrative and managerial proficiencies on the technical side, and counselling and mediating functions on the social side.

When it comes to the deployment of health care professionals in the different European countries one recurring theme is the challenge of finding enough people with the full range of skills and qualities particularly managers believe to be desirable. This issue specifically addresses the balance or tension between technical and cognitive

skills development and values associated with expressive caring. Should nursing identities be primarily based upon mastery of a distinctive body of (scientific and clinical) knowledge similar to doctors and other professions allied to medicine? Or does their identity principally derive from their role as expressive specialists, with particular skills, knowledge and understanding of therapeutic relationships? If it is to be the latter – and that is what most experienced nurses identified with in their work context – then it is important that the curriculum for nurse training also facilitates the development of a discourse about feelings, psychological stress and care, particularly to support newly qualified nurses. And it would suggest that the values underpinning expressive care need to be developed during initial training or, as some of the interviewees argued, that those recruited to the profession should already have developed these values.

However, concerning nurse training we could observe that apart from very few exceptions (like, for example, the specialisation as child nurse in Germany) the increasing cognitive demands remain underdeveloped in most training programmes and curricula. As a consequence any shifts in practice towards more expressive caring are therefore largely dependent upon the degree of personal commitment of staff. In this case it would be important that personal and professional values are in broad alignment. It was interesting to see that technical proficiency is often taken as a given and little attempt is made to examine the interplay of trying to develop both caring and technical competence at the same time.[5] In practice, it is often the work experience that bridges the gaps. Some of the respondents pointed out that particularly in complex non-routine situations the newly qualified were 'less expert' than the more experienced staff. Interviewees in Germany, for example, considered a balanced mix of 'experienced nurses' and 'newly qualified nurses' as crucial for smooth work processes and working in a team as this combination of staff would stimulate mutual learning processes. The newly trained nurses often possess the most recent up-to-date and more 'technical' knowledge and theory, whereas experienced nurses convey security in difficult situations and competence through their many years of experience. That they might work at a slower pace often even turns out to be in line with a more patient-oriented approach.

It has been outlined that those working in caring professions are exposed to emotional involvement, stress, work constraints and role uncertainty. This reinforces the need for having mechanisms in place that allow individuals to talk these issues through with colleagues and supervisors. Interviewees confirmed that colleagues are the most important source of support when it comes to situations of psychological stress, particularly when institutionally that kind of support was lacking. Although from the manager's point of view most hospital departments had certain support mechanisms in place, health care professionals perceived these mechanisms as inadequate and not being supportive in practice. At this point more guidance and support is needed at all levels (from the employer, the training system, at the institutional level, etc.), particularly in the light of difficulties of recruitment and retention of qualified medial staff in all European countries.

[5] Particularly managers of departments in UK hospitals that regularly recruit newly qualified staff (because they do not get experienced applicants) emphasised how they liked to recruit staff who would be effective learners. However, when appointing staff they showed an in-built bias towards technical proficiency rather than the encouragement of the development of more rounded, caring performance.

For the foreseeable future the supply of 'natural carers', with highly developed cognitive and technical skills, wishing to work in nursing or other professions allied to medicine, is likely to be less than the demand. But it is not only the balancing of technical skills and caring abilities that posts a major challenge in training and development. When it comes to the dynamics of nurse-patient relationships one also has to take into account how the social organisation of care influences care-giving, not least by assuming that nurses have a relatively high degree of autonomy in how they carry out their work. The increasing drive for efficiency and performance within health care systems also considerably limits the time nurses have for activities that convey caring and this was stated to be one major conflict nurses and other medial staff are exposed to today.

In the light of the demographic shifts taking place in Europe and the anticipated staff shortages in all segments of the sector of health care provision and services enhancing opportunities for continuous professional development and broadening the range of occupational tasks and profiles of health care professionals will become a key challenge in the future. In most European countries pursuing a nursing career is still a one way road without many professional alternatives. As work profiles are becoming more complex and flexible by, for example, shifting the focus from 'cure' to 'prevention' or increasingly incorporating counselling and coordinating functions those developments need to be taken into account when developing curricula and training programmes for nurses and other professions allied to medicine. In addition, facilitating opportunities for vertical mobility should be more strongly combined with financial incentives. In most countries nurses who assume higher level managerial responsibilities including supervising a large number of staff are not necessarily rewarded with higher pay. Thus the motivation for taking on more responsibility and stress is almost entirely based upon personal commitment and/or professional interest. Although mobility in nursing generally is not put in the context of 'making a carrier', but with enriching professional competencies and skills, for example by being horizontally mobile, it is important also to create alternatives for mobility.

Last but not least, raising the status of the nursing profession will become a key challenge in the light of recruitment and retention of professional staff in the future. Professional pride and self-esteem are key elements of occupational identities and need to be supported for the nursing profession. Certain institutional mechanisms may be one way of achieving status elevation (like, for example, establishing academic career paths, increasing nurses' salaries, reforming the curriculum, etc.). However, some of these measures may ultimately be counterproductive. For example, the formalisation of training for elderly care nurses into a three-year training course in Germany has raised the status of the profession, but has at the same time created high job entrance requirements which should be considered when it comes to severe staff shortages. In the UK the creation of an academic degree for radiographers has lead to over 50% of graduates from some courses never entering the profession since with a science degree they also have an abundance of other job opportunities in the UK labour market. Thus one may also consider other options like, for example, supporting the increasing number of nurses' associations to lobby for the profession.

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6 Annex

3 Illustrative Cases: Individual strategies of nurses adjusting their work identities when coping with changes and new demands in the work context

CASE I: "Redefinition Strategy"

Marianne is female and 48 years old. She is married with no children of her own, but has a step-son. Since her childhood she always wanted to become a nurse as she grew up with a bedridden mother who had a heart attack at the time of Marianne's birth. After three years of vocational training as an ordinary nurse in a church-run hospital she decided to join a public hospital, as she found that the church hospital was "too small". Marianne began working in the same unit where she is still working today, the urology ward, in 1974. At that time she was immediately offered a good post and this strengthened her view that "it was good to have changed the hospital".

Today, Marianne has been working in the same hospital and also in the same ward for 28 years, which she herself regards as being "very rare in these changing times". She is still satisfied with her area of work as she finds urology extremely interesting in its connection to various other areas of medicine. Therefore she still feels that this ward is "her place". Marianne helped to establish the urology ward and has been the director since 1979 supervising around 15 nurses.

When Marianne was around 40 years old, she experienced a personal crisis and considered reducing her working hours. At that time she began to feel tired of the routine – she felt that she had been 'caring too much' putting a lot of her personality and energy into her professional life. As Marianne reflected upon her personality, she realised that already in the beginning of her career as a nurse she was too close to the patients, which was "good for them, but not for myself." She identified with the sufferings of the patients to the extent that she often felt exhausted and fell sick herself. As a consequence she even considered leaving the profession and the health care sector. It was through her personal initiative and with the help of seminars that she learnt how to maintain an emotional distance from the patients and to cope with psychological stress caused, for example, by deaths of patients. With the help of these seminars she learnt to redefine her role as a nurse shifting towards a concept that emphasises the supportive functions of a nurse. Today Marianne has learnt to apply a more professional approach and is very happy with her work situation and the responsibilities she assumes.

Marianne is still highly motivated to widen her knowledge and regularly attends different training courses which the hospital offers. She also considers it necessary to be up to date with latest medical technologies and treatments. Often such learning takes place informally through colleagues and representatives of pharmaceutical and medical-technical companies, with which she cooperates. Broadening her knowledge brings a lot of movement into her field of work and motivates her to continue learning, even after 28 years of working in this area.

When asked about her career development Marianne states that she never really chose to become the head of department, it "just happened." In this function she is predominantly responsible for administrative and organisational tasks and is hardly involved anymore in direct caring and nursing. That is something she regrets as she would prefer to work more closely with the patients. Nevertheless, Marianne feels

strongly attached to her job and place of work. She sees herself destined to work where she is at present and accepts the negative aspects which she experiences at work, for example, a high stress level. In her current position Marianne sees herself as an "all-rounder", who carries out a whole range of different tasks, some of which are not necessarily outlined as being her responsibilities. This has led to an increase in her workload and Marianne regards this to be part of a "fundamental change within the whole health care sector", which not only affects the work of nurses, but also that of doctors and other medical staff.

Cost-reduction has played a dominant role in the discussions about reforms in the German health care sector for the last five years. As the ward director Marianne was not given any formal training in accounting or finance, which is usually necessary for the implementation of cost-reduction schemes. Instead, she had to learn this for herself on the job. Today, she also trains her colleagues on this informally.

Marianne lays emphasis upon her counselling role and encouraging the patients to do as much as they can by themselves. Today, she sees her role much more as an advisor or a supporter than as a helper. The nurses do the complete nursing job only when the patients totally depend on external help. But the 'empowering' approach takes a lot of time, which is more and more scarce, thus creating a strong time and work pressure that they perceive as stress. Furthermore, the reduction in the number of beds from 36 to 20 has further contributed to work intensification, because the number of patient admissions is at the same time increasing. The result is to improvise with provisional solutions by, for example, organising temporary beds.

Despite these organisational problems staff fluctuation in the urology ward remains low. Marianne credits this to the interesting field of work, a good work environment and her supportive attitude as ward director by which she is always encouraging her staff. She regrets, however, that she cannot give financial rewards to those who work very well, because in her view financial incentives would be a very effective incentive for the staff.

Marianne cannot imagine herself working until she reaches retirement age, because she does not think that she could continue to cope with the workload with increasing age. She thought of changing her field of work but at the same time was doubtful whether this would be possible at her age. Indirectly, Marianne also expresses her disappointment about the fact that she is not sufficiently remunerated for her performance at work. However, Marianne's job satisfaction is still very high and she does not wish to work in any other area or field.

In her position Marianne has to mediate and balance different interests. On the one hand, as a nurse Marianne is dissatisfied with work intensification and the high stress level that also affects her colleagues and the working climate. But on the other hand, as the ward director she tries to understand the concerns of the management and the need for cost reduction. Marianne sees herself (together with most of the hospital staff) struggling with the conflict between the pressure for efficiency and cost reduction and the demands of providing high quality care. Marianne also states that the expectations of the nursing directorate are difficult to put into practise and that she would expect the directorate to more strongly lobby for the concerns of nurses.

Although Marianne likes to carry out organisational tasks, she experiences an inner conflict since she does not have enough time for direct patient care. She wished she had additional staff, for example a secretary, who could take over some organisational tasks so that she would have more time for the patients. Structural changes have increasingly lead to unsatisfactory care conditions of patients, but this

matter is not taken seriously. According to her the health care sector is lacking a strong a lobby. She envisions that it probably requires a breakdown of the system for people to realise that more money and personnel are needed to improve the situation.

CASE II: "Horizontal Mobility"

Yvonne illustrates the case of an ordinary nurse who is a member of the *Service de Compensation et de Suppléance* in a French public hospital. This 'pool' is considered as an effective intermediary promoter of the fluidity of the nurses' voluntary transversal flexibility and mobility between different health care departments within public hospitals belonging to the same corporate group. She represents a nurse with a strong professional identity who has the capacity and the will to combine her strong attachment to the work context (including changing requirements in terms of flexibility and mobility) with her involvement (also in her function as a nurse) in other socio-cultural and humanitarian activities outside her usual occupation.

Yvonne is an ordinary nurse in her late thirties. She joined the 'Pool for Compensation and Replacement' in June 1995 through a voluntary internal transfer on a permanent work basis (as an assimilated civil servant). Her tasks and missions are basically the same as those exercised by a non-member of the 'pool'. The only difference lies in the fact that she is more flexible and mobile transversally through different health care departments for short-term replacements (of less than two months).

On the basis of a Scientific Baccalaureate and after 33 months of nursing studies at Strasbourg Nursing School she obtained the French State Nurse Diploma in 1983. It is this usual national nursing diploma which gave her direct access to her first job as an ordinary nurse in the "medical reanimation (resuscitation) department" within one of the public hospitals in Strasbourg in September 1983. Since then, she has not benefited from any further formal certification-based education and training, which automatically would allow for climbing up the hierarchy in the nursing profession (to become, for instance, an executive or a specialised nurse). However, since her first job in nursing she has been benefiting from a variety of short CVT, for example Cancer treatment (1984); Health care courses of action and medical filing (1986); Reanimation (1986); English language (1986/87); Feeding (1987); Non-verbal communicability with patients (1989); Physical and human challenges to surgical reanimation (1990); Sense of touch (1990); and the Introduction to communication, computing and the management of emergency (1995).

For her, all these forms of work-related learning and training undertaken basically within employer-directed CVT schemes (but upon her own initiative) are to update and enrich her competencies in accordance with requirements of technological and professional change. These courses also helped her to develop her professional polyvalence and transversality in the light of required flexibility and mobility within and between different departments of hospitals. In addition, they enhanced her capacity of self-reflection as a nurse and relational interactivity within and outside the workplace.

Like for any ordinary nurse, Yvonne's work is organised on a moving-shift basis (3 x 8). But being a member of the 'pool', she usually only works on the first two moving shifts: the morning and the afternoon shift. In either shift, she works in a team (usually composed of an assistant nurse and a doctor) in charge of about a dozen patients. As is the case with all other nurses she benefits from a certain autonomy in her basic mission ("acte propre"), but is relatively dependent on the

doctor in any medically prescribed act ("acte prescrit"). However, her professional responsibility is normally engaged for both acts, especially towards the patient. For her, the level of relational interactivity with colleagues and the patients is dependent on the nature of the respective department to which she is temporarily assigned. But on the whole, the duration of two months maximum for each assignment does not allow her to develop a high level of personal and professional relational interactivity within the working teams.

As a member of the 'pool' she has been experiencing a high level of work-related functional mobility within and between different departments. It is a voluntary system (concerning the choice of shift-working time), but planned two months ahead and confirmed just 15 days before the effective implementation of the assignment. Accordingly, this mobility requires a high level of functional flexibility and polyvalence, i.e. the capacity to be constantly prepared to cope with different work situations. Her working time flexibility is voluntarily pre-planed within each work assignment by the 'pool'. For her, this mobility and related flexibility have some advantages and disadvantages. The advantageous effects are basically a) the development of spontaneity, transversality and openness to change; b) less problems of conflict, tensions and hence less stress linked to being attached to regular working teams; and c) more independence and freedom of choice at work. However, in her view, the temporary replacement does not give priority to professional development and knowledge in one particular domain. Also, the lack of lasting work-related relational interactivity within working teams is regarded as negative since the lack of integration may lead to the development of "individualism" and even introversion.

Initially, Yvonne stayed for two years in her first job in the department of "medical reanimation". After a personal non-paid leave of two months in South America (Bolivia) she asked for a transfer to the department of "surgical reanimation" within the same hospital where she stayed for 6 years (1985 to 1991). Her reasons for the change were basically two:

- The heaviness of work assignments combined with lack of fluidity in work-related relational interactivity with the hierarchy within the department of "medical reanimation";
- The work and interaction with colleagues within the department of "surgical reanimation" was professionally more interesting.

Halfway working with the department of "surgical reanimation", she took another period of personal non-paid leave for six months for undertaking a certification-based training in "tropical medicine" in Belgium. Then before her move into the "intensive care" unit of the cardiology department within the same hospital in June 1992, she took an-eight-month non-paid leave for a humanitarian mission for refugees in Afghanistan.

After about three years of work with the intensive care unit of the cardiology department she voluntarily joined her present job within the 'pool'. This choice was motivated by at least two basic considerations: a) her attachment to a nursing profession more open to change, new challenges, polyvalence and the development of a wider range of relational interactivity; and b) her preference for pre-planned working time.

Yvonne is highly committed to her profession as a nurse with openness towards change and the challenges of undertaking a wide range of actions and relational interactivity based on human solidarity and values. She is professionally satisfied with

her work as a member of the 'pool', because it allows her to be more mobile and continuously experiencing new kinds of relational interactivity. It also helps her to develop her personal human capital of know-how. It gives her the liberty of choice and action to choose and pre-plan the time of her work in shifts.

Her commitment to nursing as an occupation did not prevent her from having a passion for other activities such as supporting Afghan refugees (since 1991) and her involvement with the association "médecins sans frontières" since 2001. Her personal assessment of the current situation of the nursing profession confirms the reflections made by other interviewed nurses: that is in spite of the progress made so far within the overall health care sector, the nursing profession still has not gained enough social recognition, especially in terms of incentives and support for a sustainable career development. The evolution of wages is still at a level which does not compensate for the increasing responsibility and burden of work.

CASE III: "Vertical Mobility"

Sabine is female and in her mid thirties. She was born and trained in Austria and worked there as a qualified nurse in a public hospital for thirteen years (1984-1997). During the last 6 years of this period she worked as deputy head nurse and also pursued a further qualification as a certified head nurse. In 1997, due to personal reasons, she moved to the North of Germany, where she started to work in a public hospital, initially as a deputy head nurse and later as head nurse.

While increasingly taking over administrative tasks Sabine was offered a job as assistant to the managing division of health care. This was a newly created position and the management division created a new job profile for it. Initially, Sabine was recruited into a kind of young professional programme following a one-year *training on the job* model. After completion of the programme she was officially promoted to management assistant and later as provisional head of the care division. Her current job profile covers the organisation and coordination of tasks of the care division and includes representation, documentation, public relations and management. For about 2 years she has been wholly involved in administrative and organisational tasks and has stopped any kind of nursing activities or interacting with patients.

Sabine predominantly pursued *training on the job* learning to perform new tasks from her supervisors on an informal basis. This mode of learning, however, was accompanied by additional formal training. She states that her affiliation and competency for performing managerial tasks is more of a personal interest and disposition than a result of training.

Sabine regards her decision to move from Austria to Germany as very positive for her personal and career development. She can imagine moving to another city or to change her field of work (i.e. apart from the health care sector). She is highly motivated in pursuing a university course in Nursing Management which she plans to start in autumn of 2002 in Hanover. In that she is supported by her employer under the condition that she commits herself to continue her current work with the same employer for a certain period of time.

Sabine wanted to become a nurse like her aunt from her early childhood. Being personally engaged and committed towards social issues, an ideal which arose during her adolescence, she for a long time strongly identified with her work, particularly during the initial years of her career as a nurse. Later on, however, Sabine became more critical against her previous attitudes. Today she states that her work took much of her youth away compared to others of her age at that time as she matured very

rapidly during her nursing profession. "The constant confrontation with suffering and death is more exhausting than one can imagine". Retrospectively Sabine states that "in the initial years I thought I was doing a great job, and I felt great about the thought that I had the power to decide upon life and death. But as time passed I realised that my work caused me more distress than contentment." Finally, Sabine could not imagine herself working as a nurse till she retires. This, she says, does not mean that she did not like the job she only knew that "it would do me no good in the long run." Today, Sabine is glad to be performing managerial tasks instead of directly working with the patient. She has not been performing nursing activities for the last 1-2 years.

When Sabine started working in Germany she had the chance to compare the health care systems of Austria and Germany and she found that the Austrian system was far more advanced compared to the German system. "When I came to Germany I got the impression that the German system was very backwards compared to the health care system in Austria, particularly when it comes to the role and status of the nursing profession. I felt like being taken back 40 years." Her impression was that nursing as a profession was not independent and "did not have self-confidence". Compared to doctors nurses could not put forward their interests and demands. There was a lack of staff and no independent decision-making was possible for the nursing divisions (as they were completely supervised by the nursing directorate).

Regarding structural changes that have taken place in the health care sector Sabine states that this has resulted in an emancipation process and increasing self-confidence of nurses in relation to the other health care professions, especially doctors. These changes also fostered Sabine's personal motivation to take on managerial responsibilities and to put forward her own opinion and knowledge. According to her, nurses in the hospital now clearly define their own tasks and work more autonomously. They also have an opportunity to be involved in the decision-making processes. Sabine actively participated in and pushed forward the implementation process of these innovations, which to her view are considerable improvements for the staff.

Being actively engaged in improving the condition and status of the nursing profession in Germany, Sabine considers hospital management to be open towards new ideas. Personally she felt a lot of trust coming from the management that encouraged her to contribute her ideas and suggestions to the reform process. Today she identifies much more with her managerial position than with nursing itself. "I realized that I like performing organisational tasks and that this is actually my strong point." But although she identifies with the goals of the management, she is also critical and very confident about her own views and suggestions regarding how caring and nursing should be organised. Due to her experience in this sector in two different countries she can compare the systems and has very clear ideas about how financial and human resources should be used. Overall she states that there is less waste of such resources in Germany compared to Austria. Sabine also mentions that the requirement for more flexibility in the areas of working hours, different tasks and further training has increased during the last few years and also has significantly augmented responsibilities of staff and their decision-making power about the planning of the working process.

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