CHAPTER 11

Black Canadian Nurses and Technology

Karen Flynn

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INTRODUCTION

Proficiency in the use of information and communication technology (ICT) by nurses in the new millennium is not only expected but also required. Nurses, for example, are expected to be computer literate, as care work is now done via the Internet or over the phone. Furthermore, ongoing implementation of E-health[1] initiatives will continue to fundamentally change

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[1]E-health may be defined as the combined use of information and communication technology (ICT) and electronic systems for various purposes, such as clinical (e.g., recording, retrieval, sharing, and maintaining patients' records), educational (e.g., training and learning by means of Internet and other electronic devices or through televideo consultation with the specialist doctors), research (e.g., evidence-based case studies, surveys, and trials), and administrative (e.g., identifying demographic indicators, trends of diseases, populations affected, policy decisions, implementation status query, etc.), which can be either at the local site or at distance in the health sector. See for example, Subhagata Chattopadhyay, "A Framework for Studying Perceptions of Rural Healthcare Staff and Basic ICT Support for e-Health Use: An Indian Experience," *Telemedicine and e-Health* 16, no. 1 (January/February 2010): 80–88, doi:10.1089/tmj.2009.0081. See also, http://www.ehealthinitiative.org

how health care is delivered and subsequently how nurses define the scope of their practice. The ubiquitous presence of modern technology in health care has led to an uncritical acceptance of these systems and devices by clinicians. This, however, holds the potential to foreclose exploring technology's complicated meanings. Reaction to the implementation of modern technology in nursing—as I will demonstrate—varies according to the historical context and the actors involved. An exploration of how practitioners initially grappled with the introduction of technology into nursing provides a context to understand current debates around its practice and use.

As part of a larger research project on Black Canadian and Caribbean immigrant women in Canada, this chapter is based on interviews of 35 nurses AQ02 from 1995 to 2007 regarding their childhood, nursing education and training, family, work, and community among other themes.[2] The objective is to map Black nurses' conflicting and contested relationship to technology while being attentive to their social location—that is, how they were situated within nursing. The exclusionary practices of nursing schools and the Department of Citizenship and Immigration meant that in the world of post–World War II nursing in Canada, Black practitioners were the exception rather than the rule. Black nurses worked alongside a primarily white clinical staff within a culture that reinforced whiteness and white cultural practices and norms. Notwithstanding the fact that the interviewees identified themselves as nurses—and not as *Black* nurses—they remained far from oblivious to the fact their blackness was not always invisible to other clinical personnel and patients. Subsequently, Black nurses' response to technology is not only intricately connected to economic, social, and political processes but is also a tacit mindfulness of how their own raced bodies might be read.

Gender then cannot be the sole or primary analytical paradigm used to articulate social relationships in health care. In doing so, we run the risk of underestimating the myriad and complex ways in which structures of power produce and reproduce social divisions in the workplace, not only among physicians and nurses, but also between nurses. Though Black nurses remain differentiated by education, age, training, time of migration, and other factors, incorporating their voices as knowing and self-reflective subjects in the discussion of technology not only allows for a polyvocality of perspectives

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[2]See Karen Flynn, *Beyond Borders: Moving beyond Borders: Black Canadian and Caribbean Women in the African Diaspora* (University of Toronto Press, forthcoming). In addition to signing consent forms, the interviewees were also given the option of using pseudonyms; only four of the women chose this option. The tapes are currently in the possession of the author.

but also serves to legitimize their knowledge. Simply put, including Black practitioners' perspectives render a more dynamic reading and interpretation of nursing relationship to technology.

Generally speaking, when feminist scholars conceptualize the meaning of technology for women in relation to paid work in North America, they either view technology as reinforcing social inequality—that is, women are viewed as victims of technology—or they see technology as a mixed blessing. For the first group, a major concern is how technology reinforces and maintains social inequality, based on race, class, gender, age or other markers of difference. Eileen B. Leonard, for example, points out that "for many women workers developing technologies have yet to deliver as promised . . . . it has done little to improve the status of women in the workplace."[3] Furthermore, she continues, women of color are often concentrated in "labor-intensive, low technology work."[4] Alternatively, those who view technology as a "mixed blessing," caution against a reductionist and positivist view of women's relationship to technology. Instead of accepting that technology automatically means progress, it is important to explore how it contributes to the creation of a sexual division of labor, but also how this division of labor is dismantled and re-established through individual and collective efforts.[5]

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Larger feminist debates about women and technology also resonate within nursing. Nursing scholars undoubtedly concur that the introduction of technology into nursing has substantially restructured the physical aspect of the occupation and has affected how patient care is administered.[6] For example, American nursing scholar Margarete Sandelowski, in *Devices and Desires: Gender, Technology, and American Nursing*, noted that introduction of new technologies operated simultaneously to impede and benefit nurses. Nursing scholar Ruth Minard remains less optimistic. Even though nurses gain new skills to operate new technologies, she argues, there is the fear that such technologies actually deskills them because they detract from the caring aspect of nursing which is fundamental to the occupation. In the long run, Minard intimates, technology drains the skill requirements resulting in a demand for semi-skilled rather than skilled workers. Furthermore, she

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[3]Eileen B. Leonard, *Women, Technology, and the Myth of Progress* (New Jersey: Prentice Hall, 2003), 116; See also selected chapters in, Mary Frank Fox, Deborah G. Johnson, and Sue V. Rosser, eds., *Women, Gender, and Technology* (Urbana, IL: University of Illinois, Press).

[4]Leonard, *Women, Technology, and the Myth of Progress*, 118.

[5]See for example, Juliet Webster, *Shaping Women's Work: Gender, Employment and Information Technology* (New York: Longman Sociology Press, 1996).

[6]For a contemporary discussion see, Margarete Sandelowski, "Visible Humans, Vanishing Bodies, and Virtual Nursing: Complications of Life, Presence, Place, and Identity," *Advance Nursing Science* 24, no. 3 (2002): 58–70.

continues, "Technology is not confined to the introduction of machines, but includes changes at the site of production, in the transfer of production between the workstations, and in the coordination of the two."[7] Rinard further equates the increase in the numbers and types and use of drugs by nurses to the introduction of machines in manufacturing. In contrast, Julie Fairman offers an alternative view of nurses' relationship to technology that moves beyond the traditional machine/human dyad. She pushes instead for an analysis that is grounded in history and context, further proposing that we understand technology as socially constructed rather than as some abstract entity that remains disconnected from political, social, and economic processes.[8] Drawing on Fairman's analyses, this chapter explores Black nurses' responses to technology from the perspective of nurses who were retired, nearing retirement, and those who were still employed at the time of the interview.

TECHNOLOGICAL TERRAIN

Once Black Canadian nurses gained formal admittance to train and work in Canada's nursing schools and hospitals beginning in the early 1950s, they entered a field undergoing rapid technological, diagnostic, and surgical transformations. In addition, the introduction of myriad new drugs was also common. In some ways, the occupation benefited from these changes as nurses ventured into male-dominated terrain. Once the purview of physicians, tasks such as taking blood pressure and starting intravenous drips were relinquished to RNs. Technological changes accelerated into the twenty-first century. Increased electronic machinery and specialized care units such as the intensive care unit (ICU) characterized the mid-1950s to the 1980s. Moreover, as a way to control both cost and control care, new technologies were implemented in the 1980s and 1990s. Undoubtedly, similar patterns existed in Britain where most of the Caribbean nurses trained. Of course, by the mid-1970s, the Caribbean migrant nurses discussed in this study had already migrated to Canada. Indeed, these nurses who entered the occupation during the early 1950s to the 1970s had to reconcile traditional nursing values with the introduction of modern technology.

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[7]Ruth G. Minard, "Technology, Deskilling and Nurses: The impact of the Technologically Changing Environment," *Advances in Nursing Science* 18, no. 4 (1996): 62.
[8]Julie Fairman, "Alternative Visions: The Nurse-Technology Relationship in the context of the history of technology," *Nursing History Review* 6 (1998): 129–146.

How Black nurses articulated their reaction to technology cannot be attributed to any single factor. Indeed, for Black Canadian-born and Caribbean-migrant nurses their presence as racialized women is but one factor. Nurses who trained in the British system, whether in the Caribbean or Britain, and who migrated to Canada mostly during the 1960s to the 1970s, felt that their training, knowledge, and skills superseded that of their Canadian counterparts. Consequently, their discussion of technology is integrally connected to how they positioned themselves vis-a-vie Canadian nurses regardless of color. Black Canadian nurses, on the other hand, understood the intrusion of technology as not only inevitable, given transformations in the health care field, but also in some cases vital.

Black nurses in this study were cognizant of the fact that the introduction of technology had implications for how they performed their duties. Still, none of the nurses expressed an outright aversion to technology. Of the two groups, Black Canadians expressed more optimism about its use. They advocated and applauded the use of technology as long as patient care was not compromised and if there were actual improvements at the bedside. Caribbean migrant nurses, on the other hand, while conscious of how technology extended the range of nurses' work (from which some of them benefited), were less laudatory than their Canadian counterparts. Consequently, there was some conjecture about how technology not only altered nurses' work, but also relationships between nurses.

As racialized women working in predominantly white spaces, some nurses acquired training in specialized areas where demands for technological skills were valued, and consequently they gained more respect. Besides developing new skills, the interviewees also mentioned other advantages, including accepting the challenges of a new unit, autonomy, a more egalitarian relationship with physicians, and the opportunity to develop their confidence in a given area. Throughout their careers, some of the nurses were employed in the emergency room (ER), operating room (OR), hemodialysis unit, the ICU, and cardiology.

An RN with midwifery training, Inez Mackenzie, immigrated to Ontario from Jamaica during the 1960s where she worked in pediatrics for almost a decade. Mackenize wanted a new challenge in more specialized area, so she enrolled at Humber College in Ontario. For Mackenize, the OR was a more ideal site because it demanded greater technical skills and knowledge. At the same time, as a proponent of specialization, Mackenzie was not only interested in the challenge these units present for nurses, but also underscored how patients benefit:

> It is good to specialize. I am thinking of intensive care. There was a time when you could go in intensive care and rotate whereas you probably didn't

> like intensive care; you just go because you are sent there because there is an opening. I find the more you specialize is the more care you give because that is your personal choice, so you are able to do more for the patient then.[9]

For nurses such as Mackenzie, technology is viewed in a dialectical manner. Thus, when nurses make decisions regarding the extent of their involvement in specialized areas that demand increased technological aptitude, they are hardly passive recipients of technology. Moreover, Mackenzie's inclusion of patients in her rationale speaks to their centrality as important subjects critical to any discussion about technology.

Notwithstanding the fact that Black nurses all trained in the apprenticeship system, those trained in the Caribbean and Britain felt the training far exceeded that of their Canadian counterparts. Upon migrating to Canada, the majority of interviewees found that tasks that they had been responsible for in the Caribbean and Britain remained in the physicians' domain. This was especially so for nurse-midwives. Barbadian-born, British-trained Muriel Knight noted that upon arrival in Canada also in 1960:

> There were a lot skills (such as giving aspirins to patients) being done by physicians that was being done by nurses in England and the Caribbean. Inserting a tube in somebody's nose and their stomach was what I did as a second year nursing student. And I couldn't do that as a nurse when I came here.[10]

Indeed, wanting to capture some aspect of the professional life left behind might also explain why some Caribbean nurses chose more specialized and technologically driven areas where they were able to utilize the knowledge and skills from their previous training. For example, nurses who worked in high-intensity areas such as the ICU and the ER felt that physicians valued their input and expertise which added to their confidence. They also emphasized the mutual respect that existed between nurses and physicians.

When she migrated to Ontario in the early 1970s, Caribbean-born British-trained Dorette Thompson first worked in the hemodialysis unit and several years later took the necessary courses that enabled her to move to the ER. For Thompson, nursing encompassed more than managing the technology that necessitates the smooth functioning of the unit:

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[9]Inez Mackenzie, tape-recorded interview by author, Markham, Ontario, October 13, 1999.

[10]Muriel Knight, tape-recorded interview by author, Scarborough, Ontario, September 9, 2006.

> Nurses are more autonomous and you have responsibilities, and the fact that you work alongside the doctor [who] relies on you like in Emerg and Hemo . . . that's why I like those areas . . . the doctor relies on us a lot because we know the patient, they don't. And that's the good thing about the areas that I'm working in now it's where I get the satisfaction.[11]

Other nurses such as Knight who already had experience working in the ER department in Britain and the casualty unit (similar to the ER) in Barbados also expressed a profound sense of satisfaction working in the ER in Canada. In addition to discussing how important it was for her to be as, or even more, knowledgeable than the physician, Knight also highlighted the reciprocal relationship that existed between physicians and nurses.

Fairman's contention that any discussion about technology is narrow when the primary focus is fixed on machines and their function is certain applicable to Caribbean migrant nurses. When these interviewees made decisions about upgrading into critical care nursing, they did not act on impulse but weighed their options carefully. That is, they took into consideration multiple factors. Certainly, the prestige was one reason, but there were also the social relationships—especially with physicians—coupled with their own skills and ability. Like some of their Caribbean counterparts, a few of the Black Canadian interviewees also worked in coronary care units where they navigated their roles with machines used to diagnose patients.

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TECHNOLOGY AND ITS BENEFITS FOR BLACK CANADIAN NURSES

Canadian-born Marlene Watson's first worked as an RN in the recovery unit at Toronto Western Hospital in Ontario during the early 1960s. Watson graduated from Victoria General Hospital in Halifax, Nova Scotia, in 1961 and moved to Toronto immediately thereafter. She left Toronto Western in the mid-1970s to work in the ICU at the York Finch Hospital in North York, Ontario. To improve efficiency and cut costs, York Finch configured the ICU to include coronary care, postcoronary care, endocrinology, and gastroenterology; and Watson rose to a supervisory position in the mid-1980s. Drawing on her extensive nursing and supervisory positions in these specialized areas, Watson explained that in many respects, "technology has been great,

[11]Dorrette Thompson [pseudonym] tape-recorded interview by author, Scarborough, Ontario, August 17, 1999.

and I think it offers a whole lot more of nurses 'interpretation of patients' wellness . . ."[12] To support her point, Watson used the example of a patient who underwent open-heart surgery. In a situation such as this, Watson maintained, a highly experienced and skilled nurse would look after the patient. This nurse, she continued, would be able to examine the monitor the patient is hooked up to "see if they are going to fibulate . . . You could be forewarned because you have a nurse sitting there responsible [for] checking those monitors as they go along." Of course, one can argue that Watson's mention of the "nurse sitting there" is precisely the issue with some aspects of technology. Some of it could be monotonous, repetitive, and boring.

From Watson's and other nurses' vantage point, *they* used technology, it did not use *them*. That is, they were not dupes who naively assumed that modern technology and scientific advances would resolve all medical troubles, but they recognized the advantages. Some nurses, including Watson, felt that patients profited the most from technology. To elucidate her argument, Watson hearkened back to an earlier period in her training before the introduction of certain technological devices, such as the tympanic thermometer[13] which was introduced during the mid-1980s:

> We don't have patients biting thermometers and cracking them in their mouths, [since] we had oral thermometers. Now we get a needle [probe], and we can just stick them in the ear, and in two seconds the temperature is taken. It [technology] has taken the danger aspect away as well.

In tandem with prompt and accurate diagnosis, technology helped to protect patients from unnecessary harms.

Viewed as an efficiency-saving mechanism, certain technological devices ultimately meant the saving of lives. Frieda Steele, another Black Canadian-born nurse who graduated from Hotel Dieu in Windsor, Ontario in 1950, noted that "we can get reports right away; we don't have to rely on invasive surgery for answers. It [technology] is fast and efficient."[14] References were made to how specimen tests produced more accurate results and were done at a much faster pace than the older method. One such older method involved nurses testing urine samples on the hospital unit, using special plastic and paper tests strips, where estimates were made about the amount of chemicals in the urine, such as glucose, blood, or proteins. These tests relied on nurses' visual comparison of color results. With the new technology, the tests were

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[12]Marlene Watson, tape-recorded interview by author, Toronto, Ontario, January 18, 2000.
[13]Thanks to Cynthia Toman for her technological expertise.
[14]Frieda Parker Steele, tape-recorded interview by author, Windsor, Ontario, June 9, 2001.

done in the labs by machines, which guaranteed a much higher degree of accuracy rates.[15] Watson and other Black Canadian nurses pointed out that AQ05 nurses in critical care units who were well trained to operate the machines could assess their patients more intelligently. The use of certain technology further prevented the overcrowding of certain departments, another benefit to patients and nurses alike. Drawing again on the example of the patient who had a surgical operation, Watson pointed out, "we whip them into the recovery room, and most recovery rooms can take a respirator," which then freed up space for other postoperative patients.

Watson's and Steele's optimism about technology and patient care was sometimes interrupted by further introspection as they contemplated their overall perception of the various devices upon which nurses relied. Steele mentioned, for example, how technology affected nurses' skills—skills that remain intrinsic to how nurses care for their patients. She explained:

> I think that the observation skills of nurses have been downgraded. I feel that the nurses don't have time, and doctors don't seem to listen or rely on them like they used to. The machines are not able to tell us, for example that, Mrs. Jones is worried about a sick child at home, or that she is worried about leaving her ailing mother at home.

Referred to as the "psychological aspect of caring" by a Caribbean nurse, Steele recognized that nurses, not diagnostic machines, were best able to satisfy the emotional needs of some patients. Regardless of the ubiquitous presence of technology in the field of health care, it can never replace some of the vital functions perform by nurses.

Watson insisted that once nurses were trained to operate a particular technology, it was easier to make more intelligent decisions with respect to patient care. But she also acknowledged that sitting in a room for 8 hours observing a machine did not encompass all that a nurse was trained to do. Furthermore, in a situation where a nurse was monitoring a patient from a different location it was difficult to simultaneously use technology and provide "hands-on" patient care. Thus, there was some recognition that practitioners who monitor devices were being deskilled because this work can be monotonous, unchallenging, and rendered obsolete other abilities that are central to nursing. How both groups of Black Canadian nurses conceptualize technology was far from reductionist. They aptly weighed the advantages and disadvantages of the various technological devices and their relationship to them.

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[15]See for example, Joel D. Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century*(The John Hopkins University Press, 1995).

TECHNOLOGY AND ITS LIMITATIONS FOR BLACK BRITISH AND CARIBBEAN NURSES

Unlike the Black Canadian interviewees, Caribbean nurses' discussion of technology was more encompassing. These nurses situated their discussion of technology within the broader political economy of health care in tandem with how they as migrants viewed the Canadian health care system. Indeed, they too, acknowledged the advantages of technological and scientific advances within the health care. Yet Caribbean nurses were not always convinced that the quality of patient care improved, especially at the end of their careers with the restructuring of the Canadian health care system. While they could not alter the inevitability of technological interventions in nursing, these practitioners hardly accepted these devices passively. Rita Maloney, paraphrasing educator and scholar Marie Campbell, points out that "technology continually transforms the context and ideas people use to think about it, making it difficult for nurses or anyone else to stand back and judge its impact. But nurses must stand back and judge."[16] Indeed, Caribbean nurses' articulation of technology suggests that they *did* more than standing back and judging.

Trained in Jamaica, June Heaven migrated to Northern British Columbia in 1967; 7 months later she left for Ontario, where she worked for a short time at two different hospitals. She then left Toronto for Ottawa to complete her baccalaureate degree in nursing in 1969, while working as a team leader at the Centenary Hospital. Heaven returned to Toronto and began teaching at Humber College in 1971 (she also completed Master's Degree during this time) through her retirement in the mid-1990s. Heaven's discussion of technology thus adopts the perspective of both a nurse and a nurse educator.

For this interviewee, debates about technology and the effect on patient care requires contextualization. That is, how technology is deployed is intricately connected to how the wider society sees and values the role of caring. For Heaven changes in nursing education and the concomitant skills that nurses have acquired have benefited the discipline as a whole. "Without a doubt, nurses have required more skills with high tech procedures. You have better educated nurses to handle more high tech procedures," she remarked. Yet, Heaven expressed some concerns. She saw a connection between technological advancement, working conditions, and society's overall attitude about caring, links that ultimately affects the patient. Heaven noted that during the early 1990s the patient/nurse ratio was much higher than in previous

[16]Rita Maloney, "Technological Issues," in *Canadian Nursing Face The Future,* eds. Alice J. Baumgart and Jenniece Larsen, 2nd ed. (Toronto, ON: Mosby Year Book, 1991), 295.

years, which affected not only nurses' well-being but also how patient care was delivered. She further posited that we currently live in a society that is indifferent, and she argued that technological advancement contributes to this process as nurses come to depend on machines and caring takes a secondary role. According to Heaven, "People are coming into nursing from a society where caring is less." For Heaven, then, increased technology usage cannot be understood in isolation from the changes taking place in society, and, by extension nursing. Thus, her conceptualization echoes Susan Reverby's often-repeated stance that "nursing is a form of labour shaped by the order to care in a society that refuses to value caring."[17]

Caribbean interviewees also spoke critically of how the implementation of technology in nursing created divisions between differently situated nurses. In this scenario, Heaven (who is a nursing educator) and specialized nurses (those with technological skills) might view the bedside as the prerogative of less well-trained nurses. Surely, some nurses acquired technological expertise to distinguish themselves from other practitioners while removing themselves from the bedside; however the Caribbean- and British-trained nurses interviewed did not express this motivation. They continually emphasized the significance of patient care, which they found lacking upon migration to Canada.

British- and Caribbean-trained nurses were hardly reticent in their criticisms of their Canadian counterparts regardless of color. One area they found their Canadian counterparts lacking was in ministering to the needs of their patients. Though both groups trained in hospital-based nursing schools, Caribbean nurses felt that their practical and theoretical training put them at an advantage. They also pointed out that their training was more comprehensive which allowed them to care for multiple patients at any given time, compared to their Canadian nurses who could only manage, for example, three patients. Finally, a few Caribbean nurses suggested that that they placed more value on patient care, which they saw as critical given the transformations occurring in nursing.

Jamaican-born British trained nurse-midwife Daphne Bailey immigrated to Brantford, Ontario, in 1960. She worked at Brantford Hospital for 2 years before leaving for Toronto where she worked at then Doctors Hospital for 8 years. She then completed a certificate in public health at the University of Toronto and subsequently found employment in 1971 with the Victoria Order of Nurses (VON), an organization that provides in-home nursing care. During the twenty five and half years that Bailey worked with the VON, she

[17]Susan Reverby, *Ordered to Care: The Dilemma of American Nursing 1850–1945* (New York: Cambridge of University, 1987), 1.

earned a BA and several certificates taking courses which she felt "would help me with the VON." Among her multiple positions Bailey also worked as an Intravenous (IV) Nurse, another specialty area.

Bailey insisted that Black nurses valued caring more so than white nurses did. She noted that Black nurses were kinder, more empathetic, and had a more holistic way of viewing the patient. "We were taught to look after the whole patient," Bailey points out. Bailey attributed this difference in caring to Caribbean nurses' religious upbringing and sense of community, a perspective that she felt that was corroborated by white patients when she worked in England and Canada. "I think we have a more caring sprit. When I came here [referring to Canada], I found it very difficult, the nurses had their own little patient, and if your patient wanted water, they would say "I'm not your nurse."[18] While working as an IV nurse, Bailey noticed that "the nurses would leave the tray [while] the patients are lying flat. They didn't raise the bed or anything." She would then go around "raise the bed and put the trays in front of them [patients]", tasks that were normally the auxiliary staff's responsibility. Compared to many other Black and white nurses, Bailey was not only more educated, but also had more experience, yet this did not preclude her from being attentive to the basic needs of the patients.

British-trained Grenadian-born Dorothy Jones also migrated to Canada during the 1960s and worked as a Registered Nursing Assistant (RNA). She later went back to school to become an RN. For Jones, technology appeared to be replacing traditional nurses' knowledge, especially among newer nursing graduates. Missing from nursing in the 1990s, she felt, was a system whereby older more experienced nurses acted as mentors for younger nurses passing on their knowledge as opposed to giving machines precedence over nurses' experience. An aspect of this knowledge to which Jones referred was the practical aspect of nurse training that she perceives Canadian nurses, especially those trained in colleges, might not have received. Here she explained:

> The younger people are just graduating and coming in, they don't have the older nurses to prime them, you know, to pass on their experience. But with the new technology, they do everything by the computer, but the basic hard working experience that the older nurses had, you wouldn't find that among the new nurses coming in. So in that way it's more or less left for computers and machines . . . .[19]

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[18]Daphne Bailey, tape-recorded interview by author, Toronto, Ontario, May 5, 1995.
[19]Dorothy Jones, [pseudonym], tape-recorded interview by author, Rexdale, Ontario, February 29, 2000.

According to her, the older nurses were "just holding on, doing the best that they could, they are waiting to get out".

RESTRUCTURING AND TECHNOLOGY

Interestingly enough, while the interviewees generally accepted the use of technology such as cardiac machines and respirators in critical care units, they were especially critical of computers. The introduction of computerized systems was seen as more of a nuisance due to its time-consuming nature. Generational differences between the two groups of nurses further accounted for how each viewed and employed computer technology. Essentially, those nurses who began working in the 1950s and 1960s displayed more discomfort with the use of computers in the hospitals than those who were still working at the time of the interview. The former mostly saw it as greatly impeding bedside care, while the latter viewed computer as part of the transformation the health care field was undergoing. It appeared, one interviewee from the first group lamented "that nurses spend more time putting things in the computer, and trying to work this computer." That most of these nurses were much older and not accustomed to using computers undoubtedly made the task much more difficult. Mackenzie further explained that due to "a lot of documentation . . . you find that sometimes you have not done enough for the patient physically." She added, however, that despite the excess use of computers, that patients and nurses were protected in the event of a legal dispute. Clearly, nurses such as Mackenzie are watching and judging; they did not use these technologies uncritically.

While the interviewees pointed to the time-consuming nature of computers, Canadian nursing researcher Jacqueline Choniere maintains that computerized systems are often accompanied by new management protocols in an effort to manage the workplace. Speaking specifically about the computerized and the patient classification system implemented in the 1970s and 1980s, Choniere argues that:

> Management, in an effort to rationalize the workplace, had created a new work organization to enhance the new technology. More specifically, management had found a technology which they believed would help them to rationalize the workplace. The new technology supports the new organization, and the resulting changes in the nature of work exert pressure on the worker, in an attempt to prevent her from functioning as before.[20]

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[20]Jacqueline Choiniere, "A Case Study Examination of Nurses and Patient Information Technology," in *Vital Signs: Nursing Work in Transition,* eds.Pat Armstrong, Jacqueline Choiniere and Elaine Day (Toronto, ON: Garamound Press, 1993), 66.

The end result, Campbell argues, was that "a scarcity of time orientation was programmed into nurses' thinking about caring, through their involvement in classifying patients in units of time needed for care."[21] Essentially, nurses were forced to rethink how they managed patient care.

If the implementation of computerized technology in hospitals was one way for management to control nurses' labor, this did not always have the desired effect. Nurses were not always compliant subjects. Watson, for example, avoided using the computer, finding other ways such as the telephone to communicate when she needed to. Watson insisted:

> I don't even bother with the computer . . . By the time I type in I.D.'s and all that stuff; I could have done another I.V. By the time I get done with this information input and then I have to do my charting afterward, I find that for me it does not save me any time. If I had my own way, I would probably do away with computers.

Clearly, Watson and some of her counterparts astutely assessed the ineffectiveness of various forms of technology instituted in the workplace. Moreover, nurses who, like Watson, figured out how to avoid using the computer exercised some form of agency.

Technology and Cost Containment

As illustrated thus far, Black Canadian and Caribbean nurses recognized that not only did technology offer nurses' options, it also reinforced their claims to professionalism as skilled and knowledgeable workers. At the same time, the structural and organizational changes hospitals made during the 1990s, as a part of larger health care reforms in Canada, led the interviewees who were still working during this time to conclude that hospitals had their own agenda, which did not always include them or the patients. Thus, technological systems were thus bound up in efforts to reduce expenditures. While some nurses tried their utmost to resist the encroachment of certain forms of technology upon their daily work, this was a difficult endeavor.

Trained in Canada during the 1970s, Caribbean-born Janet Barrett explained how some technology instituted by hospitals not only increased profits, but also allowed management to reduce the number of nursing personnel. Barrett used the following example to illustrate her point:

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[21]Marie Campbell, "Knowledge, Gendered Subjectivity, and the Restructuring of Health Care: The Case of the Disappearing Nurse," in *Restructuring Caring Labour: Discourse, State Practice, and Everyday life,* ed. Sheila M. Neysmith (Toronto, ON: Oxford University Press, 2000), 190.

> [Before] when you [took] a temperature you had to stand there and wait for the thermometer to reach its level. Now in seconds, you can do the temperature. Because the technology wasn't there you had more time then to spend with the patient. They have cut the staff in nursing because they [management] are saying its taking less time to do the things you used to do. The patient interaction is no longer there like it used to be.[22]

For Barrett, management deliberately engaged in the centralization of work to control the labor process at the expense of health care workers and patients. Hence, "to restructure the delivery of patient services and inject it with more of the vigor of the market means organizing caregivers to do their work differently."[23] AQ06

In the midst of cutbacks, short staffing, and stagnant wages, Black nurses found themselves questioning the very philosophy and foundation on which nursing has been constructed. For those interviewees who were still employed, the ability and desire to "care" had certainly been eroded. Hospitals, they felt, had adopted a business-like model which remained antiethical to patient care. Here, another interviewee illuminated the following:

> Hospitals run like businesses and nurses are at the bottom of the totem pole. They know that nurses will work anyway, because you can't walk off a unit and abandon your patients. They cash in the whole philosophy of what a nurse does, the caring, nurturing, so you are going to continue nursing. We are held hostage to that.

The above interviewee clearly recognized nurses' vulnerability as hospitals implemented strategies to compete in what had become an "increasingly market-or quasi market-oriented health care system."[24]

Once the beneficiaries of modern technology—at least in the beginning of its implementation—hospital restructuring ultimately affected how patient care was administered. Brenda Lewis earned her RN diploma in psychiatric nursing in Trinidad, but upon migration to Canada in the early 1970s found out that her diploma was not recognized by the College of Nursing. Subsequently, she too earned her registered nursing licensure. Lewis had this to say:

> You don't have time to do that [patient care] now. You have got to do your paper work and you have so many patients to look after, before you had less, and you could really do bedside nursing for your patients. But now it's a matter of survival, of getting the workload done. So you cut corners to survive.[25]

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[22]Janet Barrett, [pseudonym] tape-recorded interview by author, Toronto, Ontario, June 5, 2000.
[23]Campbell, "Knowledge, Gendered Subjectivity, and the Restructuring of Health Care," 188.
[24]Ibid.
[25]Brenda Lewis, tape-recorded interview by author, Toronto, Ontario, February 24, 2000.

The use of new technology not only reorganized the daily routine of nurses' work, but also affected social relationships between nurses and their superiors. While Caribbean nurses tended to overlook the skill and educational differences between themselves and the ancillary staff, this did not always extend to supervisors. Indeed, nurse managers were often in a conflicted position as those responsible for ensuring that the new technologies and management systems were being implemented. Canadian nursing scholars Alice Baumgart and Jenniece Larsen argued that "nurses who occupy middle-management positions are often laden with budget, staffing and related functions as a result of decentralization and frequently have very little time to provide necessary 'support work' to ensure that nurses feel valued [or] will take risks to find out creative solutions to workplace problems."[26] Thompson offered her insight into how management has changed in the past 20 years in a way that reaffirmed Baumgart and Larsen's analysis. According to Thompson, management showed very little interest in the welfare of workers and her frustration was evident:

> Managers used to care about you. You are not well, just go home. People would care and you would get your vacation. Now I can't even get a vacation this year because we don't have enough staff, and they can't grant you vacation, if they don't have any staff. Nurses are caught in a catch twenty-two because we work in the health care field and caring for people whose lives are in your hand, you can't take a vacation because there is no staff.

CONCLUSION

Indeed, clinicians working in health care in the millennium have accepted the ongoing technologization of health care as normal. For Black Canadian nurses who entered nurse training during the late 1940s and 1950s, and their Caribbean counterparts who joined them during the 1960s and 1970s, modern technology drastically transformed and expanded their scope of practice. Black Canadian nurses generally felt that patients gained the most as a result of modern technology. Caribbean nurses, on the other hand, remained more tentative especially in their analysis. This was mostly evident in the case of nurses who were still working at the time of the interview and had to deal

[26]Alice J. Baumgart and Jenniece Larsen eds., *Canadian Nurses Faces The Future*, 2nd ed. (Toronto, ON: Mosby Year Book, 1992), 233–234.

with the effects of restructuring. Even though there were some nurses who actually acquired certain skills and training that placed them in areas that demanded technological expertise, this did not mean they acquiesced to the changes wrought by technology. Caribbean nurses interviewed insist that technology cannot be divorced from the political economy of health care. Cost-containment measures proposed and implemented beginning in the 1970s and 1980s, and the restructuring of health care in the 1990s, has led to disillusionment among nurses who were still working at the time of the interviews. Whether they were trained in the Caribbean, Britain, or Canada, Black nurses did not view themselves as victims of technology, or that technology automatically meant progress. What the interviews reveal is that discussions about technology have to be contextualized and placed within a political, economical, and social context. In doing so, Black health care professionals emerge not as victims of technology, but as active agents who were able to navigate a contested terrain while ensuring that patient care was rarely compromised.

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AQ 4	Page 159, 3rd para.	AQ: Meaning seems unclear. Please check.
AQ 5	Page 161, 2nd line	AU: Please provide location for the footnote xv.
AQ 6	Page 167, 2nd para, last line	AU: Please check the word "Private" in footnote xxiii.