

**An Institutional Ethnography of Substance-Use  
Practices Among Nurses and Related Management  
Intervention Practices in a Province in Western  
Canada**

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## Abstract

When nurses have problems with substance use and are reluctant to seek treatment, their health and wellness are put at risk and their care provision to the public is potentially compromised. Nurses' substance-use problems and their management through professional organizations' treatment programs are underresearched and poorly understood overall, and particularly from a Canadian perspective. The disjuncture I experienced between my own embodied experiential knowledge as a nurse and the conceptually based, decontextualized, individuated "official accounts" of the issue I found in the professional and scholarly literature became the problematic that I explored in a multiphase, manuscript-based doctoral study. I carried out a critical integrative review of the literature on nurses' substance-use problems, followed by an institutional ethnographic inquiry, in which I aimed to discover (a) how dominant discourses in nurses' talk about their everyday worlds organized their substance-use practices and (b) how nurses' experiences were managed in a regulatory treatment program. I utilized data from interviews with 12 standpoint informants (nurses in a regulatory program for substance-use problems) and six secondary informants from different standpoints in the institution, as well as analyses of relevant institutional texts.

This work yielded significant original findings. Dominant individuated, moralistic, decontextualized discourses in nurses' talk about their everyday worlds and in professional and scholarly texts silenced nurses' experiences of work stress. Employers' roles in nurses' working conditions were obscured. Nurses' substance-use practices, particularly alcohol, were organized in ways that enabled them to silently manage their distress and keep working. Nurses gaining capacities to self-advocate for improved working conditions was linked to their recovery from substance-use problems. The standardized regulatory treatment program studied was not based on current norms of practice; did not afford nurses the right to choose treatments; privileged physicians while silencing and subordinating nurses; and was rife with conflicts of interest, power imbalances, and private corporate benefits—all acritically accepted by the regulatory body.

The important new nursing knowledge gained informs prevention, treatment, regulatory, and education processes aimed to address nurses' substance-use problems. It does so from nurses' everyday knowledge and standpoint, furthering their interests and those of other disciplines concerned with professional power and domination.

**Keywords:** nurses, addiction, substance use, work environment, impaired health care professionals, regulatory policies

## **Dedication**

For my dear late friend, Bon. This one's for you and all of the other nurses who had so much to tell us, but whose voices were silenced. Throughout the many years of our friendship, you told me that I would do this, and I didn't believe you. You always said that you wanted to be the first person to call me 'doctor.' Know that I heard you.

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I always tell my nursing students that, in this biz, without your nursing network, you are lost. This has been so true in my career and in this endeavour. I thank all the nurses who I have worked with over the years for their friendship and collegial support, particularly my cheerleading squad of friends (especially bestie Kathleen), colleagues (particular shout-out to the 'A Team'), and students in the BSN Department at Douglas College. The incredible support of my employer, Douglas College (and particularly my Director Linda), has made it possible for me to achieve this goal. Paula, thanks for being a true friend since our wild nursing school days—age may have settled us down, but we're still wild at heart!

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## List of Acronyms

ANA	American Nurses Association
APA	American Psychiatric Association
ATD	Alternative to Discipline
BCCSDRP	British Columbia Coroners Service Death Review Panel
BCCSU	British Columbia Centre on Substance Use
BCNU	British Columbia Nurses Union
BSN	Bachelor of Science in Nursing
CAD	Canadian Dollar
CNA	Canadian Nurses Association
CRNBC	College of Registered Nurses of British Columbia
CRNNS	College of Registered Nurses of Nova Scotia
DA	Discourse Analysis
DSM	Diagnostic and Statistical Manual of Mental Disorders
HCP	Health Care Professional
IC	Inquiry Committee
IE	Institutional Ethnography
IME	Independent Medical Examiner
KM	Knowledge Mobilization
LRJ	Lead Researcher's Journal
NCSBN	National Council of State Boards of Nursing
OAT	Opioid Agonist Therapy
PHP	Physicians' Health Program
PSU	Problematic Substance Use
RB	Regulatory Body
RN	Registered Nurse
RPN	Registered Psychiatric Nurse
SFU	Simon Fraser University
SUD	Substance-Use Disorder
TSF	Twelve-Step Facilitation

# Chapter 1

## Introduction

### 1.1 Entrée to the Study

The topic of nurses' problems with substance use<sup>1</sup> emerged as the focus of my scholarly inquiry over the course of my 36-year nursing career. I have seen from personal experience how nurses practice substance use—our harmless recreational use, and the tragic personal and professional consequences when it is not so harmless. This was brought home to me most painfully by the loss of my best friend, a highly respected and very experienced nurse. She collapsed suddenly at her workplace in a major health care institution, where she had worked for decades with friends and colleagues. Within a matter of days, she succumbed to what was discovered to be a severe substance-use problem that no one (including me) had any idea that she had. This heartbreaking experience was at the forefront of my mind during the literature review for my doctoral work. I wanted to understand how all of this had happened. How had she come to have such severe substance-use problems? How was this so invisible to all the nurses around her—a group of competent, caring health professionals? My review of the scholarly and professional literature on nurses' problems with substance use shed no light on this puzzle. This was in no small part due to the strong sense of unease and confusion, or disjunctures, that I felt as I continually met authoritative accounts that seemed irrelevant or contrary to my decades-long accumulated experiential knowledge of nurses' work lives and substance-use practices. The term disjuncture denotes a "knowledge wedge [being driven] between the experiential and ideological" (Deveau, 2008, p. 12), whereby people's embodied knowledge of the actualities of their lives is subjugated to dominant institutional discourses. These disjunctures were the entrée into and the foundations of my doctoral research. In this introductory chapter, I provide a background to my thesis topic, the goals and objectives

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<sup>1</sup> I use the terms *problems with substance use*, *substance-use problems*, and *substance use practices* in this research. My intent in doing so is to reference the issue being researched in a descriptive way. In consistency with institutional ethnography methodology (Smith, 2005), I purposefully avoid drawing from or imposing any preexisting diagnoses, concepts, theories, or categories.

of the research, a discussion of the mode of inquiry and research design that I employed, and an overview of the subsequent thesis chapters.

## **1.2 Background**

I am familiar with many of the realities of nurses' typical everyday work lives and have experienced the numerous demanding and even dangerous working conditions that nurses encounter. Such conditions have been identified and well-explored in nursing literature, including physical, emotional, and sexual violence (Anderson & Stamper, 2001; Choiniere, MacDonnell, Campbell, & Smele, 2014; Hesketh et al., 2003; Jackson, Clare, & Mannix, 2002); interpersonal aggression originating from colleagues—often conceptualized as “horizontal violence” (Becher & Visovsky, 2012, p. 210; see also Farrell, 2001); job strain and fatigue from understaffing, compulsory overtime, and shift work (Shields & Wilkins, 2006); bearing witness to patients' suffering causing traumatic stress (McGibbon, Peter, & Gallop, 2010) and moral distress (Pauly, Varcoe, & Storch, 2012; Rodney, 2017); difficulties in navigating entrenched hierarchical and gendered power inequities (Choiniere et al., 2014; McGibbon et al., 2010); corporate-driven reorganization and redefinition of nurses' work, whereby efficiency, not excellence in nursing care, has become the employers' highest priority (Rankin, 2009); and nurses' overall knowledge, education and skills, as well as the considerable emotional work that they must undertake to cope with all of these stressors being consistently undervalued (Choiniere et al., 2014; McGibbon et al., 2010).

Given these actualities of nurses' work lives, it is little wonder that they have been found to have very high rates of physical and psychological health problems. For example, nurses suffer incidence of physical pain due to musculoskeletal disorders and arthritis that are disproportionately higher than other Canadian female workers (Shields & Wilkins, 2006). Over one-third of Canadian nurses live with a level of chronic pain that limits their day-to-day activities, and three-quarters of the nurses so afflicted reported that their pain condition occurred as a result of their work activities (Shields & Wilkins, 2006). Canadian nurses who provide direct patient care also reported that they were “almost always” (Banerjee et al., 2012, p. 396) mentally and physically exhausted and experiencing back pain at the end of their shifts. In one study, 88% of nurses reported that they had used pain medication within the past month, and the intensity of their workplace's physical demands upon them was strongly correlated with their amount of

pain medication use (Trinkoff, Storr, & Lipscomb, 2001). Furthermore, nurses are a significantly overrepresented group within the population of those who have mental illnesses (Kidd, 2008) and have been found to have a much higher incidence of depression than other working people in Canada (Shields & Wilkins, 2006). Even more disturbingly, Australian statistics have shown that nurses had the highest rates of suicide among all females in that country (Taylor & Barling, 2004).

Despite that amassed scholarly knowledge, I saw little inquiry into how acknowledged institutionally situated stressors may have been linked with or contribute to nurses' substance-use problems. Instead, dominant discourses in the nursing literature framed nurse' substance-use problems as solely a consequence of phenomena related to the individuals' characters, such as "sensation- ... [or] thrill-seeking" (Trinkoff & Storr, 1998a, p. 584) personality (see also West, 2003); cocky, overconfident attitudes toward their ability to manage their substance use (Kenna & Lewis, 2008); or general lack of fortitude—"they did not know how to effectively cope" (Storr, Trinkoff, & Hughes, 2000, p. 1463). To me, these inquiries appeared to depict the nurses studied as though they were not carrying out their work in any actual environments, let alone that their conditions of work could have any relevance to their substance-use problems. In my review of the literature (Ross, Berry, Smye, & Goldner, 2018), I found that the few sources that did acknowledge these conditions as contributory still took a predominantly individuated and blaming stance, redistributing responsibility for the use of substances back to the individual nurses, who purportedly needed to correct their moral and attitudinal shortcomings. It was they who supposedly needed to accept, adjust, or, in the parlance that permeates literature on health care workers' well-being, have more "resilience" (Beckwith, 2016, p. 457) in the face of workplace stressors. This stance did not align with my own observations of nurses who had come to use substances in an attempt to manage the extreme and unremitting stressors in their work lives. My experiential knowledge was much more consistent with the persuasive body of public health literature that rebuts and contextualizes overly individuated viewpoints such as these and asserts that people employ substance use as a purposeful strategy to manage their environmental stressors (Alexander, 2010; Csiernik & Rowe, 2017; Maté, 2008; Moore, 2004). I did not see this perspective taken up in the literature on nurses' substance-use problems.

I saw very little of nurses' own experiential perspectives being sought as expert knowledge. My comprehensive literature review (Ross, Berry, et al., 2018)<sup>2</sup> revealed a total of only 11 works published on the topic from 1980–2017 that utilized nurses' own voices as data (via qualitative interviews) to delve deeply into the issue (Bannois, 1989; Breslin, 1992; Brewer & Nelms, 1998; Darbro, 2005; Dittman, 2008; Horton-Deutsch, McNelis, & O'Haver Day, 2011; Hutchinson, 1986, 1987; Lillibridge, Cox, & Cross, 2002; Stammer, 1988; Strom-Paikin, 1996), three since that original search (Burton, 2014; Matthias-Anderson, Yurkovich, & Lindseth, 2016; Mumba, 2018), and none of these were from a Canadian perspective. What is more, I was only able to locate one study that employed the knowledge of Canadian nurses as quantitative data (Kunyk, 2015). In that work, 91.5% of the nurses surveyed who self-identified as having problems with substance use were actively practicing and did not obtain help (Kunyk, 2015). These data aligned with well-established findings that nurses are extremely reluctant to admit to or seek treatment for problems with substance use (Darbro, 2011; Lillibridge et al., 2002). Entrenched, historical stigmatizing attitudes toward fellow nurses with substance-use problems persist within the profession and have been found to perpetuate nurses' concealment of these problems (Darbro, 2005; Darbro & Malliarakis, 2012; Heise, 2002; Howard & Chung, 2000c). These stigmatizing professional attitudes also are situated within a broader societal discourse that marginalizes those who have substance-use problems (Csiernik & Rowe, 2017; Rhodes et al., 2012). Nurses' strong identification with a caregiving role is also believed to impede their help-seeking behaviour (Lillibridge et al., 2002; Siebert & Siebert, 2007). Unlike the literature on contributory factors, the works on stigma and nurses' reluctance to obtain treatment were consistent with my experiential knowledge of nurses' social relations, work lives, and how nurses talk about other people's or their own problems with substance use. That is, nurses speak disparagingly about others who have substance-use problems and do not talk about their own. I could easily understand how peers' and society's stigmatizing attitudes, as well as nurses' own feelings of contravening a professional identity could contribute to nurses' silence, preventing them from reaching out for help.

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<sup>2</sup> This article is my critical review of the literature on nurses' problems with substance use and is presented in Chapter 2.



I was also aware that nurses greatly fear professional repercussions if they do disclose, and so was unsurprised that nurses with substance-use problems were not seeking out the existing treatment programs intended to assist them. I have no personal experience in the provincial regulatory program for nurses identified as having problems with substance use (subsequently referred to as *The Program* in this thesis). Upon reflection, I realized that in over 36 years of being a nurse, I had not known any nurse colleagues to speak of being involved with The Program prior to undertaking this study. I had only known through the nursing grapevine of a few nurses who had been off work to attend treatment. This seemed to me a profoundly telling statement about nurses' silence around their substance-use problems. The nurses I had known as colleagues who (in my estimation) had substance-use problems either never spoke of their experiences with The Program or had evaded engagement with it. Most of these colleagues, to the best of my knowledge, did not obtain treatment, and their conditions visibly worsened; some, like my late friend, deteriorated to the point of their deaths.

The professional and scholarly works on the policies and programs to address nurses' substance-use problems primarily focus on the need to shift from traditional punitive and disciplinary models to more supportive recovery and rehabilitation-focused, alternative-to-discipline (ATD) approaches (Ross, Berry, et al., 2018). It has been well-established that more nurses self-report to and seek treatment from the ATD programs than the punitive ones (Monroe, Kenaga, Dietrich, Carter, & Cowan, 2013; National Council of State Boards of Nursing [NCSBN], 2011). Nevertheless, my experiential knowledge concurred with the literature, in that nurses still tend to avoid self-reporting for treatment and workplace support even to the ATD programs, due to mistrust of their employers and regulatory bodies and fear of sanctions if they do so (Kunyk & Austin, 2011; Malloch, 2013). Upon a more in-depth investigation conducted as part of my doctoral research, I was dismayed to find that, like the literature on predisposing factors, the ATD policies and programs also took a decidedly individuated posture toward addressing the issue (Ross, Berry, et al., 2018). The interventions posed did not address any structural inequities inherent in the nurses' work environments, such as stigma (Darbro & Malliarakis, 2012) and challenging working conditions that negatively influenced their recoveries (Shaw, McGovern, Angres, & Rawal, 2004). I was also alarmed to find that the basic structure and efficacy of these programs and the nurses' experiences of them were profoundly underresearched and not rigorously evaluated.

From all of this review and reflection, I set out to undertake a different kind of analysis, one that was timely and important, in light of current approaches to substance-use problems found outside of the nursing literature and in terms of the urgency of this problem to nurses and ultimately to the people to whom nurses provide care.

### 1.3 Research Objectives

The disparate knowledges of nurses' substance-use practices and work lives, as discussed in the previous section, became the topic of inquiry, or problematic, of my research. The *problematic* is regarded as a feature of people's experience in their everyday world that is an "unfinished arena of discovery in which the lines of social relations are present to be explored beyond" (Smith, 2005, p. 39). I explored this problematic ethnographically, with the overarching goal of discovering how nurses' problems with substance use and a regulatory program to address the same were socially organized. *Social organization* refers to how people's daily lives are linked into and managed by broader, largely unseen ideological discourses external to them, in ways that do not serve their interests (Smith, 2005). I then addressed that overarching goal with the following objectives:

- Describe nurses' embodied experiences of their substance-use problems.
- Describe nurses' experiences in The Program.
- Describe and map the institutional processes and practices in The Program.
- Investigate and describe the dominant ideological discourses central to managing nurses' substance-use practices.
- Investigate and describe the dominant ideological discourses organizing and coordinating The Program.
- Explicate, or uncover, describe, and map, how the knowledge and actualities of the lives of the individual nurses situated in the problematic were being organized and managed by these ruling discourses.
- Uncover whose interests were being served by these arrangements.

I aimed to produce new knowledge regarding nursing from a Canadian perspective that would also be useful to nurses in other regions. This knowledge is intended to further the interests of nurses through, for example, the creation of effective prevention strategies, treatment programs, regulatory policies, and relevant nursing

education. It would also contribute to disciplines other than nursing and advance knowledge about substance use, treatment, and recovery in general.

## **1.4 Mode of Inquiry**

To achieve these goals and objectives, I required a research approach that met the following criteria: it would allow an ethnographic exploration of my problematic utilizing nurses' embodied experiences and expert knowledge as data; it would enable the lens of inquiry to extend beyond the everyday level of those individual nurses into their broader social worlds, illuminating how these experiences came to be organized as they were; and, it would ultimately serve nurses' best interests. Therefore, I chose to explore this problematic using the critical, feminist mode of inquiry, institutional ethnography (IE).

IE has been utilized as an effective approach in researching numerous health care topics, including treatment decisions in cancer care (Sinding et al., 2010), nursing education (Campbell & Jackson, 1992), nursing home care (Diamond, 1992), people living with HIV/AIDS and medical power (Mykhalovskiy, McCoy, & Bresalier, 2004), care pathways and hospital restructuring (Mykhalovskiy, 2001), injured nurses' return to work (Clune, 2011), nursing inside Canada's health care reform (Rankin & Campbell, 2006), the work of paramedics (Corman, 2017), community nursing work (Campbell, 2001), emotion work in the care of children with diabetes (Watt, 2017), workplace mental health discourse and management (Wipond & Jakubec, 2016), and health care workers' mental ill health (Moll, Eakin, Franche, & Strike, 2013).

IE is a research approach that foregrounds the embodied ethnographic knowledge of the expert informants who are situated within the local, material experience under investigation (Smith, 2005). An IE inquiry begins in and aligns with the standpoint (i.e., the particular social and epistemological positioning in relation to the problematic) of a specific group of people. A substantial component of meeting the objectives of this study involves giving voice to nurses' embodied experiences of substance-use problems and The Program. This is not merely intended to provide these nurses with a venue for expression, although that importance is acknowledged. The primary rationale underpinning this decision is that only nurses have the expert embodied knowledge of the actualities of their lives. Absenting this insiders' knowledge

of their everyday work worlds creates a very real likelihood of drawing mistaken conclusions and advancing ineffective or even counterproductive recommendations.

Smith (1999) used the metaphor of a map as an orienting device to situate the standpoint informant within the problematic under study. Smith (1999) explained how a map (depicted diagrammatically or by means of words) is “indexical” (p. 125), or points people to what is truly happening in the actualities of individuals’ lives: “You find this map that says, ‘You are here.’ And it is that kind of finger pointing off the text, into the world in which you stand” (Smith, as cited in Carroll, 2010, p. 27). In such an IE map, the standpoint informants’ day-to-day embodied experiences are utilized as analytic ‘doors’ through which the links in the chains of their everyday social relations are revealed and then traced to the ruling relations that coordinate those everyday experiences (Deveau, 2008; Kearney et al., 2018). The term ruling relations denotes “the socially organized exercise of power that shapes people’s actions and their lives” (Campbell & Gregor, 2002, p. 32) and ruling occurs when those people’s lives are subjugated to the interests of those in power.

I aimed to uncover the ruling relations that socially organized nurses’ everyday substance-use practices and their experiences in The Program. IE is an apt approach for this endeavour, as its central analytic focus is revealing the material and empirical links to ruling relations that are articulated to and manage individuals’ day-to-day experiences in ways that are not immediately evident, or in their interests (DeVault & McCoy, 2002; Deveau, 2008; Smith, 2005). Rankin and Campbell (2006) contended that ruling relations operate in nurses’ work worlds as they do in all other institutional settings. Campbell and Gregor (2002) also observed that whereas “the effects of institutional power pervade nurses’ work lives, the negative effects may appear ... as personal problems” (p. 16). IE offers a mode of inquiry to uncover how the ruling accounts had decontextualized and reconstructed nurses’ substance-use problems as solely their personal problems and erased the role of the institution from the discourse. Accomplishing this end provides an important opportunity for nurses’ regulatory bodies, professional leadership, and employing institutions to institute any organizational changes found to be needed that would improve the conditions of nurses’ work lives.

The research goals in this study also represented critical and emancipatory aims. These goals were supported by the ultimate product of IE research, which is the

cocreation of “a piece of social cartography” (Deveau, 2008, p. 3) that is a working tool for sociopolitical change in the interests of the people involved (Deveau, 2008; Smith, 2005). In this case, the individuals involved include nurses who experience problems with substance use and, in the end, all nurses and other health care professionals.

## **1.5 Research Design**

The “analytic core” (Campbell & Gregor, 2002, p. 59) of IE is the explication of how social relations operate in people’s daily lives, and all aspects of the research design are focused on this task. The design of an IE research study involves data collection at two levels: the entry-level data that provide an entrée into the problematic via the standpoint informants’ experience in their day-to-day worlds and the level-two data, which are the institutional processes that organize those individual experiences (Campbell & Gregor, 2002, p. 59). Both levels of data are analyzed to discover and trace the material and empirical links between them and create a map to the ruling discourses whose generalizing effects organize those individuals’ experiences (DeVault & McCoy, 2006; see Section 1.6 Methodological Congruence for a fulsome discussion of generalization in IE).

The data in this study included interviews with the primary and secondary informants, researcher’s reflexive journaling, and textual retrieval and analysis (see descriptions below). Data generation and analysis are not linear, discrete, or sequential processes in IE. Rather, these are inherently iterative endeavours in which data collection and analysis are concurrent and ongoing and “analytic thinking begins in the interview” (Mykhalovskiy, as cited in DeVault & McCoy, 2006, p. 23). My analytic aim was to uncover the ruling relations that organized and managed nurses’ day-to-day work lives and explicate how these were generalized “elsewhere and elsewhere” (Smith, 2005, p. 225) across the institutions in which the nurses were situated via their talk in their everyday worlds or by people activating institutional texts.

### **1.5.1 Primary Informants**

As noted above, an IE study is grounded in the standpoint of a group of people with a particular social and knowledge location within the problematic. The standpoint anchoring this study is that of nurses in a western Canadian province who had

participated in The Program. These nurses provided data in the form of their embodied experiential knowledge of their everyday worlds, which served as entry-level data in the study (Campbell & Gregor, 2002). The inclusion criteria for selection of these primary informants were the following: they were a registered nurse (RN) or a registered psychiatric nurse (RPN), they were a current or former participant in The Program, and their primary work responsibilities involved the provision of direct client care. Volunteers for the study who did not meet these criteria were excluded as primary informants, although some of these individuals qualified as secondary informants (see Section 1.5.2 for more information). Considerations in formulating these inclusion and exclusion criteria involved the following:

- Nurses who have been in The Program have necessarily experienced problems with substance use and, therefore, possessed the expert, embodied, contextual knowledge required to inform the research objectives.
- Different provinces have different regulatory bodies and programs to manage the practices of nurses who have been identified as having problems with substance use. Delimiting the scope of the study to nurses in a single province allowed for more precision in explicating the social organization within The Program.
- An a priori assumption was made that informants who were already in The Program were in a process of recovery and had, therefore, developed a level of insight that would enable them to reflect meaningfully upon their experiences.
- Excluding nurses whose work was not the provision of direct client care created as homogenous a group as possible with respect to informants' work practices and standpoints within the social organization of the institution.
- The primary informants represented a variety of demographics, such as age, gender, geographic region in the province, specific workplace, and substances used. This provided a group of standpoint informants with a broad range and diversity of experiences with respect to the problematic (Bisailon & Rankin, 2013; see discussion of this rationale in Section 1.6 Methodological Congruence).

I recruited primary informants through the assistance of the provincial nurses' union, who published my study invitation in their members' e-newsletter. I received 31 email responses to the study invitation. A total of 22 of these respondents were excluded as primary participants, either because they did not meet all inclusion criteria or because they did not follow through with participation in the study. I also included three nurses

who contacted me because they had heard about the study from other nurses. The final number of primary informants was 11 RNs and one RPN.<sup>3</sup>

### **1.5.2 Secondary Informants**

I also utilized a total of six secondary informants from different locations within the institutional complex in the study. These included two nurses who responded to the union e-newsletter invitation and were excluded as primary informants because they had not been enrollees in The Program. They replied to the newsletter invitation because they wished to contribute to the study, because they had worked with nurses who had been in The Program. One of these nurses was also a union representative who had supported nurses through the process of their involvement in The Program. I also purposively recruited three secondary informants who had expert knowledge of the workings of The Program by direct email invitation. These individuals were lawyers who worked as program administrators: one with the union, one with the regulatory body, and one in a comparable program for other health care professionals. I also recruited one physician who worked in a similar program for other professionals by direct email. Secondary informants provided level-two data that assisted in locating and tracing relevant institutional texts and facilitated the explication of the standpoint informants' experiences by revealing links to the institutional processes and ruling ideologies (Campbell & Gregor, 2002).

### **1.5.3 Interview Processes**

I collected data from primary and secondary informants by means of 60- to 90-minute audio-recorded, face-to-face or Skype (Microsoft, n.d.), semistructured, interviews occurring in 2016–2017. I arranged for a professional transcriptionist to transcribe the audio-recordings into written form for analysis; the transcriptionist had signed a confidentiality agreement prior to providing assistance. I confirmed accuracy of the transcriptions by listening to them while reviewing the transcribed product. Three informants were re-interviewed to follow up on data leads or clarify information as required. I designed the interviews conducted with the primary informants to gather data

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<sup>3</sup> The RPN served as a secondary informant in my investigation of *The Program*. A full discussion and rationale for that informant's placement is presented in Chapter 4.

about their day-to-day work and their substance-use practices as well as to discover their links to institutional processes that coordinated the actualities of their work lives. I piloted brief topic guides in the initial stages of the interviewing process, which included intentionally broad invitations for the informants to open the discussions. Questions in the preliminary topic guides sought the following information: how participants came to use substances while working as a nurse, experiences that were occurring in the workplace at the time of their problems with substance use, the institutional processes and texts they were involved in, how the workplace and profession established help, and what worked and what they believed should have been done differently to better assist them.

Interviews of secondary informants focused not only on their work experiences, but also on their working knowledge of the texts and processes in The Program. The purpose of the questions for these informants was to glean information about the institutional processes involving the nurses, such as what the process was when a nurse was identified as having problems with substance use; what documents, protocols, procedures, or other institutional tools were used in this process; the textual and procedural links between their organization and other organizations; and what they felt was effective in this process and what wasn't. Interview questions with both primary and secondary informants were refined, further elaborated, and became increasingly specific as data collection and analysis progressed. For instance, as disjunctures in informants' experience emerged, I probed these more deeply with the informant in question and with subsequent informants. One such example was when I began to experience a disjuncture in my analysis, whereby the data revealed that nurses actively endorsed their use of substances to manage everyday stressors, yet data also showed that nurses vilified their peers who were seen to have problems with substances. When I came to this realization, I then verbalized this observation to the informants and asked them direct questions to ascertain where and how the 'line was crossed' that categorically changed nurses' substance-use practices from acceptable to unacceptable in the eyes of other nurses.

This strategy was consistent with the nonstandardized approach to informant interviews typical in IE, in which data collection is an emergent, nonlinear, iterative, and open-ended process of discovery (DeVault & McCoy, 2006, p. 23). I also utilized member checking to generate feedback on my emerging analysis and increase the



trustworthiness of the data (Streubert & Carpenter, 2011) by confirming the accuracy of my understanding of the informants' statements with them on an ongoing basis throughout interviews. I also provided informants with a transcript of their interview and invited them to correct, edit for clarity, and/or add any information they wished.

As I gathered data, I created a diagram of The Program.<sup>4</sup> I also employed member checking by providing primary informants with a copy of the diagram during the interview. I asked these participants if the diagram was accurate according to their experience and to correct any information that was not correct. I also provided the secondary informants who were program administrators with a copy of that diagram during the interview, and again later with the final diagram of my understanding of the totality of institutional processes in The Program, asking them to correct the information if necessary.

#### **1.5.4 Textual Retrieval and Analysis**

Analyses of institutional texts provide crucial level-two data, as texts are viewed in IE research as mediators of the institutional ideologies and ruling discourses that coordinate people's activities (Campbell & Gregor, 2002; Deveau, 2008; Rankin & Campbell, 2006; Smith, 2005). I carried out document retrieval and analysis on texts that were (a) identified and provided by informants and (b) current and/or archived regulatory body, union, and employer policy documents accessed via the public domain that related to nurses' substance use in general or were specific to The Program. In IE, central analytic importance is afforded to determining how individuals activate the texts (Smith, 2005). This means situating texts in people's action and locating how "it is produced, circulated, and read, what people do with the text ... [in] sequences of action" (Turner, 2006, p. 40). For instance, in The Program (see Appendix A), the Independent Medical Examiner's report (discussed in Chapter 4) on the nurse was activated when the designated person at the regulatory body took the recommendations within that text and used them to create the contract that the nurse was required to adhere to if they were to

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<sup>4</sup> For a full discussion of *The Program*, please refer to Section 1.5.5.7 The Program; see also Appendix C for my diagram of *The Program*, an accompanying description of its components in Appendix D, and Chapter 4, which explores how nurses' experiences in The Program were organized and managed.

return to practice. The nurse then activated that contract by attending the compulsory activities that were designated as ‘treatment’ in that text. Texts were also analyzed to identify accountability circuits. This refers to sequences of action whereby people’s activities needed to be converted to textual realities in order to become institutionally actionable, or produce a “warrantable account” (Rankin, 2017a, p. 6).

### **1.5.5 Analytic Methods**

In addition to the textual analysis discussed above, I employed analytic strategies that are typically utilized in IE research, including indexing, mapping, and writing (Rankin, 2017b). I performed a preliminary review of the data, making manual notations on the transcripts to index the following subjects, as discussed under the subsections that follow: informants’ day-to-day work processes, practices, and organization; informants’ practices around substance use; antecedents and follow-up work processes; power relations; and ruling discourses. This undertaking provided an initial coherence and organization to the data (Rankin, 2017b). I mined these indexed data to construct a map of The Program (see Appendix A), which allowed all of the complex processes involved to be displayed in a clear, understandable way (Rankin, 2017b). I also wrote selections of primary informants’ data into rich, thick descriptions, or “analytic chunks” (Rankin, 2017b, p. 6), to begin to illuminate links to ruling relations. I then carried out an iterative process of reading and re-reading the data, making further notes and revising as more data were collected and integrated into the analytic process.

#### ***1.5.5.1 Informants’ everyday work processes, practices, and organization***

Locating work in data that provides information about people’s everyday worlds is fundamental to an IE analysis, as ruling relations are seen to be discoverable through people’s work activities (Smith, 2005). Work is defined in IE as “what people do that requires some effort, that they mean to do, and that involves some acquired competence” (Smith, 1987, p. 165). Information about informants’ work uncovers their expert knowledge of how to competently engage in their social relations and manage the actualities of their daily lives (Campbell & Gregor, 2002). This “generous” conceptualization of work activities allows for the inclusion of unseen types of labour involving emotional, thought, and communication work, in addition to observable physical labour and practical skills (Smith, 2005, p. 151). Accordingly, I sought out the

sequences of activities in the nurses' day-to-day work and the knowledge that informed those actions. I located people's institutional roles and capacities and mapped how their work had linked to and coordinated with the activities of others, to texts, and to institutional processes.

#### **1.5.5.2 Informants' practices around substance use**

This encompassed physical actions as well as language practices (Smith, 2017). I included how nurses did and did not talk about their substance use and what knowledge informed these practices. I subindexed how substance use was discursively categorized and how substance-use practices were articulated to nurses' work and to other people.

#### **1.5.5.3 Antecedents and follow-up work processes**

Following McCoy (2006), I conducted "another interview, this time with the data" (p. 111) after carrying out the above analysis, by applying the following questions to the data around work processes:

What is the work that these informants are describing or alluding to? What does it involve for them? How is their work connected with the work of other people? What particular skills or knowledge seem to be required? What does it feel like to do this work? What are the troubles or successes that arise for people doing this work? What evokes the work? How is the work articulated to institutional work processes and the institutional order? (p. 111)

#### **1.5.5.4 Power relations**

I located and mapped data about the people and activities involved in power relations, including where and how power entered into what individuals did; who the beneficiaries and disempowered were in the power relationships; language in talk and text indicating a power relation (e.g., terms such as required, had to, mandatory, will); and how knowledge was authorized. I scrutinized contracts for their contents and who constructed them, who was obligated to follow them, and what the consequences were for noncompliance.

### **1.5.5.5 Ruling discourses**

I interrogated the body of professional and scholarly literature on nurses' problems with substance use, as well as institutional texts available on the public domain (see the Literature Review in Chapter 2) prior to collecting data from informants to locate what ideologies, concepts, theories, and categorizations had discursively organized the texts, institutional processes, and official accounts (Campbell & Gregor, 2002; DeVault & McCoy, 2006; Rankin, 2017a). I also paid particular attention to informants' talk that reflected either their adoption of or dissent from the ideological accounts and any disjunctures between their embodied experiential knowledge and the objectified, ruling discourses. These are important data, as they direct the researcher to instances in which the informants' embodied experiences may be subordinated to the categories of ruling institutional discourses (Campbell & Gregor, 2002; McCoy, 2006; Rankin, 2009). For example, I uncovered how the notions of 'recovery' and 'success' in The Program were organized as the nurse's adoption of, voicing, and adherence to specific moralistic ruling ideologies (see Chapter 4 for a full discussion). I took note of institutional language, recurring events or use of words, 'insider language,' and tacit, taken-for-granted assumptions, which may demonstrate the ways in which people's knowledge about their work lives were being generalized to other people at other loci and times (Bisaillon & Rankin, 2013; Campbell & Gregor, 2002; DeVault & McCoy, 2006).

### **1.5.5.6 The Program**

I mapped and described the institutional processes in The Program and the primary and secondary informants' work in navigating those processes (please see a truncated diagram of The Program in Appendix A, its description in Appendix B, and Chapter 4 for my analysis of the social organization of nurses' experiences in The Program). In brief, a nurse may enter The Program either by self-reporting that they have problems with substance use and wants assistance, or by being reported by another person who had concerns about the nurse's impaired practice. This report can be made to the nurse's employer, regulatory body, or labour union, which are all potential points of entry into The Program. Once reported, the nurse is offered entry into The Program, which is a voluntary ATD program. Its goals are to protect the public from impaired nursing practice and support the nurse through a treatment process that is intended to facilitate her or his recovery and return to work. If the nurse chooses to participate in The Program, they sign a contract. This contract stipulates that for the

duration of that contract (usually 3 years, but it may be longer), the nurse will comply with both a mandated standardized program that has been organized as the ‘treatment and recovery,’ and the monitoring of the nurse’s practices for the purpose of public safety.

## **1.6 Methodological Congruence**

A credible IE analysis is one that creates a thorough, and confirmable accounting of how the actualities of people’s lives are socially organized by ruling ideological discourses (DeVault & McCoy, 2006). This is accomplished by uncovering and explicating how people’s knowledge has been organized as ruling relations; how that knowledge coordinates people’s everyday activities; and how these knowledges and activities are coordinated with the actions of others and generalized across other times and settings (D. E. Smith, personal communication, May 15, 2015). Generalization in IE refers to a recursive pattern that is socially organized to be repeated in different places and different times across an institutional ruling complex as people activate, or carry out, the discursive imperatives situated in talk or texts (Deveau, 2008; Smith, 2005, 2017). In Chapter 3, I provide details of how day-to-day insiders’ talk among nurses generalized ruling discourses and, in Chapter 4, how institutional texts did so in The Program.

The IE approach to generalizability differs fundamentally from both quantitative and other qualitative approaches. Firstly, theoretical generalizability (Lewis, Ritchie, Ormston, & Morrell, 2014) does not apply to IE as, unlike some other types of qualitative analyses, IE studies do not begin from, conform to, or develop any predetermined themes, categories, concepts, or theories (Campbell & Gregor, 2002; Smith, 2005). This is because in IE all knowledge is seen to be socially organized; therefore, the discourses that organize such conceptually based knowledges must themselves be interrogated, rather than granted facticity (Smith, 2005). Accordingly, my research did not begin with preexisting schemas or preselected categories, nor were categories created, organized, or coded from the data, although I had set an analytic aim to identify discursive categorizations as they were revealed in the analysis. Secondly, IE data are not intended to represent a sample of any population; instead, the standpoint informants are comprised of people who are situated in the same positionality within an organization of institutional ruling relations (Smith, 2005). Therefore, IE analysis does not support statistical (Malachowski, Boydell, Sawchuk, & Kirsh, 2016; Moll et al., 2013; Smith,

2005), representational, or inferential (Lewis et al., 2014) generalizability to any populations.

Given that samples and populations are not involved, the number of informants required for an IE study is not traditionally defined or prescribed. Upon reviewing the original research proposal for this study, Dorothy E. Smith (personal communication, August 14, 2015) counselled that “no more than 10” primary informants would be sufficient to meet the research objective in this particular study. Rather than numbers, the crucial considerations in selection of standpoint informants are that they all are situated within the same experiential positioning inside the institutional complex of ruling relations, yet have sufficient range and diversity of experience within that positioning to explicate the problematic (Malachowski et al., 2016, p. 219). DeVault and McCoy (2006) asserted that the IE researcher must “consider how the perspectives from different locations illuminate the relevant social relations ... [and] how people living in these different circumstances are drawn into a common set of organizational processes” (p. 32). Accordingly, the standpoint informants in this study were all located inside the same organization of ruling relations in both the provincial nursing regulatory complex and The Program (as specified in the discussion of inclusion criteria for primary informants in Section 1.5.1). These participants represented a diverse range of experiences, in that they worked in a variety of different agencies and types of clinical practice areas throughout the province, were of varying ages and gender identifications, and had problems with differing substances.

In the IE tradition, it is critical that researchers identify and be aware of their own standpoint in relation to the primary informants and the problematic (Campbell & Gregor, 2002). As is the case with the primary informants, I am a practicing nurse (with both RN and RPN credentials) and have been so for 36 years. On the other hand, I have not had any involvement with my nursing regulatory body due to the effects of substance use on my practice. This dual standpoint had the potential to be a double-edged sword and presented me with a number of complexities that I was required to navigate mindfully throughout the course of the study. Firstly, as I have not had the experience of being a nurse involved with a professional nursing regulatory body because of my substance use, I needed to approach the study and all interview work with sensitivity. Building trust and rapport with the informants, many of whom had experienced discrimination and

negative attitudes from their colleagues (Darbro & Malliarakis, 2012; NCSBN, 2011), demanded particular reflexivity in the research process.

My nursing background was also advantageous, however, as it provided me with an insider's understanding of professional norms, conditions of nurses' work, and a high degree of corporate and operational knowledge of health care institutions. My standpoint also encompassed a critical perspective, as I am currently employed as a clinical nursing educator at a community college, and this role is external to the institutional framework under investigation. Nevertheless, my vast experience in the health care institutional framework increased my potential susceptibility to institutional capture, which occurs "when both the informant and researcher are familiar with institutional discourse, know how to speak it, and hence can easily lose touch with the informant's experientially-based knowledge" (Smith, 2005, p. 225). I was, therefore, at risk of becoming snared in and reflecting institutionally based ideological ways of thinking, rather than critically scrutinizing the empirical data (Smith, 2005).

To avoid that outcome and enhance the credibility of my analysis, I employed researcher reflexivity as a tool for vigilance for the possibility of institutional capture as well as for data generation and analysis (Campbell & Gregor, 2002; Carolan, 2003). I carried out a reflexive process by writing reflections in a journal throughout the course of the research when prompted by experiences during data collection and analysis. The intention of journaling was to clarify and locate my positioning within the study. This journaling process provided me with opportunities to re-read and reflect on the data, which made visible to me the aspects of my discoveries that could have been taken for granted and were, therefore, vulnerable to institutional capture. An example of how my reflexive engagement with the data brought to light my institutional capture was when I began analyzing data about the power relations between the nurses and physicians in The Program. Prior to interviewing the nurses, I had been analyzing the physicians' reports on the nurses, which were the primary guiding texts in The Program. While undertaking that textual analysis, I had been taking for granted that the nurses' treatment processes would 'naturally' flow from the physicians' assessments. I did not realize that I had been institutionally captured until I began journaling on my feelings of discord about the nurses' feelings of extreme subjugation that resulted from the power differentials with doctors in The Program (see Chapter 4 for a full analysis of these power relations). From my long experience within the ruling practices in health care institutions, my own

knowledge had been socially organized in such a way that I viewed these power relations, as Pence (2001) said, as natural and to be expected, instead of the ideologically based arrangements that they were.

Ongoing feedback by supervisory committee members also provided me with valuable alternative perspectives outside of my own frame of reference. Prior to the interviews, I also prepared nurse informants (who knew from my credentials that I was a nurse) that when I heard nurse-speak or jargon that I recognized as insider talk among nurses, I would ask them to clarify their terms, even though the meaning would have been obvious to any nurse. For example, if a nurse had said, “I stole drugs from work, so I had to have enough for when I finished my set,” I would have asked them to explain for the tape that ‘set’ referred to their scheduled days on duty. I also employed member checking to enhance credibility or trustworthiness of the data, as has been discussed previously (Streubert & Carpenter, 2011). As well, I was mindful of avoiding “analytic drift” (McCoy, 2006, p. 109), an error that can occur in IE research, whereby analysis shifts from explicating how individuals’ experience has been socially organized to categorizing and explaining the individuals’ behaviours.

### **1.6.1 Ethical Considerations**

I upheld the principles of consent and mitigated conflict of interest throughout the study. Prior to conducting the research, I obtained approval from the Simon Fraser University (SFU) Office of Research Ethics, and written, signed informed consents from all individual participants and agencies prior to their involvement in the study. I strictly adhered to requirements for confidentiality and anonymity throughout the study. All participants’ names have been changed to pseudonyms and the specific agencies and province under investigation have been de-identified in all dissemination of study results.

In the invitations and consent documents (see Appendices C through to F), I acknowledged the potential psychological harm to primary informants, as a risk existed that they could experience strong emotional reactions from reflecting upon and discussing sensitive and emotionally charged material. I mitigated this risk by employing an intentional strategy within the formulation of the inclusion criteria, which required primary informants to be enrolled in a treatment and monitoring program for substance use. As such, it was reasonable to assume that they would have already reflected upon



the material as part of their recovery process and had achieved a level of emotional stability that would enable them to tolerate this reflection. Nonetheless, I also included as part of the consent process that primary informants were required to indicate that they had supportive resources in place during and after the study, should they require them.

## **1.7 Overview of the Chapters**

Smith (2006) created a simple map-type diagram illustrating how an individual, who she named “our small hero” (p. 3), located at the indexical point of that map is connected to ruling institutional practices that coordinate their experiences. I have adapted Smith’s diagram (see Appendix G) to map how I have researched my problematic.

The ‘small nurse hero’ (or standpoint informant) in my study is a nurse in a Western Canadian province who has been declared to have problems with substance use. This standpoint locates that nurse’s day-to-day life at a point within a multitude of connected social relations, extending from her or his everyday world to the institutional realms. As countless possible avenues of study exist within the totality of a nurse’s social relations in this problematic, my finite resources dictated that I delimit the scope of my inquiry. I, therefore, trained a proverbial magnifying glass on the three select roads that I followed, as shown on the mini-map of the ‘small nurse hero’s’ everyday work world depicted in Appendix G. These avenues of focused inquiry included the organization of the knowledge of nurses’ substance-use problems in the scholarly literature, the discourses around substance use in nurses’ talk in their everyday worlds, and the social organization of The Program for treatment of nurses’ substance-use problems. I explore each of these topics of inquiry in Chapters 2, 3, and 4 respectively, and synthesize the findings in Chapter 5, as outlined in the subsections that follow.

### **1.7.1 Chapter 2 – A critical review of knowledge on nurses with problematic substance use: The need to move from individual blame to awareness of structural factors<sup>5</sup>**

As with any other research, an IE inquiry begins with a literature review. However, an IE review of the existing knowledge involves far more than discovering what is known of the topic. IE researchers must “position the literature as ‘data’” (Rankin, 2017a, p. 5) in their readings, as data analysis begins in the IE literature review. The researcher is called upon to mine that data and uncover how preexisting concepts, theories, discourses, and ideologies have been used as ruling ideologies and discourses that socially organize the official knowledge of the topic (Rankin, 2017a). In this way, a framing of the field as it is written and talked about in the literature is part of how a critical exploration like this project proceeds.

Accordingly, I carried out a critical appraisal of the literature. Whereas my critical integrative review did not employ IE as a research method, it provided me with important data about the issue that positioned the IE analysis of interview and textual data that I subsequently undertook. This critical interrogation yielded data that showed connections between the individual nurse’s experiences and the institution and revealed how the scholarly knowledge on the topic had been discursively organized. I discovered how nurses’ problems with substance use had been decontextualized, individuated, and framed as personal moral failings, while the role of the institution was erased from the discourses. This literature review is presented in full in Chapter 2. Beginning from this understanding of how the dominant discourses in the literature had organized the professional knowledge around nurses’ substance use, I then narrowed my lens of inquiry. I collected entry-level data from primary informants’ interviews and level-two data from secondary informants’ interviews and institutional texts (as discussed prior), then extracted specific data from this database to research two further avenues on the map of the problematic (as discussed in Chapters 3 and 4).

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<sup>5</sup> This chapter is a modified version of the article by Ross, C. A., Berry, N. S., Smye, V., & Goldner, E. M. (2018). A critical review of knowledge on nurses with problematic substance use: The need to move from individual blame to awareness of structural factors. *Nursing Inquiry*, 25(2), e12215. <https://doi.org/10.1111/nin.12215>

### **1.7.2 Chapter 3 – “A two glass of wine shift”: Dominant discourses and the social organization of nurses’ substance use**

In this chapter, my attention remained on interrogating discourses regarding nurses’ substance-use problems, but my focus shifted to the local level of individual nurses. Here, I undertook a novel IE approach by utilizing how nurses talked in their day-to-day lives about their work and substance use as the main source of data, rather than institutional texts. I uncovered how the dominant discourses within nurses’ talk managed their substance-use practices and work lives. As the diagram in Appendix G of the small nurse hero depicts, the discourses found in nurses’ talk in their everyday work lives are also nested within those in the professional and scholarly nursing literature.

### **1.7.3 Chapter 4 – The business of managing nurses’ recovery from substance-use problems**

My investigation of a third avenue of the problematic focused on how the institutional practices in The Program organized and managed the experiences of the nurses therein. I analyzed the interviews with the primary informants, the secondary informants who were program administrators, as well as relevant institutional texts. This analysis revealed a very flawed standardized treatment and recovery program with deficiencies that were concealed by the dominant individuated and moralistic discourses. The work also brought to light nurses’ experiences of subjugation in The Program, including power imbalances, misuses of power, removal of their choice of treatments and rights to quality, ethical health care, as well as furthering of corporate interests. As the small nurse hero diagram (see Appendix G) illuminates, the practices and dominant discourses in The Program were articulated to the discourses I uncovered in the professional literature (see Chapters 2) and in nurses’ talk (see Chapter 3).

### **1.7.4 Chapter 5 – Concluding Thoughts**

In the totality of these works, I have realized my original overarching research goal, which was the explication of the social organization of nurses’ substance-use problems and their experiences in The Program. In my final chapter, entitled, *Concluding Thoughts* (see Chapter 5), I discuss the key organizing institutional features found in Chapters 2, 3, and 4, present the original contributions and significance of my research,

limitations of my research, outline a plan for knowledge mobilization, and offer implications and recommendations for policy reform and avenues of future inquiry.

## Chapter 2

# A critical review of knowledge on nurses with problematic substance use: The need to move from individual blame to awareness of structural factors

A modified version of this chapter was published under the title “A critical review of knowledge on nurses with problematic substance use: The need to move from individual blame to awareness of structural factors,” by C. A. Ross, N. S. Berry, V. Smye, & E. M. Goldner, 2018, *Nursing Inquiry*, 25(2), e12215. <https://doi.org/10.1111/nin.12215><sup>6</sup>

### 2.1 Introduction

Problematic substance use (PSU) is a serious health issue that affects people in all walks of life, including those in the nursing profession. Prevalence estimates of nurses in North America who have problems with substance use vary widely, ranging from 6% to as high as 20% (Dunn, 2005; Kunyk, 2015; Monroe & Pearson, 2009; Servodidio, 2011). The Canadian Nurses Association (CNA) takes the position that nurses’ use of substances is considered to be problematic when the effects or after effects of substance use impair their work performance to the extent that expected standards of professional practice are not met (CNA, 2009).

The issue of nurses with PSU has broad-ranging, adverse implications. It directly affects nurses’ health and wellness and contributes to morbidity and mortality rates in this population (Cross & Ashley, 2007). Quality nursing care and public safety may be jeopardized, as a substantial number of nurses who do self-identify as having PSU report that they are actively practising (Bell, McDonough, Ellison, & Fitzhugh, 1999; Kunyk, 2015; Monroe et al., 2013). Current, in-depth knowledge of this problem is necessary for the creation of effective prevention strategies, treatment programs, and regulatory policies (Darbro, 2011; Kunyk & Austin, 2011). Despite the importance of this

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<sup>6</sup> As with the other coauthored chapters in this thesis that have been published in, or submitted to journals, I was the lead researcher in this published paper, and it represents my original work. I designed the research, carried out the data collection and analysis, and was the lead author in writing up the findings. My coauthors were members of my doctoral supervisory committee, who provided ongoing supervisory support and feedback throughout all phases of the research and writing processes.

complex, multifactorial subject, the issue of nurses with PSU remains a largely underresearched and poorly understood area of study.

## 2.2 Background

We began by undertaking a review of the extant literature on PSU among nurses.<sup>7</sup> In our preliminary readings of the works on predisposing factors, however, we found that the literature was almost exclusively centred on the identification and measurement of individual risk factors. These included the following: use of substances, particularly benzodiazepines or opioids prior to entering nursing (Mynatt, 1996; Rojas, Jeon-Slaughter, Brand, & Koos, 2013); comorbid medical (Sullivan, 1987b) or psychiatric (Breslin, 1992; Darbro, 2005; Rojas et al., 2013) illnesses; history of childhood abuse or sexual trauma (Breslin, 1992; Dittman, 2008; Strom-Paikin, 1996; Sullivan, 1987a, 1987b); socializing with others who have problems with substances (Kenna & Lewis, 2008); absence of proscriptions against substance use (Beamer, 1991; Trinkoff, Zhou, Storr, & Soeken, 2000); sensation or thrill-seeking personality (Trinkoff & Storr, 1998a; West, 2003); family history of addictions (Bugle, 1996; Kenna & Lewis, 2008; Kenna & Wood, 2004b, 2005; Stammer, 1988); use of substances to self-medicate emotional distress or physical pain (Darbro, 2005; Dittman, 2008; Hutchinson, 1986, 1987; Lillibridge et al., 2002; Stammer, 1988); and male gender (Bugle, 1996; McNelis et al., 2012). Some authors offered multifactorial explanations involving any combination of these individual risk factors (West, 2002, 2003). As our examination of the literature progressed to policy and treatment approaches for nurses with PSU, we were similarly struck by the predominant focus on the culpability, shortcomings, and correction of individuals.

Overall, we found a notable lack of critical scholarly inquiry into how the structural factors embedded within nurses' professional culture, regulatory policies, and their conditions of work might be involved in their use of substances. The term structural factors refers to the influences situated at micro and macro levels within the physical,

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<sup>7</sup> We would like to acknowledge our late co-author, Dr. Elliot Goldner, whose invaluable contributions shaped this article from its inception until his untimely passing. Although we are heartbroken by his loss, we are grateful for his friendship and wisdom, which will remain in our hearts and continue to guide us in this work.

social, economic, and policy environments that shape individuals' risk environments for substance-related health harms (Rhodes, 2002, 2009). Some examples of these factors include sociocultural norms (at both local and broad cultural levels), physical working conditions, corporate policies, public health programs, social inequities, and political trends (Rhodes, 2002, 2009). In recent years, health professionals have become more and more aware of how important these factors are in contributing to health outcomes. Indeed, structural factors are argued to be far more significant than individual risk factors in accounting for the health outcomes we see, particularly harms related to substance use (Rhodes, 2002; Wilkinson, 2012). It was of great concern to us that we did not see this current knowledge reflected in the literature on PSU among nurses.

## **2.3 Methods**

As a result of our observations, we adopted a research goal of critically reviewing the existing literature as it related to the presence or absence and treatment of the structural factors involved in nurses' substance use. We chose to do so by undertaking an integrative review of the extant literature on the topic. A critical integrative review is considered to be an appropriate literature review strategy for a mature research topic (Torraco, 2005). As the topic of PSU among nurses has been explored since the time of Florence Nightingale (Dossey, 2010), we believe that it is reasonable to categorize it so. This review strategy is particularly apt when significant gaps in the literature have been identified that limit the development of knowledge (Torraco, 2005). Given the emphasis on the influence of structural factors on health harms related to substance use in current scholarly thought and clinical practice (Rhodes, 2002; Wilkinson, 2012), we assert that the limited nature of the scholarly inquiry into structural factors as they relate to nurses with PSU severely constrains the development of nursing knowledge.

Following Torraco (2005), we undertook a staged critical integrative review of the body of literature on nurses with PSU. Each of these stages is discussed in the subsections that follow.

### **2.3.1 Stage 1**

As is customary with integrative literature reviews, we first performed a comprehensive literature search on the subject of PSU in the nursing profession to

broadly discover what is already known about the topic. The full details of the literature search and selection processes are shown in the flow diagram provided in Appendix H. This flow diagram includes information on the databases and key search terms, search methods, inclusion and exclusion criteria, and article selection processes that we used.

This initial search for Stage 1 yielded a total of 714 unique records. Ross, the first author of this paper, reviewed the title and abstract of each of these sources and included the sources in the literature review if they contained information on PSU among nurses, were in English, and were published after 1980. Sources that provided only reports or summaries or consisted of anecdotal, informational, or testimonial accounts were excluded. At the end of this exercise Ross had identified 74 scholarly sources for review.

### **2.3.2 Stage 2**

Each of the 74 sources identified in Stage 1 was printed out in hard copy. The first author read each of the full texts with a dual goal of discovering content relating to nurses with PSU and, more specifically, to note the treatment of structural factors involved. We drew on the work of Rhodes (2002) to operationalize our definition of structural factors and looked for influences that were positioned within nurses' physical, social, economic, and policy environments that could potentially shape nurses' use of substances in some way. We marked the documents that did contain material on nurses' substance use with notations and coded these by hand. We then reviewed these sources to ascertain whether they contained information pertaining to structural factors and excluded those that did not. This process yielded 61 sources, which we then analyzed to uncover thematic categories that related to structural factors, with a goal of "deconstruct[ing the] ... topic into its basic elements" (Torraco, 2005, p. 361). We identified five major categories for organizing sources that dealt with structural factors (see Appendix I). Sources that contained data on predisposing factors tended to fall into three categories, which mirrored those that have been commonly summarized in the literature as "stress, access and attitude" (Wright et al., 2012, p. 122). We identified two other categories of important influences in the body of literature: treatment policies for nurses with PSU and the culture of the nursing profession.



### **2.3.3 Stage 3**

Once the major thematic categories were established, we engaged in a critical evaluation of the existing knowledge regarding nurses with PSU. The literature pertaining to each theme was summarized and then critically analyzed for the overall assumptions driving the research agenda, as well as attention to the importance of structural factors in nurses with PSU. In the next section we present the results of this process of discovery. We have organized our paper to reflect the critical integrative review process and thus address each of the five identified thematic categories under its own heading. In each section, we review the treatment of the category within the current literature and critically appraise this literature.

## **2.4 Contributory Factors of Access, Stress, and Attitude**

### **2.4.1 Access**

Nurses' easy access to drugs, a structural factor situated in nurses' physical work environments, is commonly posed as a chief contributor toward their use of substances (Darbro, 2005; Dittman, 2008; Kenna & Wood, 2004b; Lillibridge et al., 2002; Trinkoff, Storr, & Wall, 1999). To support this contention, researchers have frequently cited data showing that the level of nurses' workplace access to drugs correlates with their prevalence of using the accessible drugs therein (Bozimowski, Groh, Rouen, & Dosch, 2014; Bugle, 1996; Trinkoff & Storr, 1998a; Trinkoff et al., 1999). The access discourse is also heavily buttressed by findings in various studies that identified opioids as the first (Bozimowski et al., 2014; Rojas et al., 2013; Sidlinger & Hornberger, 2008) or second (Clark & Farnsworth, 2006; Kenna & Wood, 2004b; Sullivan, 1987b; Tipliski, 1993) most common substances that nurses have problems with.

We noted a significant scholarly gap in our review of the literature on access. We found no challenge to the maxim that access is in itself a prime independent structural causative factor for nurses with PSU. We assert that the extant data do not support this position. First, the data that show higher levels of opioid use among nurses than among the general population may be skewed. Nurses with a partiality toward opioids would likely be more readily discovered than those abusing substances not accessible in their workplaces. The higher levels may, therefore, reflect the effectiveness of controlled drug

policies in eventually exposing drug diversions, rather than the types of substances that nurses predominantly use. Second, the pronounced rates of problematic use of substances that are not accessible in nurses' workplaces draw into question the notion that access to pharmaceutical drugs is a primary contributor to their PSU. Indeed, several studies have found alcohol, not opioids, to be the primary substance that nurses used (Clark & Farnsworth, 2006; Kenna & Wood, 2004b; Kunyk, 2015; Sullivan, 1987b; Tipliski, 1993). Other data on nurses' use of substances that are not accessible in their workplaces suggest that environmental factors other than access may serve to influence the patterning of nurses' substance use. For example, one study showed that nurses who work in hospitals have greater levels of alcohol and cannabis use than those who work in community settings and nurses who work in critical intensive care specialties use more cocaine and hallucinogens than those working in other areas (Collins, Gollnisch, & Morsheimer, 1999). Other researchers found that oncology nurses are twice as likely to engage in binge use of alcohol, and emergency nurses are 3.5 times more likely to use cocaine or marijuana than nurses who work in women's health, pediatrics, or general practice (Trinkoff & Storr, 1998a). Third, despite the paucity of data on this matter, a specific temporal relationship is fundamentally presumed in the access discourse—that access to pharmaceutical drugs necessarily precedes problematic substance use. We claim that this inference is unsubstantiated by the evidence and constitutes the elementary research error of conflating correlation with causation. We found only one study that had even inquired whether nurses purposefully sought out high-access work areas due to a preexisting drug problem, or whether the high access preceded their problematic substance use (Sullivan, Bissell, & Leffler, 1990). The authors of that study reported that approximately one-quarter of the respondents in a sample of nurses in recovery from PSU who used drugs available in their worksites had indeed changed their worksite to increase their access to drugs (Sullivan et al., 1990).

The access discourse remains fixedly framed in terms of individual attributes, in which the "real problem" is constructed as one of thieving nurses who cannot resist drugs' presumptive inherent temptations. The solution typically posed is for health care institutions to prevent PSU among nurses by imposing more stringent narcotic handling practices to constrain nurses' access to restricted drugs (Trinkoff et al., 1999). While we do agree that policies to control access to potentially dangerous drugs are prudent, we affirm that simplistic, blaming conclusions such as these could be considered illustrative

of Bourgois's (1998) concept of "symbolic violence" (p. 2332) in their tone deafness to the stark realities of the many distal, institutionally situated structural stressors in nurses' daily work lives that could drive their exploitation of proximal access to substances. Our assessment of the literature revealed that this exclusionary overemphasis on access appears to have overshadowed critical investigation into other, less explored structural stressors situated in nurses' conditions of work that may play a more significant role.

## **2.4.2 Stress**

Nurses' jobs are arguably stressful, and this fact is often posed as central to development of PSU (Darbro, 2005; Kelly & Mynatt, 1990; Lillibridge et al., 2002; Trinkoff et al., 2000). Storr, Trinkoff, and Anthony (1999) found that nurses who worked in jobs with high levels of physical or psychological strain were 50–60% more likely to use marijuana, cocaine, and psychoactive medications than their counterparts in lower-strain jobs. Shift work, particularly the combination of long and rotating shifts (Lillibridge et al., 2002; Trinkoff & Storr, 1998b), job burnout (Haack, 1988), job strain (Storr et al., 1999; Trinkoff et al., 2000), and "the increasingly demanding and often traumatic nursing work environment" (Lillibridge et al., 2002, p. 219) have all been specifically implicated as sources of contributory structural stressors. Other works have redistributed the responsibility for nurses' inability to cope with difficult working conditions onto nurse educators. It is they who are ostensibly erring by not educating nursing students "realistically about the demands and commitments of a nursing career" (Kelly & Mynatt, 1990, p. 40).

One of the few discussions of a structural factor contributing to nurses with PSU that we found within the literature on stress was that of gender. Gender-based stressors have been found to influence substance use among both men and women, albeit in different ways. Woman nurses identified gendered oppression, power inequities, dominance by men in the workplace (Breslin, 1992), and social pressures to adopt a "traditional" women's role (Stammer, 1988) as stressors that contributed to PSU. Men reported that they were generally viewed by their peers as competent nurse leaders, and this image enabled them to conceal their substance use from colleagues for protracted periods of time (Dittman, 2008).

We noted in our review that nurses' arduous work conditions appear to be tacitly accepted as realities and were not engaged as an important structural factor that resulted from a particular policy environment. We did not see robust recommendations for nurses' employers, professional bodies, or policymakers to seriously consider, let alone remedy, the challenges to nurses' coping that arise from structural factors. Only Lillibridge et al. (2002) offered a structural intervention in endorsing improvements to nurses' working conditions as a remedy for stress. These authors articulated the overarching goal of "occupational health and safety regulations is to ensure that all workers have a safe work environment" (Lillibridge et al., 2002, p. 226) and observed that, "due to the traumatic and stressful nature of the nursing workplace, this right is in jeopardy" (p. 226). This sort of intervention has already been applied to first responders in the Ontario Workplace Safety and Insurance Act (1997), which was amended to recognize posttraumatic stress disorder among first responders as a "work-related illness" (Leslie, 2016, p. 1). Inexplicably, nurses have been excluded from this category.

Structural influences in the form of the conditions of nurses' day-to-day work have obvious importance in contributing to their workplace stress and potentially shaping PSU. Nevertheless, we have once more seen a superficial treatment of structural stressors and lack of inquiry into broader, contextual factors that may influence nurses' substance use. The culpability is again redistributed back to individual nurses, who are framed as inadequately coping with or holding incorrect attitudes toward the challenges that they encounter in their nursing work.

### **2.4.3 Attitudes**

Common attitudes among nurses toward their use of medications have been theorized as influential factors in their development of PSU (Solari-Twadell, 1988). Lillibridge et al.'s (2002) work revealed that nurses with PSU justified substance use with assertions that they required drugs to cope with their workplace stressors. The nurses in that study defended their use of substances toward these ends as merely a reasonable extension of their professional knowledge and legitimate use of drugs to treat patients' needs (Lillibridge et al., 2002). Other studies found that nurses have a high degree of pharmacological overconfidence, meaning unduly self-assured attitudes regarding their ability to successfully control and manage self-administration of medications (Darbro, 2005; Kenna & Lewis, 2008; Lillibridge et al., 2002). It is believed that such attitudes

arise from nurses' professional knowledge and skills regarding administering medication to their clients, as well as from fundamental beliefs that drugs are solutions to distressing conditions, particularly physical pain and uncomfortable emotional states (Patrick, 2010; Solari-Twadell, 1988). In this way, nurses' knowledge of the addictive nature of drugs and their deleterious effects may not serve as protective factors or deterrents to their misuse. In fact, the converse may be the case, because their extensive knowledge of the properties of psychotropic agents may actually enable those nurses who are seeking specific drug effects (Trinkoff et al., 1999).

Such propensities are of particular concern for three key reasons. First, nurses have reported significantly higher levels of chronic pain conditions (Ratner & Sawatzky, 2009), depression, and use of tranquilizers, antidepressants, pain relievers, and sleeping medication (Shields & Wilkins, 2006) than the general population. Second, the extent of nurses' pain-relieving medication use has been associated with the physical demands in their workplaces (Trinkoff et al., 2001). Finally, self-medication of emotional distress and physical pain is believed to act as a gateway to PSU in general (Clark, 2011) and among nurses in particular (Bugle, 1996; Hutchinson, 1986; Lillibridge et al., 2002; Tipliski, 1993).

We assert that the complexities of this high-risk substance-use behaviour are not adequately illuminated by the predominant individual focus in the literature, in which these behaviours are seen as arising from "faulty" attitudes and poor choices on the part of individual nurses. Instead, we believe that the matter may be more fully comprehended if one considers Moore's (2004) notion of cultural logic. Moore posed that members of cultural groups engage in characteristic ways of reasoning and problem solving that enable them to evaluate, navigate, and manage the risks in their unique contexts in ways that may seem illogical to those outside the group. Understanding the phenomenon in this way permits a challenge to the common conceptualization that nurses develop PSU as a maladaptive response to stress resulting from illogical reasoning or faulty overconfident attitudes (Kenna & Lewis, 2008), despite their knowledge of the deleterious effects of drugs (Trinkoff et al., 1999). It would instead appear that, in some circumstances, nurses may rationally and purposefully utilize their specific scientific knowledge base and intimate awareness of the contextual challenges embedded in their workplaces to adapt to the physical and emotional distress imposed by their unique risk environments.

In the risk environment model, the environment is the primary unit of analysis and locus for change and all of the structural elements proximal and distal to the individual are thought to drive and shape risk behaviour (Rhodes, 2002). Numerous structurally situated factors that influence nurses' work lives have been highlighted in the broader nursing literature as being significant contributors to their risk environments (Anderson et al., 2009; McGibbon et al., 2010). These include hierarchical and gendered power inequities arising from the historical legacy of patriarchy and the privileging of the medical profession (Choiniere et al., 2014; Dossey, 2010; McGibbon et al., 2010); crushing workloads and poor working conditions resulting from oppressive corporate management strategies (Rankin, 2009) that unduly predispose them to physical injuries (Shields & Wilkins, 2006); devaluation of their caring work and emotional labour (Choiniere et al., 2014; McGibbon et al., 2010; Rankin, 2009); high levels of emotional, physical, and horizontal violence in their workplaces (Hesketh et al., 2003; Longo & Sherman, 2007); and being subject to secondary traumatic stress (Dominiguez-Gomez & Rutledge, 2009) and moral distress (Pauly, Storch, & Varcoe, 2010).

Curiously, however, these issues are scarcely addressed, if at all, in the literature on nurses with PSU. We believe that reflecting upon nurses' ongoing exposure to such overwhelming structural challenges in light of the claim that PSU is "a form of 'self-medication' for [oppression illness]" (Singer, 2004, p. 17) could provide a much richer contextual understanding of the self-medication of emotional and physical pain that has been found to drive PSU among nurses (Hutchinson, 1986). Recommendations for structurally based 'non-health- oriented interventions' (Rhodes, 2002, p. 88), meaning relevant fundamental sociopolitical reforms to address these contributory structural issues, are conspicuously absent in the discourse on nurses with PSU. We found this to be a significant omission. As an example, education is an intervention recommended in the nursing literature to prevent PSU among nurses (Collins et al., 1999; NCSBN, 2011). However, the opportunity to address contributory structural factors is overlooked here as well. In conducting this review, we found a distinct lack of works that endorsed any educational initiatives geared toward targeting structural factors, such as capacity-building education aimed to empower nurses with the knowledge and skills necessary to advocate for improving the working conditions that increase their vulnerability to substance-related harms.

## 2.5 Policies for Treatment of Nurses with PSU

Nurses have historically viewed PSU among their own as wilful misconduct, and approaches to address it have been driven by a “deterrence theory” (Monroe, 2009, p. 273) aiming to control individuals’ deviant behaviour by punishment. In this traditional punitive approach, the inevitable outcome of the discovery that a nurse had PSU was automatic firing from their job, public disclosure, loss of license, and in many cases, criminal prosecution and incarceration. This phenomenon came to be referred to as “the throwaway nurse syndrome” (Heise, 2003, p. 6). Fear of such humiliating and devastating repercussions understandably triggered a silencing response, resulting in affected individuals’ refusal to seek help and gross underreporting of PSU-related incidents to employers and nursing professional bodies by peers (Heise, 2002).

In the early 1980s, the rise of alternative-to-discipline (ATD) approaches challenged the punitive policies that conceptualized nurses’ PSU primarily as an issue of their moral failing (Heise, 2003). An ATD perspective instead viewed nurses with PSU as having a health issue and emphasized treatment and rehabilitation (Monroe, 2009; Ramer, 2008; Trossman, 2003) to ultimately enable a return to practice (Monroe, Vandoren, Smith, Cole, & Kenaga, 2011). An ATD approach involved voluntary participation, temporary suspension of licensure, supervision of an individualized recovery program, and workplace monitoring upon return to work (Smith, Krinkle, & Barnett, 2013). Removal from practice and disciplinary action were considered as last resorts to protect the public in situations in which the nurse would not agree to or could not meet the terms of supervised rehabilitation programs (Monroe & Kenaga, 2010).

In the United States, ATD programs receive 75% more new enrollees than the discipline-based state programs (Monroe et al., 2013). Furthermore, ATD yields more favourable outcomes overall than discipline-based approaches, primarily because there is considerably more service uptake when it is offered to nurses in lieu of discipline (Kunyk & Austin, 2011; Monroe & Pearson, 2009; NCSBN, 2011). Long-term overall ATD treatment outcomes have also been positive, with completion and recovery rates ranging from 48% to 95% (Monroe et al., 2011; Smith et al., 2013; Trossman, 2003).

Although the advantages of the ATD programs have been so identified, the use of disciplinary approaches continues in many jurisdictions (Kunyk & Austin, 2011;

Monroe, Pearson, & Kenaga, 2008). We find this persistence in use of punitive approaches inexplicable and very troubling for two reasons. First, the superiority of ATD's treatment uptake and outcomes has been well supported in the literature, as noted above. Additionally, disciplinary approaches discourage treatment uptake, hindering rather than aiding efforts to protect the public from impaired nursing practice (Kunyk & Austin, 2011).

Nurses with PSU also experience significant barriers to their recovery following treatment in the form of structural inequities arising from uncontested corporate imperatives and labour policies. For example, nurses were found to return to work sooner, work longer hours, and have more intense workplace climates with more inherent environmental triggers for relapse than other health care professionals recovering from PSU (Shaw, McGovern, Angres, & Rawal, 2004). This is in stark contrast to current population and public health practices, which aim to strengthen social determinants of health by creating physical and social environments conducive to positive health outcomes and address structurally embedded health inequities (Wilkinson, 2012).

Even though the ATD treatment approach is arguably more progressive than the historical punitive ones, we assert that it still poses a significant limitation. This drawback is that it views nurses with PSU through the same lens that also pervades the access, stress, and attitude literature, in which the focus remains situated solely on individual determinants and health manifestations. We believe that the persistent focus on the individual at the policy level both reflects and perpetuates existing structural inequities situated in sociocultural norms within the nursing professional culture that marginalize and stigmatize nurses with PSU.

## **2.6 Culture of the Nursing Profession**

While ATD programs may diminish nurses' fear of punishment by employers and/or professional bodies, the historical blaming and punitive attitudes within the culture of the nursing profession persist, serving as major structural impediments to nurses obtaining treatment (Darbro & Malliarakis, 2012; NCSBN, 2011). Nurses with PSU have been found to perceive their employers as unsupportive (Kunyk, 2015) and mistrust their workplace management and professional bodies, fearing negative judgment and



repercussions, such as loss of licenses and jobs and public disgrace, despite assurances to the contrary (CRNNS, 2008; Kelly & Mynatt, 1990; Kynyk, 2015; Kynyk & Austin, 2011; Malloch, 2013; Monroe & Kenaga, 2010; Strom-Paikin, 1996). This fear may well have some grounding in reality, as nurses have been found to be subject to harsher sanctions by their professional associations (such as being placed on probation even after treatment) than other health care professionals (Shaw et al., 2004).

Some professional nursing associations have taken the position that nurses ought to treat colleagues who have PSU with compassion and refrain from ostracizing or stigmatizing behaviours and that nurse administrators are morally obligated to create a supportive climate in which affected nurses can come forward without fear of retribution (American Nurses Association [ANA], 2015; CNA, 2009; Monroe et al., 2011). Regardless, nurses with PSU may understandably have little confidence in such directives when they are continually confronted in their day-to-day work lives with evidence of colleagues' negative attitudes toward patients with PSU. Nurses are reported to often perceive these patients as people of deficient character, disagreeable to care for, and with doubtful chance of recovery (Howard & Chung, 2000a, 2000b, 2000c). Nurses with PSU are also acutely aware of the stigmatizing attitudes that other nurses generally hold toward their colleagues so affected. These are particularly evident when they encounter harsh and demeaning treatment prior to obtaining treatment and upon their return to work (Brewer & Nelms, 1998; CRNNS, 2008; Darbro, 2005; Howard & Chung, 2000c; Lillibridge et al., 2002). This situation is further compounded by the reality that when nurses complete treatment, their coworkers will become aware of this situation because of the policy restrictions on their access to controlled drugs during the graduated return to work process (CRNNS, 2008). Not surprisingly, less than 10% of nurses with PSU ever obtain treatment (Darbro, 2011).

Even among those nurses who do not hold negative attitudes toward colleagues affected by PSU and wish to be supportive, a culture of silence serves as another structural barrier to nurses receiving the help they need. Although obligated by their professional associations to report peers whose practices are impaired by PSU (ANA, 2015; CNA, 2009), nurses are often reluctant to do so for several reasons. These include fear of reprisals, perceptions that they are being disloyal to friends, being unsure of what to say or do, and a general lack of knowledge of the signs of PSU and of the supports and treatment programs available to their colleagues (Beckstead, 2002;

Breslin, 1992; Grower & Floyd, 1998; Kunyk, 2015; Malloch, 2013; Monroe et al., 2011; Pullen & Green, 1997).

Evidence has demonstrated that peer support is an important structural factor that mitigates the effects of stress, improves the general well-being of nurses recovering from PSU, and contributes to their positive treatment outcomes (Bowen, Taylor, Marcus-Aiyeku, & Krause-Parello, 2012; Darbro, 2011; Monroe et al., 2011). The literature also supported the effectiveness of structural interventions targeting peer support in positively shifting this structural influence. Data have shown that focused educational strategies can transform stigmatizing cultural beliefs by promoting positive attitudes and reducing stigma toward fellow nurses with PSU (Grower & Floyd, 1998; Pullen & Green, 1997). Education initiatives have also been successful in increasing nurses' knowledge of specific actions to take to address colleagues' PSU (Grower & Floyd, 1998) and about substance use in general (Howard & Chung, 2000c). These data indicate that peer education is one arena in which some degree of scholarly inquiry has been undertaken that has resulted in successful structural interventions. We believe that this small body of work is an important beginning, but much more action in this vein is needed to make a significant impact on the predominant attitudes in the broader nursing culture.

## **2.7 Conclusions**

Contemporary population and public health understandings of PSU have turned our attention toward the important contributing role of structural factors. Yet, the current research, treatment, and policy approaches toward PSU among nurses lack critical scrutiny from a contextual perspective and adopt a narrow standpoint centred on individual culpability and failing. Scholarly inquiry into nurses' risk environments is needed to shift our understandings and modes of addressing the problem from the existing individual focus toward awareness of structural factors.

We are called to critically reappraise the policy positions that govern practice environments and inspire current approaches to research, treatment, and policy. Serious consideration must be afforded to implementation of structural interventions designed to mitigate nurses' vulnerability to health harms from PSU. Recommendations for these include the following: capacity-building education intended to empower nurses to self-advocate for improvements to their working conditions; nursing education to strengthen

peer support; and actively engaging policymakers, employers, and professional bodies in creating safe, healthy workplaces for nurses.

## Chapter 3

### A “two-glass-of-wine shift”: Dominant discourses and the social organization of nurses’ substance use

A modified version of this chapter was published under the title publication “‘A Two Glass of Wine Shift’: Dominant Discourses and the Social Organization of Nurses’ Substance Use”, by C. A. Ross, S. L. Jakubec, N. S. Berry & V. Smye, 2018, *Global Qualitative Nursing Research Journal*, <https://doi.org/10.1177/2333393618810655> <sup>8</sup>

#### 3.1 Abstract

We undertook an institutional ethnography utilizing the expert knowledge of nurses who have experienced substance-use problems to discover: (a) what are the discourses embedded in the talk among nurses in their everyday work worlds that socially organize their substance-use practices and (b) how do those discourses manage these activities? Data collection included interviews, researcher reflexivity, and texts that were critically analyzed with a focus on institutional features. Analysis revealed dominant moralistic and individuated discourses in nurses’ workplace talk that socially organized their substance-use practices, subordinated and silenced experiences of work stress, and erased employers’ roles in managing working conditions. Conclusions included that nurses used substances in ways that enabled them to remain silent and keep working. Nurses’ education did not prepare them regarding nurses’ substance-use problems or managing emotional labour. Alcohol was viewed by nurses as an acceptable and encouraged coping strategy for nurses to manage emotional distress.

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<sup>8</sup> As with the other coauthored chapters in this thesis that have been published in, or submitted to journals, I was the lead researcher in this published paper, and it represents my original work. I designed the research, carried out the data collection and analysis, and was the lead author in writing up the findings. My coauthors were members of my doctoral supervisory committee, who provided ongoing supervisory support and feedback throughout all phases of the research and writing processes.

*Keywords:* nurses, addiction/substance use, health care, work environment, health care professionals, qualitative research, nurses' worklife

## 3.2 Introduction

Nurses' problems with substance<sup>9</sup> use can pose serious risks to their health and well-being (Kunyk, Inness, Reisdorfer, Morris, & Chambers, 2016) and potentially compromise the provision of safe, competent nursing care to the public (Kunyk & Austin, 2011). Estimates of the prevalence of nurses' problems with substance use in Canada and the USA range from 6–20% (Dunn, 2005; Kunyk, 2015; Monroe & Pearson, 2009; Servodidio, 2011). New enrollees in substance-use monitoring programs for nurses in the USA and its territories in 2009 comprised 0.36% of the national nursing population (Monroe et al., 2013). It is particularly concerning that many nurses with such problems are reluctant to obtain help and remain in practice (Bell et al., 1999; Kunyk, 2015; Monroe et al., 2013). In one study in the Canadian province of Alberta, over 90% of the nurses who self-identified as having problems with substance use were actively practicing and had not sought treatment (Kunyk, 2015).

Our concern with this serious issue arose from first-hand knowledge of both the everyday work lives and substance-use practices of nurses. Many of our nursing colleagues have lived with substance-use problems, either in secret or, if discovered, in disgrace. Tragically, some did not survive. This perspective was our entrée into a study of what, within the complex work worlds of nurses, might socially organize the conditions for them to have such problems and to be reluctant to seek help when they do.

Our next step was to review scholarly literature (Ross, Berry, et al., 2018). Dominant concepts used to explain nurses' perspectives of substance-use problems, such as stigma (Darbro, 2005), negative attitudes (Howard & Chung, 2000c), and the

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<sup>9</sup> In this article, the term substance is used to refer to *psychoactive substances*, which are those that "affect mental, psychological, behavioral functions; i.e., sensations of pain and pleasure, mood, consciousness, perceptions of reality, thinking ability, motivation, alertness" (Health Officers Council of British Columbia, 2011, p. 12). These include the categories of depressants (including alcohol, opioids, sedatives, hypnotics), stimulants, cannabis, psychedelics, and psychiatric medications (Health Officers Council of British Columbia, 2011).

culture of the nursing profession (Darbro & Malliarakis, 2013; Solari-Twadell, 1988) permeated much of the existing research. Numerous conceptualizations of substance-use problems were also offered, such as problematic substance use (College of Registered Nurses of Nova Scotia, 2017), substance-use disorders (Monroe et al., 2011), addiction, and substance abuse<sup>10</sup> (Monroe & Kenaga, 2010). Popular themes of contributory factors also pervaded: stress (Storr et al., 1999; Trinkoff & Storr, 1998b), nurses' access to drugs (Dittman, 2008; Kenna & Wood, 2004b), and nurses' attitudes toward substance use (Kenna & Lewis, 2008; Lillibridge et al., 2002). However, a critical interrogation of how these very concepts and themes originated and were constructed was notably absent. We found ourselves puzzled about how these abstract concepts and themes connected to what we knew about nurses' actual work lives and substance-use practices and believed that there was much more depth and texture to the story than was being told. Moreover, the nursing literature on the topic was dominated by quantitative research, with precious few qualitative studies that used the experiential knowledge of nurses who had substance-use problems as primary data.

We also experienced a disjuncture<sup>11</sup> arising from what we saw as the decontextualization of the issue in the extant scholarly works. Nurses' problems with substance use have been framed principally in neoliberal terms of individual shortcomings (Kunyk, Milner, & Overend, 2016), while broader institutional and organizational conditions have neither been critiqued nor researched (Ross, Berry, et al., 2018). This trend conflicted with what we knew experientially about the interconnections between nurses' substance-use practices and their workplaces. That individuated perspective also contradicted current public health-based approaches that consider the environment as the primary focus of inquiry into substance-use problems (Rhodes, 2002).

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<sup>10</sup> We have chosen to avoid the use of such conceptualizations and instead use the following terms: substance-use problems, problems with substance use, or substance-use practices. Although we acknowledge that these could also be construed as social constructs, our intent is to be descriptive and not connote any category, concept, or alignment with any theoretical perspective.

<sup>11</sup> In her work on the institutional ethnographic mode of inquiry, D. E. Smith (2005) asserted that individuals experience disjunctures when their own knowledge and experiences are being subordinated to dominant conceptual discourses.

The disjunctures that we experienced, whereby our own experiential knowledge of nurses' problems with substance use and the conditions of their day-to-day work lives met with conflicting organizing discourses, became the problematic of our study. A problematic is a 'puzzle' in the social world, in which disjunctures are explored with the aim of discovering how the lives of individuals involved are socially organized to occur as they do (Smith, 2005). We chose to address the shortcomings that we found in the existing literature and examine the disjunctures that we were experiencing by using an institutional ethnography (IE) mode of inquiry to explore our problematic.

Numerous avenues of inquiry exist within a problematic, all arising from differing *standpoints*, or the particular knowledge and social locations of individuals situated in the problematic (Smith, 2005). We elected to align with a standpoint different from our own as the entry into the problematic and utilized the expert experiential knowledge of nurses who have experienced substance-use problems to research two questions: (a) What are the discourses embedded in the talk among nurses in their everyday work worlds that socially organize their substance-use practices and (b) how do those discourses manage these activities?

### **3.3 Research Approach**

#### **3.3.1 Institutional Ethnography**

In the IE tradition, the process of inquiry is anchored in the everyday experiences and practices of people, rather than in abstracted notions such as concepts and themes. The IE researcher's main objective is to trace that local experience outward to discover how those experiences are managed, socially organized, and ultimately subordinated by broader ideological constructions of reality that are embedded within dominant discourses (Campbell & Gregor, 2002; Smith, 2005). In IE, discourses are seen as the words (in talk or texts) people take up in their day-to-day worlds that serve as maps, guiding them to the knowledge of "what they *should* be doing" (Clune, 2011, p. 41).<sup>12</sup> As

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<sup>12</sup> In this study, we differentiate our use of the term discourse from how we use the terms talk and language. Here, talk refers to people's "words as uttered" (Smith, 2017, p. 23) in speech and language denotes how people's words (in talk or written) coordinate their activities with those of others.

with Foucault's discourse analysis, Smith's IE approach aims to expose social and power relationships within textual discourses; however, Smith's IE approach examines how these discourses are joined with social practices, particularly in institutions or work environments (Campbell & Gregor, 2002).

Language is the door through which a researcher can enter into and uncover the discursive organization that is hidden within everyday activities. The ways nurses talk, like all professional conversation, is laden with institutionalized parlance. D. E. Smith (1999) observed that an "intimate connection [exists] between learning an occupation and learning a language" (p. 144), in that typical insiders' talk organizes the occupational group members' knowledge as it becomes adopted as taken-for-granted group norms. The talk is practiced, as these norms act as dominant discourses that inform and organize the group members' day-to-day activities. As the discourse is reproduced in nurses' talk, it acts as a generalizing<sup>13</sup> process that, in turn, coordinates and manages nurses' activities across other settings and times (Smith, 2005).

We uncovered how dominant discourses were reproduced within and across nursing work sites by ethnographically researching the ways the nurse participants talked in interviews about their substance use and everyday work lives, and their recounting of how other nurses talked about these matters. The historical importance of professional nursing's oral traditions has been recognized in foundational nursing work (Benner, Tanner, & Chesla, 2009). However, during our comprehensive literature review on nurses' substance problems (Ross, Berry, et al., 2018), we found that the ways that nurses talk about their substance-use practices had remained unexplored. We believed that we could utilize this untapped resource to gain access into nurses' everyday work worlds through the actual words spoken by nurses, the subtexts, the words they did not speak, the stories they told, how they talked as and among nurses about substance use, and how this talk was enacted in their everyday work lives.

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<sup>13</sup> The approach to generalization in this study differs fundamentally from that of quantitative research, in which statistical findings are intended to be generalized to populations. We instead use the traditional IE meaning of the term, which denotes a process whereby local effects are socially organized to reoccur at other times and in other locations (Smith, 2005).



### **3.3.2 Methods**

#### **3.3.2.1 Participants**

Inclusion criteria for the standpoint participants (referred to as participants in what follows) in our study required that they were registered nurses (RNs) or registered psychiatric nurses (RPNs), they were a current or past enrollee in the regulatory program in one Canadian province for nurses who were declared to have substance-use problems, and they worked in provision of direct patient care. We carried out recruitment via an advertisement posted in one of the provincial nursing organizations' e-newsletters. Participants included 11 RNs and one RPN. Nine of the participants had responded to the recruitment advertisement and three other nurses contacted us because they had heard about the study from nurse colleagues.

In IE, the number of participants is not prescribed; instead, importance is placed upon participants representing a sufficiently diverse range of experiences and loci within the institution to illuminate the generalization of discourses across different times and places (DeVault & McCoy, 2006; Malachowski et al., 2016). Our participants were employed in various types of clinical areas and in different units, hospitals, and regional health authorities throughout the province. Participants varied in age and length of time in nursing, had problems with different substances, and were of male and female gender identifications. Due to the extremely sensitive nature of the topic, we have not identified the specifics of any of these demographics in this article to protect participants' anonymity and confidentiality. We obtained all relevant research ethics board approvals and institutional consents prior to conducting the research. Participants provided informed, written consent to participate in the study. We strictly protected participants' confidentiality and anonymity, and all participants' names reported in this article are pseudonyms.

#### **3.3.2.2 Data collection**

The written and spoken language practices of nurses obtained in participant interviews and Ross's (i.e., the lead author's) journal (described below) served as ethnographic data for the analysis. The lead author conducted all of the interviews with participants, which took place either in person or via Skype (Microsoft, n.d.) in 2016 and 2017 as semi-structured, audiotaped one-to-one interviews of 60–90 minutes in length.

Most were single interviews, but the lead author contacted some participants for a second brief interview or collected subsequent information via an email if we required clarification or additional data. We provided participants with copies of their written interview transcripts and gave them an opportunity to provide comments, clarifications, or corrections as they saw fit.

Reflexivity involves making the research process itself a focus of inquiry (Carolan, 2003). As researchers' reflexivity is considered "a valid means of adding credibility to qualitative research" (Carolan, 2003, p. 10), we used the lead author's reflexive knowledge, in the form of a written journal (with entries prompted by interview experiences), as data in this study. We have included excerpts from the lead researcher's reflexive journal in our analysis, which are cited with the code LRJ in the findings. The lead author occupied a dual standpoint with respect to the participants. The lead author was also a practicing nurse (dually credentialed RN and RPN) with over 36 years of experience. This provided the lead author with an insider's understanding of nurses' typical language and expressions, their conditions of work, the corporate and operational workings of health care institutions, and systems of nursing education. Unlike the participants, the lead author had not had any involvement with any nursing regulatory bodies because of substance-use problems.

### **3.3.2.3 Data analysis**

Traditionally, IE researchers analyze the language within institutional texts as data (Campbell, 1994; Diamond, 1992; Rankin & Campbell, 2006). Recently, D. E. Smith (2017) endorsed the notion of researchers undertaking "an ethnography of words as uttered" (p. 24) in her important work, *Talk as Practice*. As with the IE research of Watt (2017) concerning emotional work in the care of children with diabetes and G. W. Smith and D. E. Smith's (1998) study of school experiences of gay students, we have taken the approach of foregrounding talk in our analysis of social practices and relations.

Rigor in IE is achieved by "the corrigibility of the developing map of social relations" (DeVault & McCoy, 2006, p. 33), and is accomplished through a confirmable and accurate accounting of the actualities of peoples' lives, discovering how individuals' knowledges have been organized, how knowledge manages people's everyday activities, and how these knowledges and actions are coordinated with those of others. To achieve our research aims, we used indexing and mapping, analytic strategies

typically employed in IE research (Rankin, 2017b). The lead author carried out a preliminary review of the data from participants' interviews and the reflexive journal, using manual notations on the transcripts to index (a) how nurses talked (and did not talk) about substance use and (b) the participants' day-to-day work. In IE, work is broadly conceptualized as "what people do that requires some effort, that they mean to do, and that involves some acquired competence" (Smith, 1987, p. 165). This "generous" notion of work (Smith, 2005, p. 151) incorporates less visible types of labour, such as cognitive, emotional, and communication work, as well as visible physical activities. Locating work in ethnographic data is fundamental to an IE analysis (Smith, 2005), as it guides the analyst's attention to the activities of the participants and the knowledge that informs these actions.

In the second and subsequent readings, these two indices were further sub indexed with the goals of (a) uncovering and describing dominant discourses in the nurses' work lives and (b) mapping how these discourses entered into the nurses' day-to-day experiences (McCoy, 2006). In IE, mapping describes and traces people's activities (including talk) by "lay[ing] out a display of what is happening (the map), either in words or diagrams, that describes the features of the social practices" (Rankin, 2017b, p. 5). In carrying out this analysis, we were watchful for tacit, taken-for-granted assumptions, and recurring events or use of words. These could uncover patterns that existed in local actors' (in this case nurses') day-to-day work worlds that were socially organized to be repeated or generalized in other locations and times (Campbell & Gregor, 2002; Smith, 2005). We were also alert for disjunctures that occurred between nurse participants' experiential knowledge and ideological or conceptual ways of knowing imposed by dominant discourses. This directed our attention to where the participants' knowledge and experiences were subordinated to those discourses (Smith, 2005).

### **3.4 Findings**

Our analysis of interview transcripts and the lead researcher's journal (LRJ) uncovered that our participant nurses' substance use and coping practices were socially organized by dominant discourses embedded in the ways nurses talked (or didn't talk) in their everyday work lives. These included othering practices, meaning, practices of distancing through stereotyping into us and them categories (non-nurses and nurses

with substance-use problems as others, and substance-use problems as other health issues); professional education practices; coping practices (coping with silence and using substances); and the work of managing disclosure (the paradox of obtaining help for and the work of concealing substance-use problems).

### **3.4.1 Othering Practices**

Our data revealed underlying discursive categorizations in nurses' talk, whereby people with substance-use problems were viewed as others who were separate from nurses; nurses who had substance-use problems were seen as different from and lesser than nurses who do not; and nurses with substance-use problems were viewed as different from and less worthy of empathy and support than those with other types of health issues.

#### ***3.4.1.1 Othering practices toward non-nurses with substance-use problems***

Participants reported that nurses typically spoke of their patients and those in the broader community who had problems with substance use in ways that were contemptuous and markedly lacking in empathy. As Paul articulated, people with substance-use problems were "just looked down upon [by nurses], not ever with any sympathy, but more of a weakness ... that they're a lesser person because they're having to use." Participants told us that, in their day-to-day work, nurses typically spoke about people with substance-use problems in terms of moral or character deficiencies, social deviance, or low standing and used phrases such as "bad," "weak," "low-class," "skanky," "uneducated," "from skid row," "addicts," and "junkies." Participants identified that prior to and even during their active substance-use problems, they had themselves thought and spoken in this typical judgmental way about people with such problems. In contrast, nurses characteristically spoke of themselves as being "educated," "respectable," separate from, and elevated above these distinctly undesirable other people. Rachel recounted, "I believed, you know, I'm not like those other addicts. I'm not a junkie that shoots heroin on the street.... I'm not the same as them."

#### ***3.4.1.2 Othering practices toward nurses with substance-use problems***

This discourse coordinated nurses' activities by stipulating that they must be seen to be able to "handle" their substance use in order to retain their elevated moral,

characterological, and social status. The participants recounted that they and their colleagues expected nurses to know better and definitely do better than to have such problems. Nurses who were discovered to have problems with substance use were othered as nurses, and viewed as incompetent, weak, immoral, and poor representations of the nursing profession. Participants reported that they had adopted and internalized this discourse as part of their nursing identity, and, subsequently, they experienced profound feelings of shame and embarrassment, and felt that they had failed as a nurse when they realized that they had a substance-use problem.

### ***3.4.1.3 Othering practices toward substance-use problems***

Participants recalled that nurses rarely spoke of people's problems with substance use as illnesses or health issues, although there seemed to be an expectation that they really should view them as such. When substance-use problems had been spoken of as health issues, it was clear to the nurses so affected they were essentially considered as illegitimate illnesses. Helen and Paul illuminated how compassion was selectively practiced toward colleagues according to the type of health issue that they were dealing with. When asked if she would have felt more supported by colleagues if she had said, for instance, that she was off work with a back injury instead of for treatment of substance-use problems, Helen explained, "I think I actually said that one of the times [laughs] actually I said that almost every single time."

Participants told us how nurses typically felt isolated and unsupported when they were "outed" as having a substance-use problem. Paul described how compassion from colleagues fell short during leave related to his problems with substance use:

Not one person sent me a get-well card. We're always putting money in for people who are off sick to buy them flowers or something, but I didn't get anything [when off work for treatment of substance-use problems].... It's all "it's an illness ... except for how we're going to treat you."

As Paul recounted about his workplace, if a fellow nurse was known to have a physical health issue, support was extended both formally and informally. Many participants reported that, like Paul, if the nurse's health was affected by substance use, then they would most likely experience blame, condemnation, and/or exclusion.

According to our participants, their colleagues did not understand relapse as an expected part of the course of recovery from substance-use problems. Instead of a symptom of a health issue, relapse was spoken about as a characterological failure and even a betrayal of the profession. As Mark described, “When I went back to work after I’d relapsed ... the head nurse told me that—to my face— ‘you’re not trusted here because you lied and you disappointed and betrayed your colleagues.’” Even nurses who had not relapsed worked in an atmosphere of deep mistrust, where it was assumed that they had or inevitably would do so. Pietra explained the attitude of suspicion present in the work setting in this way: “They wonder if you are going to relapse.... There’s a suspicion... and you can feel it because you’re judged.... I’m absolutely terrified there’s going to be a discrepancy in the narcotic count... I’ve been called in three times.” Meanwhile, within this unsympathetic climate, the recovering nurses were also attempting to not relapse, to recover their health, and do the work of their regular nursing job.

### **3.4.2 Professional Education Practices**

Several participants felt strongly that nurses lacked basic education about the reality that nurses can and do develop their own problems with substance use, and the warning signs of the same. According to Rachel,

You should learn about addiction in the health care field to really understand how prevalent it is because I think that that’s missed.... I think if somebody would have told me about it I might have been a little bit more wary or might have seen my own behaviours before the narcotics [became] troublesome.

When the topic had been spoken of in participants’ formal education, the focus was placed on how to report miscreant nurses to institutional authorities, rather than understanding lived perspectives or learning about nurses’ substance problems as health issues. As Molly explained, “There’s no understanding of what it is like to have a disease and how to help.... They [just] know how to report.”

Participants expressed their beliefs that nurses, especially novices, were inadequately prepared in their basic nursing education to cope with the intense emotional work that they were required to undertake to manage the many stressors inherent in their jobs. Work stressors dominated the ways that participants talked about

their substance use and work lives, particularly the distress that nurses felt from engaging with the suffering, traumas, and even deaths of their patients. Pietra shared her experiences of what, in retrospect, she viewed as a major gap in her nursing education:

I can look back on it now and say that I was not equipped emotionally to deal with what happens to people.... We need to recognize that when we see those horrible events ... we will need to work through those feelings and those thoughts about what's happened and the resources have to be available so we can be assisted through that ... feeling helpless and hopeless, not knowing where to go to get the proper information of how to help [our patients].... There's nothing on this [in our nursing education] except how to make a bed and put a good corner on it and take vital signs, and you don't have that, you don't have that.

Nurses also reported having to cope with numerous other sources of workplace stress, including heavy workloads, imposed overtime, fatigue from shift work, musculoskeletal strain and injuries, verbal, sexual and physical assault, and conflicts with coworkers, all of which were overlaid by unsupportive leadership. Bella articulated how she believed that a lack of any discussion in her nursing education about workers' rights and established standards for working conditions left her vulnerable and unequipped to safeguard her own health and well-being: "I just didn't know. I should have had a course about policies, and union, and that kind of stuff because I just didn't have any idea about ... my rights in the workplace."

As importantly, however, several nurses in our study conveyed that the reverse was also the case. Participants stated that learning about their fundamental workers' rights for safe working conditions and ways to advocate for these rights were crucial elements in their successful recovery from substance-use problems. They believed that this education empowered them to manage their workplace stressors in ways that better protected their emotional and physical health.

### **3.4.3 Coping Practices**

Our analysis unveiled how nurses carried out the work of coping by practicing silence and/or substance use and how these practices were managed by discourses within the nurses' talk in their everyday worlds about work stressors and substance use.

### **3.4.3.1 Coping by practicing silence**

Our participants reported implicit and explicit messages in the way nurses talked, or didn't talk, that organized the conditions for nurses to practice silence and to actively silence colleagues as they all endeavoured to cope with some of the most difficult life circumstances and pressures embedded in their day-to-day work lives. Helen's remarks revealed taken-for-granted norms in nurses' social relations that managed how participants talked or didn't talk about work stressors:

There were comments along the line that ... "everyone finds this upsetting, you just have to deal with it" ... you know, that's what the job's about ... because if you started to raise anything that was at all loaded ... people would be "yeah, that was really awful, now I gotta go to the bathroom or go do this or go do that or whatever," and it wasn't like people were mean about it. Just it was kind of like, "Okay, we have enough to deal with ourselves and we're done dealing with you too."

Another participant, Vicki, explained how nurses didn't want to discuss such problems with other nurses, lest they be perceived as incompetent: "[If a nurse is] not able to cope ... they have a poor constitution.... If you consistently were not able to cope, then you weren't cut out for this, and you'd probably be gossiped about [by other nurses]."

Helen's and Vicki's comments revealed an assumption that it is crucial for nurses to silently cope with work stresses so as to not add to the burden of others, because all nurses are thought to be working on a razor's edge and struggling to cope themselves. Colleagues' responses to an individual expressing distress, as well as the silencing of such expression, create an expectation that nurses are required to be strong, uncomplaining, and 'just suck it up,' as no one has the emotional, physical, or time resources to pick up another's 'slack.' Nurses consider peers who voice difficulty coping with work-related stress to be deficient and talking about such feelings is often perceived as a sign of weakness or even evidence of unsuitability for the nursing profession.

### **3.4.3.2 Coping by practicing substance use**

Nurses practiced substance use to cope with work demands in various combinations with talk and silence. Their selections of whether they practiced silence or talk along with their substance use depended upon the discursive categorizations of the substances and stressors in question. For example, participants revealed that nurses did not place any premium on concealing or silence around their typical practices of liberally



self-administering non-prescription over-the-counter medications and non-pharmaceutical substances that had either stimulant, calming, antidepressant, pain-relieving, sleep-inducing, muscle relaxing, and/or mild euphoric types of effects. They would openly use these to manage physical stressors, such as pain and sleep–wake cycle disturbances arising from shift work. This self-medication was often done with a wink and a nod, and with full knowledge and complicity of nurse colleagues. The lead researcher described how, as a nurse educator, she knew novice nurses to extensively use these types of substances to cope with work life: “The young nurses especially are self-medicating like mad. Energy drinks, diet pills, melatonin, St. John’s Wort, Gravol, Benadryl to manage shift work, take tons of ibuprofen and acetaminophen for pain, all this over-the-counter stuff” (LRJ). Rosie also illustrated how she knew other nurses to routinely use their professional scientific knowledge of these substances’ effects to meet the physical demands of work. According to Rosie, “a lot of nurses had migraines and they weren’t feeling well, so we gave them an injection of Gravol in the bathroom ... to get you through your shift and that was okay.”

Rosie also explained how it was not at all uncommon for nurses to pilfer non-prescription medications from their workplaces to enable them to work throughout their shift. Participants reported that nurses did not look upon the diversion of these drugs as stealing; however, they did understand that the practice is officially considered to be so. Nevertheless, we found that nurses’ use of these non-prescription substances to cope with emotional distress was not spoken of.

Nurses typically remained silent if they used legitimately acquired prescription drugs, such as opioids, sedatives, anxiolytics, or antidepressants, for either physical or emotional reasons. This was because nurses reportedly categorically regarded use of these drugs as a sign of weakness and even evidence of being a ‘drug addict.’ In describing how nurses did not talk about their use of such medications, Molly recounted how she accidentally saw a nurse colleague’s opioid prescription at work: “I know other nurses who were taking way higher doses of pain medication than me and they’re still working ... [I saw her opioid prescription in her open purse] and I thought, ‘Holy shit that’s a lot.’” Nevertheless, as Rosie described, nurses commonly, but quietly, used those drugs to cope with emotional distress on a day-to-day basis so that they could carry out the requirements of their job:

A lot of nurses are on Ativan [a prescription drug used to treat anxiety that has sedative effects] at night to sleep, to cope with the death and destruction that we see ... [nurses] are more desperate and coping with your assignment and the sickness of people in the hospital and the death, it's horrible.

Many nurse participants also reported nurses frequently used these types of medications to manage physical pain so that they could work and that their pain often arose from the conditions of their work. However, stealing drugs in these categories from the workplace was absolutely not spoken of, and the nurses who were known to do so were categorically regarded as reprehensible. Judged worst of all were those who had taken drugs from their patients. As Pietra recalled, "They cannot understand how you could possibly start filtering the medication from the hospital to your own personal supply.... To use medications that you're entrusted to give to patients, because that's where mine went ... is horrible."

Participants who had stolen these kinds of drugs from their workplaces also described how using them had actually enhanced their ability to carry out their work by enabling them to better cope with physical and emotional work stressors. These nurses were more tolerant with patients and coworkers because their emotions were numbed. They also were able to work harder and longer because they could forgo basic needs to eat and sleep, and they did not utilize their allotted sick leaves when unwell. As Rachel recounted,

When I was using [opioids], it was quite easy because I could go for hours.... I worked the next 21 days straight and I used [the drugs] every day.... I actually ended up working more because at work is where I ... got my drugs from, so I ended up being a bit of a workaholic and picking up as much overtime or extra shifts.... It made me want to work more and it kept me at work more than at home.

Rachel described here how, while she was actively using drugs that she stole from work, she regularly and without complaint volunteered to work extra hours and more successive shifts than scheduled. Nurses who stole drugs from their workplaces shared their perceptions that their peers had viewed them as particularly hardworking and dedicated because of their willingness to work overtime. Unbeknownst to their colleagues, however, they were managing their work lives in specific ways to facilitate access to their supply of drugs.

We found that nurse participants spoke about nurses' practices of alcohol use altogether differently from other substances. As Helen explained, participants reported that nurses' use of alcohol outside of the workplace was widely spoken about and tacitly endorsed as a method to cope with emotional distress, particularly work stressors:

I think to some degree having a drink after work or whatever, people were, yeah, "I'm going to go home and have a glass of wine."... People did that to debrief or calm down and that was sort of chuckled about, but nobody talked about the fact that if someone kept drinking it would be an issue.

Participants reported that 'partying' or recreational binge-type heavy alcohol use was common practice among nurses and talked about by nurses freely in a light, humorous fashion as a sanctioned way to 'blow off steam.' In fact, alcohol use was the only practice of substance use, or otherwise, that the participants said nurses talked about openly as ways to manage emotional distress arising from their work.

The lead researcher's reflections on her experiences in many nursing workplaces over several decades highlighted how nurses talked about alcohol use in a way that served as an accepted kind of shorthand signalling to other nurses that they were experiencing stress:

You'd never say, "Oh, I just can't cope with that death, or the distraught relatives," or "I'm so stressed out by the workload I'm going to have a breakdown." No, you'd say, "This was a two-glass-of-wine shift!" and everyone would laugh and agree. (LRJ)

Not all manner of nurses' alcohol use was viewed favourably, however. Study participants described a taken-for-granted understanding that it was important to be able to handle their liquor. If the alcohol use was seen as problematic, or if a nurse was found to be drinking or intoxicated on the job, the nurse was disparaged in the same way as those who had problems with other substances. Regardless, participants reported that nurses who had problems with alcohol were looked upon far more sympathetically than those who had problems with other drugs.

### **3.4.4 The Work of Managing Disclosure**

#### **3.4.4.1 *The paradox of obtaining help for substance-use problems***

A curious contradiction was revealed in the nurse participants' talk. This was that, as noted prior, under specified conditions, the uses of some substances were implicitly and explicitly endorsed as suitable practices for nurses to utilize to manage their physical pain and emotional distress. On the other hand, nurses who were believed to have problems with substance use were judged as morally deficient and incompetent others. Here, we came to a disjuncture in the data analysis. We did not understand how, or whereby nurses were seen to have crossed that line – when did they become that “other” nurse? When the lead researcher posed this question to the nurses, they answered clearly—their categorization shifted when they asked for or evidently needed help. For instance, according to Mark, “I think when you get busted ... when an individual gets caught ... or asks for help. Once you're ID'd [identified], right?” As Mark articulated, it was at the juncture when nurses sought, or were visibly in need of assistance for problems with substance use that they had received clear messages both from their peers and their own internalized discourses that they had failed as a nurse.

#### **3.4.4.2 *The work of concealing substance-use problems***

The participants were unambiguous in reporting that one of the primary reasons that nurses concealed their problems and were so distinctly disinclined to seek assistance was their fear of being harshly judged by their peers in this way if they admitted needing help. Nurses described how they feared being outed because the negative way that they and their colleagues had typically spoken about nurses and others with substance-use problems had set their expectations that they would be condemned. Consequently, nurses were typically guarded about their substance-use problems and felt compelled to mask the true nature of their problems from colleagues by practicing silence and engaging in a great deal of difficult thought and emotional work to actively conceal their problems from their colleagues.

Many participants reported that when their problems did become known to colleagues, they needed to undertake a substantial amount of emotional and interpersonal work to navigate and cope with a work environment characterized by a relentless undercurrent of hostility, contempt, and suspicion. Even those nurse

participants who ultimately did receive a positive reception from their peers when their substance-use problems were disclosed reported that they had gone to great lengths to manage potential disclosure. Liza described her hesitation in this way: “I personally have never had anything but amazing support from all my colleagues ... [but] I can guarantee you I wouldn’t have told.”

### **3.5 Discussion: Silent Angels – Moralistic and Individuated Discourses Managing Nurses’ Substance Use**

The historical nursing motto, “I see, and I am silent” (Villeneuve, 2017, p. 24) is now generally regarded as quaint and somewhat distasteful. Nevertheless, this imperative was clearly reflected in the present day, whereby nurses’ experiences of work stresses are suppressed, reconstructed, and replaced with dictates of silent endurance and performance of duty. These current discursive representations of nurses readily bring to mind the historical Christian and Victorian, gendered, moralistic stereotypes of “good” women (and nurses) as temperate, uncomplaining, endlessly altruistic “angels” (Heise, 2002; Turkoski, 1995). Our data supported others’ findings that vestiges of such virtue-based ideologies persist in current nursing discourse (Gordon & Nelson, 2006; Kunyk, Milner, et al., 2016). Our study also revealed how substance-use problems were discursively organized as character flaws that “good nurses” simply don’t have. Those who did were categorized as others, quite separate from and of lesser social and moral stature than nurses themselves.

Uncovering how these moralistic discourses organized nurses’ knowledge contributes much-needed depth to the broad and ill-defined conceptually based explanations in the literature on nurses’ substance-use practices. Specifically, this knowledge adds important nuance to the widely used concept of stigma to describe nurses’ negative judgments of other nurses who have substance-use or emotional or mental health problems and their own reluctance to seek help for the same (Kunyk, 2015; Kunyk, Innes, et al., 2016; Moll et al., 2013; Parrish, 2017).

Our findings also offer a challenge to the reductive conceptualization in the nursing literature explaining how nurses’ substance-use problems arise from cavalier attitudes toward their self-administration of drugs (Kenna & Lewis, 2008; Lillibridge et al., 2002). These data highlight how nurses’ substance use is linked to the premium placed

on their mute accommodation of punishing working conditions (from shiftwork and overtime to death and violence). Rather than possessing faulty “overconfident attitudes,” our participants reported that nurses purposefully leveraged their professional knowledge of substances to numb physical pain and emotional distress so that they could meet the discursive imperative of silent stoicism and continue to work. In this way, nurses’ substance-use practices often provided their employing institutions with compliant workers who subsidized the true cost of their work with their own health and well-being. These data also lent support to Turkoski’s (1995) notion that dominant ideologies of nurses’ “professionalism” have historically managed their behaviour in ways that deterred them from challenging their employers about poor working conditions. Another unexpected finding was the inadvertent institutional utility of nurses working more hours and shifts than scheduled in order to access the drugs they acquired from their workplaces and had become dependent upon.

The individuated, moralistic discourses that were found in nurses’ talk about their everyday worlds are also generalized throughout the professional and scholarly texts that are intended to provide nurses with guidance about their substance-use and coping practices. The clear messages sent in these texts are that the responsibility for nurses’ coping (or not) with work stressors is situated entirely with the individual nurse and that substance-use problems are evidence of their personal failure at this task. The role of the institution in the stressful working conditions that the nurses must somehow cope with appears to have been erased from this discursive construction.

For example, a professional resource document intended to assist nurses with maintaining their “fitness to practice” (College of Registered Nurses of British Columbia [CRNBC], 2008, p. 13) cryptically advises them to “set limits ... [as a] workplace and professional self-care” (p. 13) strategy. In another text, health care providers are cautioned to not “forget to take care of themselves ... say no when needed ... don’t over-identify with their patients ... [and] plan regular breaks” (Parrish, 2017, p. 147). No direction is offered as to exactly how a nurse might actually go about doing so in their real-life working conditions. Advice to distance themselves from their patients seems irrelevant to the work contexts that our study participants described, in which they experience great distress from engaging with traumatized patients in order to provide them with competent nursing care. It seems equally unhelpful to instruct nurses to “take care of themselves” (Parrish, 2017, p. 147) when the realities of their work, both

revealed in our findings and found in the literature (Shields & Wilkins, 2006), often involve punishing work environments with imposed overtime on understaffed units where they are unable to take breaks. It is also highly unlikely that they would feel safe to “say no” (Parrish, 2017, p. 147) or to “set limits” (p. 147) when they have been socialized into the professional norms uncovered here that dictated silent endurance of work stresses. Confusingly, this silencing discourse is echoed in that same document, where nurses are also advised to “avoid chronic complainers” (Parrish, 2017, p. 147), essentially counselling them to shun colleagues who do speak up. Nurses are also admonished in resource texts to “avoid self-destructive coping” (CRNBC, 2008, p. 11), in which problems with substance use are held up as exemplars of individual nurses’ failure to do so.

Similarly individuated discourses align closely with current trends for workplace wellness programs in health care institutions. These programs redistribute the job of managing workplace stressors wholly back to the individual, typically by offering assistance in the form of “self-help tools and resources with lifestyle mentoring, or health coaching” (Preston, 2012, p. 2). Initiatives to actually improve the nurses’ working conditions or organizational culture are not part of this workplace wellness package.

One can also see individuated discourse generalized to the management of nurses at institutional policy levels. For example, professional programs to manage nurses who have been identified as having problems with substance use<sup>14</sup> likewise situate their focus solely on the individual nurse (Ross, Berry, et al., 2018). These individuated perspectives are also articulated to broader discourses in the “new public management” (Rankin & Campbell, 2006, p. 14) administrative approaches that currently govern Canadian health care organizations. In that mode of institutional organization, nurses’ work stressors that arise from corporate efficiency and cost-cutting imperatives “are glossed over as nurses’ ‘constraining beliefs’” (Rankin & Campbell, 2006, p. 158), thereby eliminating the institution from the problem and framing the solution as “changing nurses’ beliefs and behaviors” (p. 158).

These discourses are also consistent with those found in the scholarly nursing literature, in which a highly individuated (Ross, Berry, et al., 2018), neoliberal (Kunyk,

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<sup>14</sup> We have researched one such treatment program for nurses in a forthcoming work.

Milner et al., 2016) perspective exists toward nurses' substance-use problems, which pays little heed to the institutional context of nurses' work lives. For instance, Burton (2014) concluded a common characteristic of nurses who had problems with substance use was that "they did not know how to effectively cope" (p. 157). Health care professionals are also counselled to "accept responsibility to modify a lifestyle burdened by stress, chronic overwork" (Storr et al., 2000, p. 1463). Rarely do studies show that nurses are encountering situations that exceed a normal person's ability to cope or that employing institutions should bear some responsibility for such conditions (Ross, Berry, et al., 2018; Lillibridge et al., 2002). Current public health-based approaches that view substance-use problems as inextricably connected to the conditions in peoples' environments (Rhodes, 2002) are inexplicably absent in the scholarly nursing literature (Ross, Berry, et al., 2018). Notable exceptions are recommendations to address nurses' substance-use problems by mitigating their "traumatic" working conditions (Lillibridge et al., 2002, p. 226), improving their organizational support, and creating more positive work environments (Scholze, Martins, Galdino, & Renata, 2017).

Our participants reported their basic education did not prepare them with factual knowledge about nurses' substance-use problems and that they merely learned, as Molly said, "how to report" other nurses' transgressions. These data were consistent with findings in the scholarly nursing literature that undergraduate nurses receive scant, if any, evidence-based knowledge on substance-use problems in general and nurses' in particular (Burton, 2014; Cares, Pace, Denious, & Crane, 2015) and that the education they did receive took a highly individuated perspective (Ross, Berry, et al., 2018).

Our data also aligned with the content seen in professional texts (at the provincial and national levels) on nurses' substance use (Canadian Nurses Association, 2009; CRNBC, n.d., 2017) that targeted reporting of colleagues, but did not offer meaningful information about prevention of or possible contributors to nurses' problems with substance use. They instead addressed the issue by framing nurses as conduits of potential threats to patients—"nursing is demanding work, in which impairment could result in direct and significant risk of injury to patients" (CRNBC, n.d., p. 1)—and directed their focus toward urging nurses to police and report colleagues' impaired practice.

These educational deficits left our participants with no means of understanding or words to talk about their substance-use problems, other than the dominant individuated,



morally centred, othering ways. Their only other alternative was silence. This crucial gap in nurses' basic education needs to be addressed. Furthermore, our study uncovered two socially sanctioned practices that nurses did use to manage the stresses in their work lives—silence and alcohol. Our data showed that alcohol use was socially organized as both the verbal shorthand that nurses could use to voice their emotional distress arising from work and the authorized strategy to cope with it. This important new finding challenges the considerable weight afforded to the largely uncontested and taken-for-granted assumption in the literature (Ross, Berry, et al., 2018) that nurses' ready access to prescription drugs is the prime contributor to their problems with substance use. Indeed, one study found that an astonishing "one in 20 of the nurses indicated that their substance use had limited their commitment to patient care" (Kenna & Wood, 2004a, p. 114) and that the (mostly women) nurses' overall alcohol use was disproportionately high, compared to typical gendered patterns of alcohol use and that of other health care groups. This predominant over focus on nurses' access to drugs has cloaked awareness of a possibly more serious situation, the largely unexamined role of alcohol in nurses' management of their work-life stressors.

### **3.6 Conclusions & Recommendations**

Our study revealed how nurses' basic education and professional resources did not provide them with ways or words for understanding their substance-use problems, other than that of the dominant moralistic and individuated discourse. A lack of protective knowledge, coupled with a virtue-based professional identity offered them an illusion of immunity from substance-use problems. This created a perfect storm that left them vulnerable to insidious development of substance-use problems, without the awareness that this could happen to them, let alone be able to ask for help if it did. Our data also showed how nurses' gaining the knowledge and skills to self-advocate for their improved working conditions was connected with their recovery from substance-use problems.

Accordingly, we call for educational initiatives to both raise nurses' awareness of the moralistic, individuated discourses that they are a part of and provide them with factually-based undergraduate and ongoing education about nurses' substance-use problems. We also recommend capacity-building initiatives to equip nurses with the knowledge and skills to advocate for physically and psychologically safe workplaces. We wish to make clear that these recommendations are in themselves insufficient. To imply

so would be perpetuating the stance that we challenge and continue to place the responsibility for the issue back on the individual nurses. Rather, we do so in keeping with the emancipatory intention of IE. This is to increase people's awareness of "the socially organized powers in which their/our lives are embedded and to which their/our activities contribute" (Smith, 1999, p. 8) and promote their empowerment with the knowledge enabling them to effect institutional change.

We assert that the role of the nurses' employing institutions in establishing the working conditions wherein nurses develop substance and stress-related health problems is conspicuously absent in the discourse and must be brought to the forefront of this issue. We uncovered dominant discourses in nursing regulation, management, and research that subordinated and silenced nurses' experiences of work stress. Nurses who deploy their knowledge of substances to silently manage these stressors are discursively organized as deviant individuals and held up as dangers to the public. We contend that a more critical perspective and empathetic approach must be taken toward nurses' substance-use problems and that organizational cultures and management approaches need to shift in ways that better support nurses.

Our data also added an important new finding—that alcohol use was the only coping strategy that nurses spoke of as being an acceptable, and even openly encouraged, way to manage emotional distress. We put forward that this as-yet under-researched finding of the role of alcohol in nurses' management of their work stressors merits more intense scholarly scrutiny.

Shining the light on these dominant discourses found in nurses' talk enables nurses to challenge, disrupt, and ultimately transform them in ways that better serve the interests of all involved—nurses and their families, health care organizations, as well as patients. It is our sincere hope that our discoveries contribute to that change.

## Chapter 4

# The Business of Managing Nurses' Recovery from Substance-Use Problems

### 4.1 Abstract

A chief goal of the widely used alternative-to-discipline programs for nurses who have substance-use problems is to support nurses through a recovery process. These recovery programs have not been adequately scrutinized. We employed institutional ethnography to investigate nurses' experiences of one such program in a Canadian province. Our analysis revealed (a) an acritical acceptance of a standardized program that was not based on current norms of practice; (b) that nurses were not afforded the same rights to quality and ethical health care as other citizens; (c) privileging of "expert" physicians' knowledge while subordinating nurses' knowledge; and (d) a program rife with conflicts of interest, power imbalances, and prevailing corporate interests. Conclusions were that regulatory bodies cannot rely on the taken-for-granted standardized treatment model. Nurses need to be offered choice of a variety of treatment alternatives based on current, scientific evidence. Nurses' knowledge, expertise, and voices must be empowered in the decision-making processes of these programs.

### 4.2 Introduction

The professional regulatory programs that manage nurses who have problems with substance use<sup>15</sup> are known and experienced in different and contradictory ways. A case study on a regulatory body's (RB's) website depicts a nurse's involvement with its program for nurses who have problems with substance use. We can see the discursive way of knowing presented in the official account that describes this nurse's experience:

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<sup>15</sup> We are using the terms substance use practices, substance-use problems, or problems with substance use as our referent to our topic of inquiry. Our intent in doing so is to be descriptive and not utilize or draw from any preexisting theory, concept, or category.

Kelsey was diagnosed with substance use disorder by a medical expert. Her recovery plan included treatment, connecting with a local recovery community, and enrolling in a medical monitoring program. After treatment, Kelsey was reassessed by the medical expert, who reports that Kelsey is in early recovery. She thinks Kelsey is fit to return to work with medical monitoring and supports in the workplace. (College of Registered Nurses of British Columbia, n.d., para. 2–3)

Yet, we heard a very different version from the actual people, like Diane, who interacted with and experienced the discourse in action. Diane, a nurse participant in our study, recounts her experience of *The Program*:<sup>16</sup>

The way I experienced [the whole process in The Program was abusive] ... being forced to side with the abuser or lose my ability to practice my profession. The degree of intimidation I experienced is really difficult to quantify or explain ... the constant threat that any transgression, accidental or on purpose, would be swiftly and severely dealt with.... I had nightmares constantly, and even hearing about participating in this study nearly gave me a panic attack ... the nurse must subjugate herself to their version of reality – any dissent is viewed as evidence of instability ... and there is no way out except total submission.... I will say that I am healthy despite the treatment, not because of it.

In this inquiry, we set out to probe the conflicting ways of knowing the issue, with the aim of understanding how the experiences of nurses like Diane had been organized to occur as they had and in ways so radically different from the discursive accounts.

### 4.3 Background

Alternative-to-discipline (ATD) programs are the current preferred model of managing nurses declared to have substance-use problems (National Council of State Boards of Nursing [NCSBN], 2011). ATD programs were developed in the 1980s in response to the historically punitive or disciplinary programs that entailed professional disciplinary measures, dismissal from jobs, public disclosure, and often criminal prosecution (Heise, 2003; Monroe, 2009). These actions were said to be in service of an overarching goal of protecting the public from impaired nursing practice (Kunyk & Austin, 2011); concern for the nurses' health or welfare was not a policy consideration. Heise (2003) colloquially characterized the punitive approach by using the term "throwaway

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<sup>16</sup> For brevity, we have used the italicized term *The Program* to reference the constellation of processes and subprocesses in the provincial program for nurses with substance use problems that we are investigating.

nurse syndrome” (p. 6), as the nurses were neither supported in their recovery nor returned to work. In fear of the devastating consequences of these programs, nurses were very reluctant to seek help or remove themselves from practice, often resulting in the worsening of their own health and prolonged practicing while impaired (Kunyk & Austin, 2011). In contrast, the primary imperatives of ATD programs include both public protection and supporting nurses as they navigate a treatment and recovery process ultimately enabling them to return to practice (Monroe et al., 2008). ATD is widely touted as “a successful alternative to traditional disciplinary approaches” (NCSBN, 2011, p. 38) and regarded as an appropriate regulatory solution to nurses’ substance-use problems (Brown, Trinkoff, Christen, & Dole, 2002; Monroe et al., 2011; Trossman, 2003). Data offer compelling reasons to conclude that ATD programs are preferable to the punitive ones, as ATDs have consistently higher program completion rates and greater voluntary uptake than punitive programs (Kunyk & Austin, 2011; Monroe et al., 2011; NCSBN, 2011; Smith et al., 2013).

ATD programs typically involved nurses’ voluntary participation, confidentiality, temporary nondisciplinary suspension of licensure until the nurse regained their health, and the supervision of a mandated treatment and recovery program (Monroe et al., 2011). Each state in the United States (Dunn, 2005) and province or territory in Canada (Canadian Nurses Association [CNA], n.d.) is governed by its own RB. These RBs have the authority to regulate the nurses within their own jurisdiction, and each has its own programs to address nurses’ substance-use problems. In 2011, the lead nursing RB in the United States, the NCSBN, issued a report that helped to standardize ATD programs by establishing clear goals and approaches that should be taken by RBs (Darbro, 2011).

An ATD program has numerous regulatory components within its overall structure, including its standardized treatment and recovery regime (NCSBN, 2011). It is this component of the ATD program that we turned our attention to.<sup>17</sup> The NCSBN’s (2011) recommended treatment and recovery program begins with a “comprehensive clinical assessment” (p. 97). This is followed by a mandatory regime that includes biological monitoring of abstinence compliance and a treatment plan that

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<sup>17</sup> We will be researching the ATD goal of protecting the public in a forthcoming article.

must incorporate the following recovery program components and philosophies:

- a. use a 12-step recovery model with 12-step group participation as a treatment expectation or comparable substitute
- b. advocate total abstinence from mood- or mind-altering drugs including alcohol
- c. offer educational components (addresses at a minimum the disease concepts, recovery process and recovery-oriented lifestyle changes)
- d. use a variety of therapeutic modalities to meet the treatment needs of clients (may include group therapy, individual counseling, lectures, family or couples therapy, written materials and written assignments)
- e. use treatment plans (reflects client-specific assessment recommendations). (NCSBN, 2011, p. 31)

Many RBs incorporated the NCSBN's (2011) standardized guidelines when they established their ATD programs' treatment and recovery regimes (Darbro, 2011; Moses, 2017; Smith et al., 2013), yet the foundational premises, structure, and overall effectiveness of this regime have not been critically scrutinized (Astrab Fogger & McGuinness, 2009; Monroe et al., 2013; NCSBN, 2011). The NCSBN (2011) itself states that there "have not been any verified best practice standards for ... [ATD recovery] programs for either nurses or physicians even though there have been requests from many sources" (p. 20). Data are available supporting the use of the Physicians' Health Program (PHP) treatment frameworks (DuPont et al., 2009), which has the same treatment and recovery components as the NCSBN model. A contradictory perspective exists, however, in that a systematic literature analysis determined that PHPs were unsupported by scientific evidence, as the extant evaluative studies were based upon "uncontrolled, descriptive studies of program participants" (Urbanoski, 2014, p. 6) that were of generally poor methodological quality. Furthermore, our own literature review did not yield any studies that compared the NCSBN or PHP treatment regimes to other treatment modalities, although other valid treatment approaches exist and are widely used in the provision of treatment to the general public.

Debates in nursing have remained fixed on the importance of punitive versus nonpunitive approaches to manage nurses' substance-use problems, while leaders in substance-use treatment are concerned with the use of evidence in treatment approaches. A "troubling disconnect" (Chapnick, 2014, p. 6) currently exists between two very different treatment models for substance-use problems. On one hand, a more traditional model has practitioners prescribing abstinence, 12-step facilitation (TSF), and

compliance monitoring as treatment interventions (viz., NCSBN or PHP programs; Csiernik, Rowe, & Watkin, 2017). On the other hand, public health-based models incorporate contemporary norms of clinical practice widely used with the general public (Csiernik, 2016). Practitioners who adopt public health approaches regard people who have substance-use problems as a decidedly heterogeneous group and endorse their active collaboration with their care provider to create individualized recovery plans by choosing from a variety of empirically supported treatment alternatives (Csiernik, 2016). These treatments may include pharmacotherapies, harm reduction, client-centred counselling options, recovery-oriented approaches, motivational interviewing, cognitive-behavioural therapies, in addition to or instead of abstinence, monitoring, and TSF or any combination of these (Csiernik, 2016; Urbanoski, 2014; World Health Organization, 2014).

Our inquiry shifts the focus in the discussions on managing nurses' substance-use problems away from the punitive versus nonpunitive debates to consider ATD programs within the wider landscape of substance-use treatment and recovery programs. As the contrast of Kelsey's and Diane's experiences at the start of this paper highlight, we were concerned with contradictory representations of *The Program* (one generated through an official institutional account and the other from nurses' experiential knowledge). Given that we wanted to understand these disparate descriptions, we researched the organization and practices of one such standardized program in a Canadian province (i.e., *The Program*) that had adopted the widely applied NCSBN treatment and recovery framework. As a program administrator for *The Program* told us, their RB had originally followed the NCSBN's model in creating its program: "It was a new program. It was cutting edge. It came out of the work of [a particular employee with the RB] who ... did some research with NCSBN and that was what formed the basis of [The Program]."

We employed institutional ethnography (IE), a mode of inquiry that offers a critical, emancipatory approach to knowledge generation and research (Smith, 2005), to explore these contradictory ways of knowing. Our overarching goal of this research was to investigate how one RB organized its treatment and recovery regime for nurses' substance-use problems (*The Program*) and how this process, in turn, coordinated the experiences of the nurses therein. To accomplish this end, we sought to (a) describe the experiences of nurses participating in *The Program*; (b) identify the institutional practices

that organized *The Program*; (c) describe, analyze, and map or *explicate* how the nurses' experiences within *The Program* were coordinated and managed as they were; and (d) uncover the power relations within *The Program*. In what follows, we outline the IE approach we took and explicate how the experiences of nurses like Diane were managed through *The Program*.

## **4.4 Method of Inquiry**

### **4.4.1 Institutional Ethnography**

An IE inquiry is anchored in the everyday experiences of groups of people who are located within a particular social positioning, or *standpoint*, in an institution (Smith, 2005). We began from the standpoint of nurses like Diane, whose problems with substance use were being managed through workplace and regulatory arrangements. The participants' descriptions of their everyday experiences, their knowledge of institutional processes, and material in the institutional texts used in *The Program* served as the ethnographic data grounding this investigation. We used those data to map how the nurses' experiences were linked to and organized for purposes external to them (Smith, 2005).

We obtained ethical approval for the project from Simon Fraser University, located in Burnaby, British Columbia, Canada, and from other organizations involved. We also gathered written, informed consents from all individual participants. In the research design, recruitment of participants, and all aspects of data management, we attended to principles that respected consent and conflict of interest. Pseudonyms are used in all presentations of data and descriptions of organizations to protect the participants involved and to stress the analytic interest in the social relations, institutional arrangements, and practices of power for nurses and others, rather than on the particular people or their behaviours.

### **4.4.2 Participants**

Our inclusion criteria established *primary participants* as registered nurses (RNs) in one Canadian province who had been engaged with *The Program* and were employed in direct patient care areas. Primary participants were 11 RNs who worked in various



hospitals throughout the province and responded to our study invitation, which was posted in the e-newsletter of one of the province's nursing organizations. One registered psychiatric nurse (RPN) volunteered as a secondary participant after being informed of the study by a nurse colleague. Even though a separate provincial RB governs RPNs' practices, these nurses were entered into the same treatment regime as the RNs and could provide us with experiential knowledge of *The Program*.

We interviewed three other secondary participants with the aim of locating and tracing links to institutional texts and processes (Smith, 2005). All three were lawyers by profession who worked in administrative roles in *The Program* and were considered to have expert knowledge of it. One was an administrator with the RB, one with the nurses' union, and one worked in a like program for other health care professionals (HCPs). The lead researcher purposively recruited these individuals by direct email invitation.

#### **4.4.3 Data Collection and Analysis**

The lead researcher conducted one-to-one audiotaped, semistructured interviews in person and via Skype (Microsoft, n.d.) with primary and secondary participants in 2016 and 2017. Participants were given the opportunity to review transcripts for accuracy and correct, add, or clarify data. In IE research, texts (such as manuals, forms, reports, etc.) are viewed as the mediators of the dominant institutional ideologies that coordinate people's activities, or "ruling relations" (Smith, 2005, p. 5) in IE terminology (see also Campbell & Gregor, 2002). Accordingly, we retrieved and analyzed relevant institutional texts that were linked to peoples' activities in *The Program*.

The lead researcher read the interview transcripts and texts and made manual notations on them to identify the following: the actors who were engaged with the texts and how those texts coordinated the individuals' day-to-day actions, the institutional processes in *The Program* that involved the nurses and coordinated their activities, dominant ideologies within the texts, and evidence of these ideologies in participants' actions. We were also particularly attentive to dissonances that occurred between participants' knowledge and official textual accounts. This directed us to where, how, and in whose interests' people's experiences and knowledge were being privileged or subordinated (Rankin, 2017b; Smith, 2005). We mapped the data from the standpoint of

the individual nurse outward to the institutional realm, with the traditional IE aim of “show[ing] what is happening, how it is happening, and why it is consequential” (Rankin, 2017b, p. 9). Mapping is an analytic strategy typically employed in IE by means of diagrams, or (in our case) with words, to reveal how the dominant institutional ideologies coordinate what the local actors (i.e., nurses in *The Program*) do.

## 4.5 Findings

*The Program* consisted of a vast network of institutional processes designed to manage the professional practices of nurses who came to their attention because of substance-use-related problems. This network involved the nurses’ RB, union, and employers, as well as the individual nurses. Some processes were specific to one or another of the organizations and some involved all three. The scope of our IE inquiry concentrated on processes that connected the nurses with their RB. What follows describes and maps the nurses’ journey through these processes.

### 4.5.1 The Program Part I – Initial Assessment by an Independent Medical Examiner

Nurses’ experiences in *The Program* began with their assignment to an independent medical examiner (IME). The IME was a physician engaged through his or her private practice and paid \$2,500 Canadian dollars (CAD) or more by the nurses’ labour union to make an initial assessment, diagnosis, and recommendations for a treatment plan that a nurse was obligated to follow if the nurse intended to return to practice. In Canada, the services of physicians are covered through the public-pay system, and the use of these public services is the norm. Some physicians have private practices that operate as for-profit businesses and are remunerated outside of the public system. No rationale was provided to us why this protocol in *The Program* bypassed the publicly funded medical insurance system in favour of making mandatory the private, for-profit services of physicians.

The RB only recognized a small, select group of physicians as IMEs in *The Program*, deeming them to be the “experts” and “specialists” in addiction medicine. The RB did not choose to recognize other physicians with the same credentials or other qualified professionals, such as psychiatrists, psychologists, or nurse practitioners,

although a clear rationale was not offered for this designation. Some nurse participants, like Harvey, reported being told that the RB would not consider assessments from other physicians:

You can go out and find another physician to get a second opinion, but you're going to have to pay \$2,500 of your own money, and we can't really guarantee that we'll accept his opinion.... We have five or six other physicians who are the only physicians that you are allowed to see to get an opinion and they also make the exact same recommendations as the physician that you saw.

Several study participants expressed serious misgivings about the RB according to these IMEs' "specialist" status, citing that The Royal College of Physicians and Surgeons of Canada (n.d.) confers no specialty or subspecialty in addiction medicine. When a program administrator, Candace, was asked about this, she responded,

They're not "specialists" in the sense of they don't have a "fellow" of whatever, but their work is in the area of addiction medicine and so they have.... There's a – I don't know if it's a society or it's an organization of docs that do this work in Canada.

Nurses in *The Program* did not have a choice in selecting who their assessing and/or treating HCP would be. This was unlike the RB's management of nurses who had health problems other than substance use that could impair their practices. Those nurses were permitted to choose, or at very least, collaborate with the RB to choose, an appropriate assessing and treating HCP. In those cases, assignment of an IME was considered a last resort when the RB had exceptional concerns with their assessment or proposed treatment plan. The reason that the RB gave to support the assignment of an IME in *The Program* was that they had established that the assessor should be impartial and not directly involved in the nurses' treatments. As Candace, an administrator, explained,

It's whether or not that person is independent. The idea behind an "independent" medical evaluation is that the person doing the evaluation—the doctor doing the evaluation—is not your treating physician. They're someone that their sole purpose is to do an evaluation.

The RB did not provide the reasons they believed it necessary for nurses in *The Program* to have separate assessing and treating HCPs, or why they were subject to this requirement that differed from nurses who had other health conditions.

Despite the stated need for separate roles, nurse participants reported what could be considered dual relationships with their IMEs. For instance, several participants expressed serious concerns about their IMEs holding financial interests in the private for-profit monitoring companies that they were mandated to utilize. As well, the assessing IMEs were also engaged to perform reassessments (costing \$1,250 CAD or more) at various junctures throughout *The Program*: following the residential program to establish the conditions for return to work, in cases of relapse, and to determine if and when the nurse may terminate his or her contract. Due to these ongoing relationships, some nurses, like Harvey, questioned the actual separation of the IME's assessing and treating roles:

[We] did in fact have an ongoing physician-patient relationship. I saw him multiple times, and he assessed whether I was following the recommendations and followed up with my employer etc. He ordered blood and urine tests, made referrals, diagnosed me, made treatment recommendations.... If you look at the [Physicians'] College Standard for IMEs, they aren't even supposed to provide treatment recommendations—just a diagnosis.

Indeed, the province's College of Physicians and Surgeons (2013) guidelines do state that the purpose of the IME "is to determine the health status and functional status at the time of the examination ... not for discussion of treatment" (p. 1), and IMEs are directed to confirm with the patient that "treatment advice will not be given" (p. 1) in the IME process.

Nurses reported other conflicted and hierarchical relationships inherent in the arrangements between them and their IMEs. For instance, some of the IMEs in *The Program* openly described how they were TSF participants themselves because of their own substance-use problems. Some led Caduceus groups, which are community-based peer-led support groups for HCPs who have substance-use problems. Although not contractually required to attend specific groups, some nurses reported being "encouraged" by their IMEs to attend the groups that their IMEs led. Nurses, like Diane, felt disempowered and coerced (in her words, "forced"), fearing that not complying could be negatively reflected in the IME's assessment reports and in the peer support sessions themselves. As Diane recounted,

At one point, I was forced to attend Caduceus groups run by [my IME and his business partner]. These groups consisted of these 2 male physicians

bragging to a room of female nurses about their former drug use while practicing, and then telling us how to recover.... [This] is a perversion of peer support.

Diane's comments illuminate two underlying issues. The first is that fundamental principles of peer support groups establish that they be voluntary and that they necessarily involve a fellowship between equals (Csiernik & Jordanov, 2017). As Diane conveys in her comment about a "perversion of peer support," a person feeling intimidated into attending a group led by someone who has a great deal of power over them indicates a situation that is neither. Second, Diane's subsequent recommendation alludes to the relationship between the nurse in *The Program* and the IME replicating an uncomfortable historical gendered and hierarchical doctor–nurse relation (Wall, 2010): "I also think that the nurse–doctor power dynamic is an important one, so perhaps using addictions expert NPs [nurse practitioners] would be an option."

Diane offers the suggestion, as did some other nurses, that specialized nurse practitioners could be utilized as IMEs in *The Program*. The nurses who endorsed this possibility felt that it was reasonable because the RBs had already deemed the quality of care that nurse practitioners provide acceptable for the public. They also felt that nurses would have a higher degree of comfort if the hierarchical power relations were equalized.

#### **4.5.2 The Program Part 2 – Standardized Treatment Regimes**

The IMEs formulated an official diagnosis from their assessment of the nurses, and if they were deemed to have a substance-use disorder (SUD) they were offered entry into *The Program*. SUD is a category within *The Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association [APA], 2013), a specific theoretical organization of knowledge about people's problems with mental health (APA, n.d.). The DSM (APA, 2013) takes a biomedical, symptom-based approach to classifying mental health problems (Deacon, 2013). It is widely accepted in North America and many other areas as the "authoritative guide to the diagnosis of mental disorders" (APA, n.d., para. 1).

The IMEs then compiled their assessments into reports that included the diagnoses, treatment recommendations, and determinations of if, when, and under what conditions the nurses should be allowed to practice. Although the RB collected and

utilized reports from the nurses' employers and monitoring services to assist their adjudication of the nurses' cases, the IMEs' reports were the primary texts the RB used in establishing their contracts with the nurses. The RB inserted the IMEs' treatment recommendations into the contracts that they offered nurses to regain and/or retain their licenses to practice nursing.

Among other stipulations, these contracts detailed a mandatory, standardized regime that the nurses were required to adhere to, which was organized as treatment in *The Program*. Both participants and key informants reported that the group of IMEs who were utilized in *The Program* consistently recommended the following regime: attendance at community-based TSF meetings and Caduceus groups (generally a minimum of 2–3 meetings/week); securing a TSF peer sponsor; completion of a specific residential program (which was also TSF based); total abstinence from all psychoactive substances (including those that had not been problematic for the individual, except nicotine and caffeine), as confirmed by regular, random biological testing; and enrolment in a monitoring program. The program administrator informants all stated that they had not seen any of the IMEs deviate from these recommendations. These recommendations were also consistent with the NCSBN (2011) guidelines discussed prior.

Nurses in *The Program* were required to attend one of two (TSF-based) designated private, for-profit residential facilities. These cost approximately \$20,000 CAD for the 30- to 45-day programs and were paid for by the nurses' labour union. As with the physician's services noted prior, residential treatment services for substance-use problems are paid for under the publicly funded health care system in Canada. Private-pay, for-profit treatment facilities are also available, which are not remunerated by the public-pay system. Nurse participants reported that they were not permitted to attend publicly funded treatment facilities when they had requested to do so instead. The rationale provided for this decision was that these two programs were specifically for HCPs and targeted their treatment needs, whereas the public ones were not. Yet, nurse participants reported that HCPs comprised a small minority of the clients in the residential centre and that the specific "treatments" offered to them consisted of only 2 hours per week of TSF groups for HCPs.

The cornerstone of *The Program's* treatment regime was mandatory attendance at TSF-based activities. Some nurses readily embraced the TSF approach and found it very helpful, but others clearly did not. Regardless, all of the nurses were not only required to attend the community TSF meetings and the residential program, they were also expected to organize their personal beliefs in accordance with this perspective and activate the philosophy as a way of life. Demonstrating said beliefs was viewed as engagement in treatment, which was utilized as a metric of their recovery status, and ultimately of their fitness to practice nursing. It was necessary that the nurses demonstrated this "treatment engagement" to the residential facility staff, because they compiled a report on the nurse's progress that the IMEs considered in their assessments of the nurses' readiness to return to work. The people employed as monitors at the monitoring company also asked specific questions about the nurses' application of the TSF philosophy to their daily lives and documented nurses' progress in quarterly reports for the RB's review. The nurses especially needed to demonstrate their engagement directly to the IMEs. Not doing so could potentially result in the IME recommending a delay of their return to work, increasing the frequency of their monitoring or length of contract, or even considering it as a breach of their contractual requirements.

Several of our participants disagreed with the moral and religious basis of the TSF activities and felt that their coerced participation was tantamount to forced religious indoctrination under the guise of medical treatment. Harvey and some other participants fundamentally objected to the TSF philosophy, whereby people with substance-use problems were categorized as spiritually and characterologically flawed individuals who are necessarily in denial of their addictions. Several participants expressed resentment that they were required to espouse and adhere to the religious imperatives in "the 12 steps," TSF's behavioural prescriptions and proscriptions. These steps included relinquishing their personal agency to a higher power that ostensibly exercised control over and could be called upon to bring about their recovery by correcting their said defective moral characters. Participants maintained that their RB had no right to mandate or police their private thoughts and spiritual beliefs and doing so infringed on

their basic right to religious freedom.<sup>18</sup> Harvey recalled his experiences with TSF groups in the residential centre:

All of a sudden people are bombarding you and getting in your face and saying, "Have you accepted Step 1 of the 12 steps? Do you realize that you're powerless?" ... We had to do an exercise where we had to identify which character defects, including the 7 deadly sins, contributed to our substance use.

Administrators reported to us that if nurses objected to the religious nature of the TSF programs or did not find them helpful, they were allowed to attend alternative recognized secular lay support groups (such as SMART or LifeRing) or see a qualified individual counsellor instead. However, some participants told us otherwise; they had been presented with the option of either accepting the TSF regime as ordered or being seen as breaching their contract. Nurses' attendance at other types of TSF groups (i.e., Alcoholics Anonymous, Narcotics Anonymous, among others) were considered acceptable for *The Program* requirements, so long as they were TSF-based. Any other counselling modalities the nurses elected to obtain were considered extraneous to the obligatory TSF activities in their contracts.

Others reported being told in the groups, at the residential facility, and by their IMEs that TSF does not fail, the *individual fails* at correctly embracing or applying the 12 Steps. Harvey recounted this experience in the residential facility:

[We were told that if the 12 Steps aren't] working for you, it's not the fault of the 12 steps; it's the fault of yourself and your flawed character and your character defects and that you're not working the program properly.

If the imposed regime was ineffective in assisting nurses to attain or maintain abstinence, the approach taken to correct "their failure" was that the IME would order compulsory attendance at additional TSF-based groups, residential activities, or out-patient services (also private-pay, although such public services exist), and admonish those nurses to redouble their efforts at applying the steps. If those nurses were still not being effectively assisted, they risked being designated "treatment resistant," which could result in their expulsion from *The Program*. If they exited *The Program*, they would

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<sup>18</sup> A nurse currently has a case before a Human Rights Tribunal and is contending the imposition of religious material and activities of the TSF approach in *The Program* (Schaeffer, 2016).



be subject to a disciplinary inquiry by the RB that could potentially jeopardize their licenses and jobs. Other nurses had objections to TSF based upon their professional (and in some cases *expert* professional) judgments that it is a lay support organization and not actual treatment, peer sponsors are not qualified therapists, and its purported effectiveness is not supported by current scientific findings. Regardless of their reasoning, those nurses who did protest reported that their dissent was categorized as “denial” of their substance-use problem and further evidence of their lack of necessary engagement in treatment.

Several participants also stated that they were told in their TSF groups and by their IMEs that the use of licit pharmacotherapies to treat substance-use problems (such as opioid agonist therapy [OAT]) was viewed as a reliance on “crutches” that would impair their actual recovery. The RB did not have any specific policies in place that prohibited nurses from utilizing such treatments, yet the IMEs did not recommend these strategies for any of our participants, nor were they permitted within the nurses’ contractual monitoring restrictions. This was particularly distressing to nurses who were offered no medical relief from the strong urges to use the drugs they were continuously exposed to in their day-to-day work lives. Pietra had been in *The Program*, abstinent for several years, and still suffered from intense cravings. She was unaware of pharmaceutical treatment options that might have assisted her:

P: I would hope that one day they invent something that blocks those [receptors], so I don’t always have to be so scared and know that I can go and be a nurse [and work with these drugs] without always having to worry in that sense.

Lead Researcher: Has that ever been presented as an option to you ... medications?

P: Sorry? No...

Lead Researcher: Because there are such medications...

P: Oh, I wasn’t aware of that.

Diane expressed her serious safety concerns about this situation:

Depriving a nurse of ... [OAT] can be fatal. In fact, the current guidelines are to not detox an opioid-dependent person because the rates of relapse are so high, and the risk of [overdose] after a period of abstinence is greatly increased due to loss of tolerance.

The premium placed on abstinence in the regime extended to *all* drugs, even those that had been legitimately prescribed by their personal physicians for preexisting mental health conditions. Some participants, like Diane, reported that their IMEs or physicians in the residential centres had encouraged them to or even mandated that they discontinue their previous medications, over their and their personal physicians' protests:

[My IME] told me that if I work the steps hard enough I could probably come off my bipolar medication.... When my psychiatrist tried to advocate she was ignored, despite knowing me for years and being a specialist in [the areas of women and HCPs] with mood disorders.... She was told what she could or could not prescribe.

### **4.5.3 The Program Part 3 – Mandatory Monitoring**

Nurses were required to undergo mandatory biological testing to confirm compliance with abstinence requirements for a minimum of 2–3 years, and some for much longer. They were assigned to specific private, for-profit monitoring companies that cost them between \$400–1,000 CDN per month. Although a clear rationale was not provided, the RB did not consider the laboratories in the publicly funded system adequate for this task. The nurses' union paid for the first year of monitoring, and although some employers paid subsequent costs, most of the nurses were required to pay out of pocket for the remainder of their contracts. If they wanted to change to a different monitoring company, they were required to go through an appeal process to have the request approved by the RB.

Many participants voiced their perceptions of conflicts of interest, whereby several of the IMEs in *The Program* held financial interests in the private, for-profit monitoring companies that the nurses were required to utilize. Program administrators were aware of this situation but took the position that it was up to the physicians to self-regulate any potential conflicts of interest. When we asked Candace, an administrator, about the concerns, she responded,

Candace: Yeah. So, we've had discussions with some of the physicians and they've put firewalls up between their practice as independent medical evaluators and ...

Lead Researcher: What are the firewalls?

Candace: You'd have to talk to one of the doctors.... That is not something we can control.

Some of our nurse participants reported experiences that raised serious questions about the effectiveness of that self-regulation. As Diane recounted,

I was seen by [IME].... He got [\$3,000 CAD] ... to do his assessment of me. When I returned from treatment, he assessed me again, [\$1,000 CAD] for one hour, and set up my ... [return to work] contract, which included mandatory enrolment in [Monitoring Co.], which he is the medical director and co-owner of. That enrolment was \$650 [CDN per] month for 3 years. The first year was paid by [the union], the second 2 years was out of [my] pocket.... They make a lot of money off nurses who are in their monitoring programs.... It's a massive conflict of interest, and somehow no one addresses it.

If a nurse was not able to maintain abstinence, the IMEs would typically order an increased frequency of the biological testing (referred to in *The Program* as “enhanced screening”), which was framed as a therapeutic intervention. Participants also reported encountering great inconsistency and lack of clarity around the criteria used in releasing them from their contracts. Molly recalled,

After the 5.5 years, they wanted me to go another year.... I said, “This is ridiculous; I've never relapsed.” ... I asked the [RB] if I could challenge the other year of monitoring and they said, “Well, then you have to go back to the addiction doctor.” So, I went back.... He said, “Okay, you don't need any more monitoring.” ... So [he was paid \$1,175 CDN] for, you know, a 45-minute visit for him to get the note to say that I don't have to go anymore.

Nurses were required to continue to participate in and pay for their monitoring until such times as their contracts were terminated. The termination of the nurse's contract with the RB was ultimately the decision of their Inquiry Committee (IC), their statutory committee delegated the organizational authority to adjudicate the cases of nurses involved in *The Program*. Nevertheless, the IC typically utilized the IMEs' recommendations as a central criterion in their adjudication.

#### **4.5.4 Managing Power Relationships in *The Program***

Several participants felt that their basic rights to high-quality and ethically principled health care were being denied in *The Program*, because they were unable to choose their own care providers and treatments and had religious-based activities imposed upon them. As Mark and Diane articulated,

The first thing is this ... [all of this] needs to be client-centred and client-directed and client-driven, just like anybody else that has an illness.... It's very fear-based, right?... It's against our human rights.... I should have choice about how this is going to go. (Mark)

Why are we not demanding that nurses be treated with current best-practice guidelines?... I think that, at a bare minimum, [the RB] needs to align nurses' treatment with current evidenced-based best practices.... The entire thing is not trauma informed. (Diane)

Participants like Mark and Diane, among others, cited several professional and ethical standards and established norms of clinical practice that they were expected to uphold in their own nursing practices, but felt were being contravened in *The Program*. These included the following standards and norms:

- the provincial RB's professional nursing care standards (College of Registered Nurses of British Columbia, 2012) and the national professional organization's "ethical standards" (CNA, 2017, p. 43) for patient-focused care, collaborative care, "autonomy" (p. 31) in health care choices, receipt of care in accordance with one's own religious beliefs, and the requirement for nurses to base their practices on current scientific evidence (i.e., knowledge-based practice);
- principles of trauma-informed practice (such as client control, choice, empowerment, and patients' trust in HCPs) that the nurses' employers expected them to adhere to (British Columbia Provincial Mental Health and Substance Use Planning Council, 2013); and
- harm-reduction interventions, such as OAT, which are explicitly endorsed in nurses' employers' practice treatment guidelines (Vancouver Coastal Health, 2015) and the national nurses' professional association's (CNA, 2012) position statement.

When nurses voiced protest with what they saw as a denial of their rights, or objected to any aspect of the mandatory regime, they were informed that *The Program* was voluntary. They were given the choice to comply as stipulated or be exited from *The Program*. As Candace, a program administrator, explained, "It's a consensual resolution agreement, so you can agree to it or not. If you don't agree to it, they have the ability to send the matter to a hearing."

Harlan, also an administrator, took a dissimilar view: "They're called agreements but ... that's not what these are: these are imposed coercively.... There are consequences if you don't sign one of these. You can't return to work; ... there's not necessarily voluntary consent."

The IMEs wielded an extraordinary degree of power over the nurses' careers and futures because their reports and recommendations were central to the IC's adjudications of their cases. Diane expressed how powerless she felt in this situation: "I was in a new job, and I didn't want to be outed, so I would have done just about anything."

Other participants, like Harlan, voiced grave concerns about the nurses' vulnerability:

[The nurse] has everything to lose; they are 100% reliant on the physician for their livelihood, and they're alone in a room with them.... I would think that they would just be at risk of abuse, exploitation, whatever.... It's a very dangerous situation for people to be in.

Harvey also questioned what he viewed as a power imbalance in this situation:

[The IME] is definitely on the top, which is insane ... because he's just [supposed to be] making recommendations. My contract is with my employer and my union and my [RB], right? But they're removing themselves of any responsibility of this and saying that "here's an addiction doctor who's telling you what to do."

It did appear to many of the participants that the IME was "on top," but our mapping of power relationships from the data told us differently—it was the RB, and by proxy the IC, that managed the nurses' activities in *The Program*. Whereas the IC's members did afford the IMEs' reports primacy in their decision making, they selectively deferred to the IMEs' judgments. When we asked if the IC always followed the IMEs' recommendations, Candace, an administrator, informed us that they did so unless they did not appear to be stringent enough: "The [IC] could say, 'You know what? This person has relapsed a number of times.... We want more monitoring than what has been recommended by the doctor.' ... And they have the authority to do that."

The IC did not elect to use its discretion to override the IMEs' judgment if the nurse disagreed with their IMEs' treatment recommendations and requested alternate therapeutic approaches, however. Candace further explained what would occur if a nurse did so:

[Then they're] probably going to have some challenges with the [RB. The IC reviews the IMEs' reports for] ... the quality of the information ... and they're going to say, "Yes, this is sufficient for us," or "no it's not." ... [and we will follow] the advice of the physicians, so long as it makes sense to us

... [and is] clear and reasonable.... If we have concerns, we'll ask questions of those doctors.

Although the IC held the balance of decision-making power over the nurses' activities in *The Program*, its members were not required to have any professional clinical or scholarly knowledge about substance-use problems or their treatment. In describing the IC members' knowledge and qualifications, Candace told us, "They do not necessarily have to have any specialization in substance use/addictions, but that would be helpful."

We were unable to determine the specifics of what the IC would consider a sufficient or reasonable alternative treatment plan, or how they would make sense of the information without any level of expertise in the matter. The results of this lack of expertise can be seen in the example above, in which Candace explained how the IC might typically adjudicate the case of a nurse who was unable to maintain abstinence. Their typical response was described as increasing monitoring of the nurse's compliance to the existing (and obviously ineffective) regime, whereas a qualified clinician might instead have queried why the current approaches were not working and what other treatment alternatives had been or could be employed.

Diane summarized her overall assessment of *The Program's* arrangements in this way: "[The RB] will work with a handful of ... 'addictions physicians' who have no actual specialist credentials, and who are clearly in a conflict of interest [and] ... the [RB] eats it up, without referring to any evidence."

#### **4.5.5 Discussion: Treatment as Subordination**

Our analysis of the data revealed that in the absence of any meaningful critical scrutiny, the dominant ideologies of the standardized regime had become reified in *The Program*. This resulted in the "prevailing features of the system ... [being seen] as natural" instead of the ideologies that they were (Pence, 2001, p. 204), which rendered the failings of *The Program* invisible. In what follows, we explicate how nurses' interests were subjugated to those ideologies in *The Program*, namely by the redistribution of systemic flaws as shortcomings of the individual nurses, overriding the nurses' rights to autonomous choice and high-quality health care, abdication of nursing power and

obscuring misuses of power, and the corporatization of nurses' treatments and recoveries.

Smith (1987) observed that institutional practices of categorizing and standardizing the people within them enables those people to be managed in accordance with the institution's dominant ideologies. Nurses in *The Program* were managed in this way by the individuated and moralistic ideological discourses around nurses' substance-use problems that categorized their problems as moral deficiencies and standardized their treatment as characterological correction. These discourses not only mirrored the individuated perspectives of nurses' substance-use problems that dominated the scholarly nursing literature (Ross, Berry, et al., 2018), they could also be mapped to the textual guidance used in the creation of *The Program* (NCSBN, 2011) and to the TSF philosophy that was the cornerstone of its standardized treatment regime. For instance, in the NCSBN (2011) guidelines, substance-use problems were attributed malevolent anthropomorphized characteristics: "a cunning, baffling and powerful disease" (p. 5). The remedy endorsed for this so-called baffling malady entailed targeting what is seen as the nurses' cardinal characterological failing, their "denial," in order to secure their submission to the dominant ideology: "Denial is the chief characteristic of all addictive diseases.... Once in a treatment process the denial normally fades and the participant can begin the process of admitting and accepting" (NCSBN, 2011, p. 67).

Nurses' dissent or disobedience to *The Program's* standardized regime, and/or its failure to effectively assist the nurse, were redistributed as the fault of an unmotivated or resistive individual (who was labelled in denial, noncompliant, and/or treatment resistant). The standardization of nurses' recovery in these official accounts created an "ideological code," (Smith, 1993, p. 50), whereby compliance to the mandated regime had become *The Program's* proxy measurement of the nurse's fitness to practice nursing. This discursive representation of wellness that we saw afforded facticity in *The Program* was also prominent in the scholarly literature, in which benchmarks used to gauge nurses' recovery are actually synonyms for compliance with established regimes (i.e., program retention or completers; Monroe et al., 2008). However, mandated compliance with specific activities and voiced agreement with imposed ideologies cannot be considered accurate metrics of commitment to, or actual recovery from, substance-use problems (Urbanoski, 2010; Wild, 2006). Lack of

compliance with the imposed treatment regime could conceivably instead be due to the participant's lack of trust or belief in that regime, flaws in its underlying premises or structure, and/or poor quality of service provision. Emphasizing this point, Darbro (2005) found that nurses were less likely to complete their treatment programs if they saw no value in the peer support groups, were not permitted legitimate prescription medications, or felt victimized by a coercive treatment process. We acknowledge that a proportion of nurses with substance-use problems undoubtedly do benefit from these standardized arrangements. Nevertheless, this situation has allowed a new type of "throw-away nurse syndrome" (Heise, 2003, p. 6) to emerge, whereby those nurses for whom the extremely narrow range of treatment options are not effective will either avoid *The Program*, or it will fail them and name them as failures.

Nurses' participation in, and compliance with, the terms of *The Program* was portrayed as entirely voluntary. However, rejecting *The Program* was not an option if these nurses wished to maintain their licensure to practice nursing. This seriously called into question the voluntary nature of the contracts and the notion of full and freely given consent. Nurses in *The Program* were ultimately managed with fewer rights to autonomous treatment choices and optimal quality health care than other citizens and nurses who had different health issues. This lack of choice in *The Program* can be traced to the NCSBN's (2011) criteria for treatment and recovery programs that provide some frankly contradictory directions. Those criteria prescribe adherence to two specified modalities in the standardized regime, TSF and abstinence. Confusingly, they also indicate that nurses must be offered a variety of individualized and client-specific treatment choices. They did not shed light on how one might simultaneously accomplish both of these seemingly conflicting imperatives; however, we saw that *The Program* accomplished the former objectives, but not the latter. Several of the nurses' reported that the lack of choice of in their treatment regime had actually been detrimental to their actual recoveries, a finding that is also reflected in the literature (Horton-Deutsch et al., 2011).

For example, the premium placed on complete abstinence from all substances effectively ruled out important scientifically endorsed pharmaceutical treatments for many of the nurses in *The Program* because those interventions conflicted with the staunchly "prohibitionist mindset" (Csiernik et al., 2017, p. 29) of the standardized regime. This was seen most dramatically with the nurses who had become dependent



upon opioids and were not offered OATs, despite their wide use in public health care and the compelling data that the nurses might well benefit from them. These data included that OATs are recommended as a first-line intervention for opioid dependence (British Columbia Centre on Substance Use, 2017); they have demonstrated superior treatment efficacy over abstinence (British Columbia Coroners Service Death Review Panel [BCCSDRP], 2018), they reduce the risk of deaths from overdose in cases of relapse (BCCSDRP, 2018), and they have been shown to successfully treat HCPs without impairing their practices (Braquehais et al., 2015; Earley et al., 2017; Roth, Hogan, & Farren, 1997).

Nurses' choice of their primary treatment modality in *The Program* was also constrained, in that they were required to participate in TSF, the mainstay of its standardized regime. Although TSF has unarguably proven helpful for many people, a Cochrane Collaboration systematic review of the literature (Ferri, Amato, & Davoli, 2006) and others (McQuaid et al., 2017) concluded that its claims of its superiority over other treatment options and the practice of utilizing it to the exclusion of other interventions are unsupported. In addition, the American Society of Addiction Medicine (2010) did not consider peer-led support groups and lay "sponsors in self-help organizations ... to be providers of professional treatment" (p. 3). TSF is also a *voluntary* self-help organization and coerced attendance undermines "the fundamental principle of all forms of self-help ... choice: wanting to be there" (Csiernik & Jordanov, 2017, p. 171).

Given the disparate approaches in the treatment community and that "provision of addictions care requires unique knowledge and clinical expertise" (BCCSDRP, 2018, p. 24), we did not understand how the decision makers in *The Program* (i.e., the IC members) could carry out their functions without having a solid clinical and/or scholarly grounding in the treatment of substance-use problems. Even the RB itself considered nurses' substance-use problems to be so exceptional as to necessitate a special program to manage them. It was, therefore, difficult to imagine how the IC could adequately appraise the standardized treatment regime in whole or in part; adjudicate whether nurses' requests for alternative treatment plans were sufficient or reasonable; or even know what questions to ask to do so without an understanding of the historical contexts, merits, and shortcomings of the various treatment approaches.

The RB abdicated and outsourced a tremendous degree of power over the nurses in *The Program* to its chosen physicians, whose “power was exercised through enforced compliance” (Mykhalovskiy et al., 2004, p. 334) to their treatment regime ‘recommendations,’ whose knowledge was afforded great privilege by the IC, and who all appeared to hold the same treatment perspectives. This was so, despite the RB appearing to have very limited understanding, if any, about the specifics of their qualifications and credentials. Other undeniably qualified practitioners were excluded from care provider roles, including the nurses within the RB’s ranks who had specialized knowledge of substance-use problems. The IC members’ lack of expert knowledge also rendered them potentially susceptible to persuasive corporate marketing strategies. The standardized regime was organized in ways that created substantial and reliable revenue streams for a number of for-profit corporations, most notably of which were the IMEs’ private medical services and/or their own monitoring companies. Very real potential existed for this arrangement to incentivise conflicts of interest and insert corporate imperatives into the nurses’ treatment processes. Curiously, the public health care system was consistently bypassed in *The Program* without explanation, even though it offered like services that were considered quite adequate for the public.

Also very troubling was the RB’s inattention to the IMEs’ seemingly unchecked management of the nurses in *The Program*. The nurses’ professional futures were largely determined by their IMEs’ evaluations of them, yet nurses’ protests of their IMEs’ decisions were discursively categorized as substantiation of their denial or treatment resistance, however valid they may have been. This, coupled with the dual relationships with their IMEs that were often imposed on the nurses, left them exceedingly vulnerable to potentials for misuses of power. Given the purported importance placed by the RB on the separation of the assessing and treating physician’s roles in *The Program* and the apparent inconsistency with the guidelines set out by the IMEs’ own RB, it was especially perplexing that the dual relationships remained uncontested by the RB.

Nursing is a self-regulating profession (CNA, 2017), but the RB’s absenting of their own expertise and enthroning unchecked power to “expert” physicians appeared to seriously challenge that notion. The schism that exists in the treatment community between different approaches (Csiernik et al., 2017) was played out in *The Program* and the RB’s decision makers’ lack of specialized knowledge rendered them unequipped to critically appraise evidence before them. Wall (2010) observed, “Although nurses wish to

be autonomous subjects, they are actually caught up in a system that involves an endless reproduction of their gendered marginalization” (p. 156). The relinquishing of power and privilege to the physicians that we saw demonstrated at a nursing leadership level and their turning a blind eye to potential misuses of that power over the nurses they regulated served as a telling example of how that subjugation is perpetuated.

## 4.6 Conclusions and Recommendations

The focus in the literature on programs to address nurses’ problems with substance use has been steadily fixed on the discussion about ATD’s superiority to the punitive approaches, although that point has now been well established (Brown, Trinkoff, Christen, & Dole, 2002; Monroe et al., 2011; NCSBN, 2011; Trossman, 2003). Meanwhile, the actual treatment and recovery components of those ATD programs has remained unexamined from the lens of the broader and more current field of treatment for substance-use problems, as well as from the nurses’ experiential perspectives. The net result of this inattention is evident in the vastly different representations of these programs that we see in the quotes from Kelsey (College of Registered Nurses of British Columbia, n.d.) and Diane in our introduction—one a glowing fictionalized official account and the other, an actual one, painful, and even harrowing narrative.

The importance of nurses’ self-regulation needs to be emphasized. As such, RBs cannot rely on standardized protocols to ensure that their responsibilities to their members are being met. Their critical gaze needs to shift from the supposed “problem nurse” to their programs’ structure and implementation. The standardized programs do not allow, let alone emphasize interventions based on current public health approaches, instead they are entrenched in outdated understandings of substance-use problems as moral failings. Abrogation of the nurses’ basic rights to choose and to ethical, high-quality health care is wholly unsupportable. Nurses must be offered a choice of individualized treatment options based upon current scientific evidence. The accredited publicly funded treatment services already in existence and deemed appropriate for the public should be incorporated into *The Program*. Accepted service providers need to include other qualified practitioners of the nurse’s choice, including nurse practitioners, among others.

Building a treatment program on this taken-for-granted “traditional model” has created an abusive situation for nurses that advantaged those who profited while ostensibly providing service to those in need of treatment, care, and support so they can better care for others. Potential and actual furthering of corporate imperatives, power imbalances, dual relationships, and conflicts of interest were rife in *The Program*, but all inexplicably unchallenged and essentially enabled by the RB. We see the abdication of nurses’ professional self-determination in the outsourcing of their knowledge and power as a major flaw in *The Program*. We further assert that RBs need to draw from their numerous registrants’ current, specialized knowledge in the treatment of substance-use problems to serve in decision-making capacities and to facilitate the creation of policies and programs that effectively and ethically meet the original goal of ATD programs—supporting the nurse through a process of treatment and recovery.

## Chapter 5

### Concluding Thoughts

My doctoral research questions originated as a response to the apparent disjuncture of two disparate ways of knowing about nurses' problems with substance use: the official accounts in the scholarly and professional literature and nurses' own experiential knowledges. From that beginning point, I explicated how three aspects of this problematic were socially organized (recalling the diagram of The Small Nurse Hero as depicted in Appendix G). The first of these avenues was my literature review (presented in Chapter 2). In the second and third avenues, data were extracted from the overall study data collection (as outlined in Chapter 1) to research how ruling discourses in nurses' talk in their everyday worlds organized their substance-use practices (presented in Chapter 3) and how nurses' experiences were managed and organized in a regulatory program for nurses identified as having substance-use problems (presented in Chapter 4). This research produced important original knowledge on nurses' substance-use problems. In this concluding chapter, I highlight the key features of institutional organization discovered in Chapters 2, 3, and 4, outline the significance and novel contributions of my work, provide a plan for knowledge mobilization, and present the implications and my recommendations for policy and practice changes and future inquiry.

#### 5.1 Organizing Features of Nurses' Substance-Use Management

Through explications of three distinct avenues of the problematic, as illustrated in my diagram of The Small Nurse Hero (see Appendix G), I uncovered key features of the social organization of nurses' substance-use management, namely moralistic, individuated, decontextualized discourses regarding nurses' problems with substance use, nurses' silence, and the exclusion of public health-based approaches in addressing nurses' substance-use problems. In the sections that follow, I summarize and illustrate the coherence of these findings.

### **5.1.1 Moralistic, Individuated, Decontextualized Discourses Regarding Nurses' Problems with Substance Use**

The first organizing feature was visible in the dominant discourses that framed nurses' substance-use problems as individual nurses' moral and characterological deficiencies and decontextualized them by excluding the role of the institution from the discussions. This highly individuated perspective stood in stark contrast to the substantial body of literature supporting the notion that people often engage in substance-use practices in an effort to manage the stressors in their environments (Alexander, 2010; Moore, 2004; Rhodes et al., 2012). In all three of my analyses, I saw how nurses' actual experiences were silenced and subordinated to organizing discourses that framed the often challenging and sometimes traumatic conditions in their work worlds as 'realities' in which they must somehow find a way to cope. Their inability to do so, no matter how extreme these stressors may have been, was redistributed as shortcomings of the individual nurses.

Language in use in the talk and texts I analyzed socially organized nurses' working conditions as an immutable object that one could not reasonably expect to be changed, rather than as circumstances arising from particular management policies and practices. The connection made in the discourse between the nurses' substance-use problems and their conditions of work was that their problems with substance use represented incompetence at managing their work lives. For example, in my initial review of the scholarly literature (see Chapter 2), I found a dearth of inquiry into organizations' roles and responsibilities in nurses' substance-use problems. This was coupled with dominant discourses that were primarily based upon the preconceived themes and conceptualizations of attitudes, stress, and access as the main contributors to these problems. These constructs were used to reorganize and categorize nurses' substance-use problems as consequences of their hubris with regard to their own capability to self-administer drugs, or their inability to competently manage workplace stressors, or resist the supposed temptations of easy access to drugs, respectively.

I also found moralistic, individuated discourses underpinning the way that nurses themselves talked in their everyday work lives about their substance-use practices (as explicated in Chapter 3) that echoed these sentiments. These discourses were also generalized throughout the professional texts that were intended to provide guidance on

nurses' substance-use problems and assist their coping with work stressors. In those texts, nurses' substance-use problems were again discursively categorized as nurses' inability to cope with the punishing conditions of their work due to their supposedly defective attitudes or ineffective 'self-care' practices (Burton, 2014; CRNBC, 2008; Storr et al., 2000). This discursive feature was also visible in the standardized treatment modality in The Program (detailed in Chapter 4), in which nurses were expected to adhere to a regime founded upon a specific moral and religious philosophical perspective that approached substance-use problems as deficiencies of individuals' characters and their treatment as moral correction. Flaws in The Program's standardized treatment regime were masked by dominant discourses that reorganized the deficiencies of that program as the nurses' own purported moral failings and inability to adequately correct their character deficits.

## **5.2 Nurses' Silence**

The silence of nurses had effectively cleared the way for the establishment and maintenance of these dominant individuated and decontextualized discourses. This was the second organizing feature that I uncovered in my data. Beginning in my literature review, I was struck by the absence of nurses' voices, as I found that precious few of the peer-reviewed works on nurses' substance-use problems had utilized nurses' embodied knowledge and experience as data. I also saw the discursive imperative in the nurses' talk and in the professional grey literature that dictated nurses' silent tolerance of the denial of their basic rights to psychologically and physically safe workplaces. Nurses were not merely expected to adapt to whatever the workplace conditions may be, they must also do so silently and without complaint. The dominant moralistic, blaming discourses in nurses' talk about their everyday worlds compelled nurses to be silent, ashamed, and avoid seeking assistance for their substance-use problems due to fear of censure by peers should they be outed.

In The Program, nurses' protests against power imbalances and their loss of rights to choose their own treatments were stifled by their fear of being seen as noncompliant and subsequently sanctioned in ways that threatened their livelihoods. The nurse leaders were not only complicit in silencing the nurses who were enrolled in The Program, they also elected to muzzle themselves by abdicating their own power to

appointed physicians and further mute the voices of nurses by not ensuring that nursing knowledge was represented in the decision-making processes.

### **5.3 Exclusion of Critical Public Health-Based Approaches to Nurses' Substance-Use Problems**

The individuated, moralistic discourses dominating the nurses' talk in their everyday worlds, scholarly nursing literature, professional documents, and The Program left no space for alternative, more modulated approaches to the issue to be taken up. This gave rise to a third organizational thread knitting together the experiences of nurses. This was that critical public health-based prevention approaches and contemporary norms of practice for treatment of substance-use problems were conspicuously and inexplicably absent. This absence disadvantaged nurses and separated them from those in the general public who had substance-use problems in a number of ways.

For example, current critical public health-based theories view substance-use related health harms as by-products of environmental stressors; as such, these approaches focus attention on modifying and strengthening people's environments and correcting health disparities to promote positive health outcomes (Alexander, 2010; Csiernik & Rowe, 2017; Maté, 2008; Moore, 2004; Rhodes et al., 2012). However, the predominantly individuated and moralistic discourses on nurses' substance use were antithetical to these approaches. This again left the need for institutional change, such as improving nurses' conditions of work and strengthening advocacy and support from nurses' professional associations, out of the discussions of ways to best address the issue. Public health-based treatment approaches, including harm-reduction interventions and pharmacological options, were also missing from the narrow, standardized mandated treatment regime of The Program. That regime was instead restricted to a unitary, moralistic, and prohibitionist treatment model that did not permit the nurses to choose from the variety of empirically grounded public health-based substance-use treatment interventions that are widely in use for the general populous.



## 5.4 Original Contributions of This Research

My doctoral research has produced original knowledge from a Canadian nursing perspective that serves nurses' interests here and elsewhere and can also transfer across disciplines, adding to the broader field of substance-use problems and their treatment. This work provides data to create current and effectual prevention, treatment, education, and regulatory policies and programs to address nurses' substance-use problems. The original contributions of my work are detailed in what follows.

My use of the IE mode of inquiry set the contributions of this work apart from other qualitative approaches. Like IE, grounded theory, phenomenology, symbolic interactionism, and traditional anthropological ethnographic approaches all utilize descriptions of people's local activities and experiences as data in various ways (Hammersley & Atkinson, 2007; Richards & Morse, 2013; Streubert & Carpenter, 2011). However, these methodologies aim to "produce an account *of or from* those insiders' perspectives ... [whereas] IE explicates *how* the local settings, including local understandings and explanations, are brought into being" (Campbell & Gregor, 2002, pp. 89–90). Accordingly, my use of IE to research nurses' substance-use problems began in the standpoint and subjectivities of the nurses, concentrating on their everyday, material experiences. I then expanded the locus of analytic interest beyond the bounds of the nurses' local experiences and environments. This allowed me to provide novel insights into how broader, largely unseen institutional ruling practices linked into and managed the actualities of the nurses' local experiences (Campbell & Gregor, 2002; Smith, 2005).

This research approach yielded knowledge that subverts the dominant decontextualized and overly individuated discourses regarding nurses' substance-use problems by bringing the role of nurses' workplace contexts to the forefront. It does so by revealing how nurses' knowledge, experience, and interests have been silenced and subordinated. My analysis provided important original data that demonstrated not only how nurses' problems with substance use articulated to their stressful conditions of work, but also linked their recoveries from these problems with their gaining the ability to self-advocate for their rights to safe working conditions.

Another critical finding in my work that had not appeared before in the nursing literature was how nurses' substance-use problems were socially organized in ways that were inadvertently useful to the institutional work organization. For instance, nurses would deploy their professional knowledge of substances to enable them to meet the discursive imperatives of silent endurance in the face of work stressors. Although this was unarguably not an intentional management strategy, nurses' substance-use practices served to provide their employing institutions with a numbed, uncomplaining labour force able to work in stressful conditions for extended periods of time without protest. A related and unexpected new finding was that the institution also unintentionally benefited when nurses had problems with substances that they obtained from their workplaces because these nurses would elect to work extra hours and shifts to access the drugs they used.

Discourses are interrogated in IE, as well as other qualitative methodologies. Foucauldian discourse analysis (DA), for instance, is similar to that of IE, in that they both involve a scrutiny of the social, language, and power relations within textual discourse (Smith, 2005). However, unlike Foucauldian DA, IE necessarily connects textual discourse with actual social practices (Campbell & Gregor, 2002; Smith, 2005). It is this unique feature of IE analysis, how discourse is activated by people, that allowed me to contribute original knowledge about the ways that nurses practiced the dominant discourses found in their talk in their everyday worlds and institutional texts. For instance, in Chapter 4 I showed how the nurses activated the moralistic, individuated discourses that were embedded in the contracts that managed them in The Program. My use of nurses' talk in their everyday worlds as a primary data source (see Chapter 3) was a highly original application of Smith's (2017) approach to the analysis of discourse in talk, which has not previously been employed in the study of nurses' substance-use problems. By utilizing this approach, I was able to show how nurses activated discursive imperatives found in their talk in their everyday worlds, such as their practices of silence around their work stressors and substance-use problems.

Other qualitative approaches conform with, abstract to, or explain phenomena by use of theoretical concepts. IE does not do so and instead offers a material and empirical explication of how people's experiences are socially organized to happen as they do (Campbell & Gregor, 2002). Gleaning knowledge in this way allows the products of the research to be used to further advocacy and change purposes. For example,

G. W. Smith (1995) carried out an IE study of the management of the AIDS epidemic in Ontario. His explication of the social organization of this problematic revealed how the typical conceptual explanations, such as “homophobia or ... ‘red tape’” (Smith, 1995, p. 22) for people’s inability to obtain life-saving treatments had fallen short. However, G. W. Smith’s (1995) uncovering of how institutional arrangements had organized these actualities to occur as they had, did enable effective sociopolitical change. As in G. W. Smith’s (1995) work, instead of adopting the existing conceptual explanations for nurses’ substance-use problems (i.e., stress, access, attitudes), my analysis yielded important original knowledge by explicating (see Chapter 3) how the nurses’ actual practices were organized by dominant discourses in their talk in their everyday worlds.

Another novel finding was that nurses’ use of alcohol was normalized and endorsed among nurses as a way for them to cope with work stressors. This significant new finding challenged a predominant theoretical conceptualization in the literature. This was that nurses’ access to pharmaceutical drugs was the prime contributor to their substance-use problems, a theory that I contend has been obscuring the potentially very serious issue of nurses’ problems with alcohol use. My use of the IE approach to interrogate the social organization of conceptual knowledge in The Program (see Chapter 4) also demonstrated how the concept of nurses’ ‘recovery’ from substance-use problems had actually been organized as compliance to a standardized regime that was ideologically based on a moralistic, religious perspective.

The concept of stigma is typically used to explain why nurses conceal their substance-use problems and avoid seeking help for the same. Rather than adopting or drawing on this construction, my IE analysis opened up and extended beyond that concept. This inquiry unveiled original knowledge about the characteristic ways that nurses talk amongst themselves. In their talk in their everyday worlds, nurses were discursively categorized differently from and elevated above people who had substance-use problems, who were viewed as undesirable ‘others.’ At the juncture where nurses disclosed their substance-use problems to other nurses or sought assistance for the same, they became discursively recategorized from the ‘virtuous’ nurse to one of these disagreeable others.

A number of deficiencies in nurses’ basic education were illuminated in my study. These were that student nurses are not being educationally prepared with knowledge

and skills that may help prevent their problems with substance use. For instance, nurses do not learn sufficient or relevant information about nurses' substance-use problems overall, and what they do learn is limited to how to report other nurses' transgressions. In addition, they are not imparted the skills they need to understand, let alone manage, the emotional labour inherent in nursing work, or self-advocate for their safe working conditions.

My doctoral research offers a critical evaluation of a standardized alternative-to-discipline (ATD) treatment and recovery program, which had not been previously undertaken. This evaluation yielded significant new information about how The Program had been organized in ways contrary to the nurses' interests, namely the privileging of medical knowledge and abdication of nurses' power, imposed treatment regimes that were inconsistent with current norms of practice, nurses' loss of rights to choose their treatments and health care providers, numerous power imbalances and conflicts of interest that disadvantaged the nurses, and the corporatization of the nurses' treatment regimes.

My work served as a venue for nurses' voices that had been otherwise silenced in the dominant discourses, in the literature, in their work worlds, and in The Program. It did so by aligning with the standpoint of the nurses and privileging their embodied knowledge and experience as primary data. As a researcher and experienced nurse, my own voice further contributed to redefining these problems and their solutions from a nurse's standpoint. The publication of my doctoral work now positions me as one of only two Canadian researchers who have authored peer-reviewed works on nurses' problems with substance use and the only one to have carried out an IE study on this topic.

## **5.5 Limitations**

My doctoral work has yielded several important discoveries, as I have detailed above. As with any research endeavour, however, it has its limitations. Any IE inquiry is constrained to its chief aim—the explication of how the actualities of people's lives are socially organized externally to their local experience (Smith, 2005). Consequently, as an IE researcher, I cannot lay claims to the generation of other types of knowledge with this work, and many other areas remain to be discovered in this important topic that I was methodologically constrained from carrying out.

An IE inquiry does not explain phenomena or delve into the meaning of experience. Furthermore, as an IE study does not examine relationships between variables, neither does this work support any conclusions about causation. Claims of generalizability in an IE study are limited to its explications of how social activities are organized to recur in other places and times across an institutional complex as people activate ruling discourses (Smith, 2005). The results of this study cannot be statistically, inferentially, or representationally generalized to populations (Lewis et al., 2014; Moll et al., 2013) as participants in IE studies do not represent samples of any population. For example, my investigation of The Program was limited to the explication of standpoint informants' experiences within an institutional complex of ruling relations in one province. Although the results would certainly be of interest and provide important knowledge to similar programs in other jurisdictions, each province (and state in the USA) has differing regulatory and institutional arrangements for managing nurses' substance-use problems.

As Rankin (2017a) noted, "IE is itself a complex theoretical lens through which to view the social ... [it] is not antitheoretical" (p. 8). Nevertheless, the products of my research are not theoretically generalizable (Lewis et al., 2014), as IE methodology does not seek to begin with, activate, abstract to, or build upon popular or dominant pre-existing conceptual or theoretical knowledge (Rankin, 2017a). My IE analysis did not utilize conceptual or theoretical terminology (as with my avoidance of terms such as addictions, and the like), neither can the products of my research be generalized to conceptual understandings of groupings of people, such as culture or society. Even so, my IE analysis revealed a generalizing social relation, which provides a more nuanced understanding of the issue that can influence and reorient concepts such as stigma and systems or structural theories to incorporate the social organization of people's experiences.

Two important avenues of inquiry within the problematic that I believe would have strengthened my research project remain uninvestigated. The first of these involves how the discourse regarding the risk to and protection of the public is socially organized in terms of the management of nurses' substance-use problems. The second encompasses how the nurses' experiences in navigating the complex labyrinth of The Program have been organized in ways that meet institutional ideological imperatives, but not the nurses' health needs, as critical treatment junctures were missed, actually

compromising nurses' health in this process. Although I have collected data and conducted a preliminary analysis on these areas of inquiry, time and financial resources constraints prohibited me from completing these analyses during the course of my doctoral work; as such, I plan to do so as postdoctoral research.

## 5.6 Knowledge Mobilization

My knowledge mobilization (KM) plan for the systematic dissemination of the products of my doctoral research focuses on establishing and maintaining connections with researchers, scholars, clinical opinion leaders, nurse educators, nurse clinicians, and policy decision makers. I have networked with communities of interest to carry out KM activities throughout the entire process of my doctoral work and will continue to do so. My KM strategies include the following: scholarly dissemination, nursing and nursing education and transdisciplinary professional development, and public dissemination.

### 5.6.1 Scholarly Dissemination

Scholarly dissemination has been integrated within the design of this manuscript-based dissertation that has included preparation of manuscripts for peer-reviewed journals as well as conference presentations. Of my work, the following papers have been published or submitted for publication in peer-reviewed journals:

- My literature review has been published in *Nursing Inquiry Journal* (see Chapter 2 for full citation and article).
- Chapter 3 has recently been accepted for publication in *Global Qualitative Nursing Research Journal* (see Chapter 3 for full article).
- Chapter 4 has been submitted to a peer-reviewed journal, and I am awaiting reviewer comments and editorial decisions.
- I plan to mine the data that I have collected for my doctoral work for two postdoctoral analyses with additional manuscripts for publication (see Section 5.5 Limitations for more information).

I have also presented or arranged to present the following at academic conferences and forums:

- I presented a paper entitled *Mapping Nurses' Experiences in a Provincial Program to Address Nurses' Substance-Use Disorders* at the Cascadia

Conference, the annual symposium on environmental, occupational and population health, in Abbotsford, BC, in January 2018.

- I will present my findings on The Program at the International Academy of Law and Mental Health Conference in Rome in July 2019.
- I intend to submit an abstract to the Society for the Study of Social Problems conference in New York in August 2019.
- I will explore possibilities for meeting with provincial Nurse Executive Committees and Councils and presenting at the BC Health Leaders Conference in 2019.

### **5.6.2 Nursing and Nursing Education and Transdisciplinary Professional Development**

As a member of the faculty in an undergraduate nursing program with membership in the Canadian Association of Schools of Nursing, I am in a position to act as a leader and share the knowledge obtained in my research with other nurse educators (in collegial and formal discussions, presentations, and reports). Relevant nurse educator conferences, journals, and websites are all areas of dissemination. I am also an active member of the Bachelor of Science in Nursing (BSN) Program's Curriculum Committee with Douglas College, where I am employed. This positions me well to specifically convey the knowledge gained from my doctoral research to colleagues and administrators in the BSN program and in the Faculty of Health Sciences. I have mobilized the knowledge discovered in my doctoral project through formal and informal professional development strategies in three main ways.

Firstly, I conducted linkage and educational outreach in the form of webinars, in-person seminars, workshops and meetings with relevant communities of practice (nurse opinion leaders, educators, and clinicians). I have given two workshop presentations thus far:

- BSN Program Professional Development Days 2016 at Douglas College, Coquitlam, BC on the topic: So, you want to do a PhD? Lessons learned.
- Faculty of Health Sciences Professional Development Days 2017 at Douglas College in Coquitlam, BC. The topic was my literature review paper, "A Critical Review of Knowledge on Nurses with Problematic Substance Use: Moving from Individual Blame to Awareness of Structural Factors."

Secondly, I sought to engage and exchange knowledge with organizations such as the British Columbia Nurses Union (BCNU), College of Registered Nurses of British Columbia (CRNBC), British Columbia Centre on Substance Use (BCCSU), Centre for Applied Research in Mental Health and Addictions, Mental Health Commission of Canada, Canadian Health Services Research Foundation:

- I am active on a provincial-level committee comprised of health policy researchers (from BCCSU and the University of Victoria), clinical leaders, union representatives, and me. This committee's purpose is to advocate for the creation of treatment programs for health care providers' substance-use problems that are based on current, scientifically based established norms of practice.
- In collaboration with the British Columbia Nurses Union, I have initiated a formal peer-support arrangement to connect nurses who have been through The Program with the nurses entering it.
- One of my chief postdoctoral professional goals is to contribute to provincial, national, and international level policies related to nurses' health and wellness, substance-use problems, and safe workplaces.
- I have already linked with BCNU and CRNBC in the early stages of my research and will reconnect with them to present the products of my work.

Lastly, I conduct undergraduate teaching activities.

- As a full-time instructor in the BSN program at Douglas College, where I have developed and currently teach clinical practice and theory courses in mental health nursing, I am in a position to integrate this knowledge into undergraduate education through teaching students. The knowledge from my doctoral work is and will continue to be integrated into my course content and imparted to the undergraduate nursing students that I teach. This research has significantly changed my practice as a nurse educator. One of the nurse informants stated during her interview that nursing students do not learn any meaningful information on nurses' substance-use problems, and "only learn how to report" other nurses who have such problems. As I listened to her, I was painfully aware that I was one of those instructors who centred much of my instructional content on what and how to "report." I now include focused content in my classes on the dominant discourses that I have learned about in this work, particularly the moralizing and silencing discourses, how to self-advocate for safe and healthy working conditions, nurses' use of alcohol as a socially authorized way to cope, and what emotional labour is as well as applicable strategies to manage it and maintain emotional health.



### **5.6.3 Public Dissemination**

The discoveries from my doctoral study have wider interest beyond the academy and professional practice and are concerns of society more generally. Substance use, particularly in light of current opioid crises (BCCSU, 2017) and new marijuana legislation (WorkSafeBC, 2018), is of escalating public and professional interest. Public dissemination strategies will be mobilized at the conclusion of all phases of the project (through to oral defense). Focused social media outreach will include:

- Production of a 1-2-page research snapshot to be uploaded at SFU and Douglas College library repositories.
- Links to the snapshot (and full dissertation if appropriate) shared on Facebook (n.d.), LinkedIn (n.d.), ResearchGate (n.d.), and Twitter (n.d.) in response to related postings and in announcements for publications and presentations.

## **5.7 Implications and Recommendations**

### **5.7.1 Organizational Change**

The discourses on nurses' substance-use problems have long focused upon individual nurses' moral failings and the expectations that they should silently adapt to unsafe and unfair working conditions. My research points to the need for a seismic shift in that focus to one foregrounding the role of nurses' conditions of work and the employers' responsibilities to enact management policies that provide nurses with physically and psychologically safe workplaces. Nurses' voices need to be actively sought out, listened to, and empowered at all institutional levels—by employers as well as provincial and national regulatory bodies—to identify the changes that are required in accomplishing this aim and how to best implement them.

My data indicate the need for nursing education initiatives that provide nurses with alternative ways of understanding and communicating their problems with substance use and workplace distress. This would involve delivering specific content in nurses' basic and continuing education that includes factual and experiential material about nurses' problems with substance use, information on how to support peers who have problems with substance use, resources for nurses to obtain assistance when they have these problems themselves, self-advocacy skills to uphold their workers' rights to

safe and healthy workplaces, and strategies to manage the emotional labour inherent in nursing work. Such initiatives would build nurses' capacities to better safeguard their health and to subvert and resist the existing moralistic, blaming, and individuated ruling discourses that demand silent passivity in the face of work stresses.

A wholesale reevaluation of The Program needs to be undertaken from a critical perspective that does not simply refer back to taken-for-granted standardized regimes. My study identified specific courses of action that can be carried out to improve The Program at this time, which are to offer nurses individualized treatment plans based on current norms of practice that include public health-based approaches; broaden the approved health care providers in The Program to include nurse practitioners with expertise in treating substance-use problems, as well as other qualified professionals who do not universally align with one particular philosophical perspective; ensure that the regulatory decision makers in The Program possess the expertise to effectively and fairly adjudicate nurses' cases; rectify the power imbalances, conflicts of interest, corporatization of nurses' recoveries, and abrogation of nurses' basic rights rife in The Program; and provide nurses with opportunities to seek alternate opinions and treatments and freely voice dissent when they disagree with their care providers.

## **5.8 Areas of Future Inquiry**

Much more study is called for overall on the extremely underresearched topic of nurses' substance-use problems. Scant peer-reviewed works have been published on the topic from the last decade. As noted, there are only two Canadian nurses researching this issue, including me, and data do not exist on the national scope of the problem, save a single study in one province (Kunyk, 2015).

My research also revealed specific scholarship lacunae in the area of nurses' problems with substance use, in addition to those cited prior for my planned postdoctoral research. My findings challenged predominant discourses in the professional and scholarly literature regarding nurses' access to pharmaceutical drugs as the chief contributor to nurses' substance-use problems. This emphasis not only redistributes the onus for the problem back to the individual nurse, it also overshadows two important considerations that merit further interrogation: the role of the many stressors in nurses' conditions of work that may compel nurses to exploit that access, as well as their

problems with alcohol use. More focused inquiry is called for related to two of my original findings about nurses and alcohol. These were the sanctioned use of alcohol among nurses to manage their workplace stress, and the role that it plays as the sole endorsed mode of communicating distress among nurses.

I offer this thesis, my “piece of social cartography” (Deveau, 2008, p. 3), from my standpoint as a practicing nurse of 36 years. I do so with the emancipatory purpose of supporting the empowerment of nurses with knowledge that enables us to name and subvert the institutional ruling relations that have been detrimental to our health, well-being, and in some cases our lives. It is my hope that we will use this knowledge to turn our traditional caring practices toward ourselves and resist the long-standing institutionalized silencing and subjugation. Doing so will indeed be a radical act for nurses and nursing, but caring for ourselves is “not self-indulgence, it is self-preservation, and that is an act of political warfare” (Lorde, 1988, p. 131). We are well worth the battle and it is long overdue.

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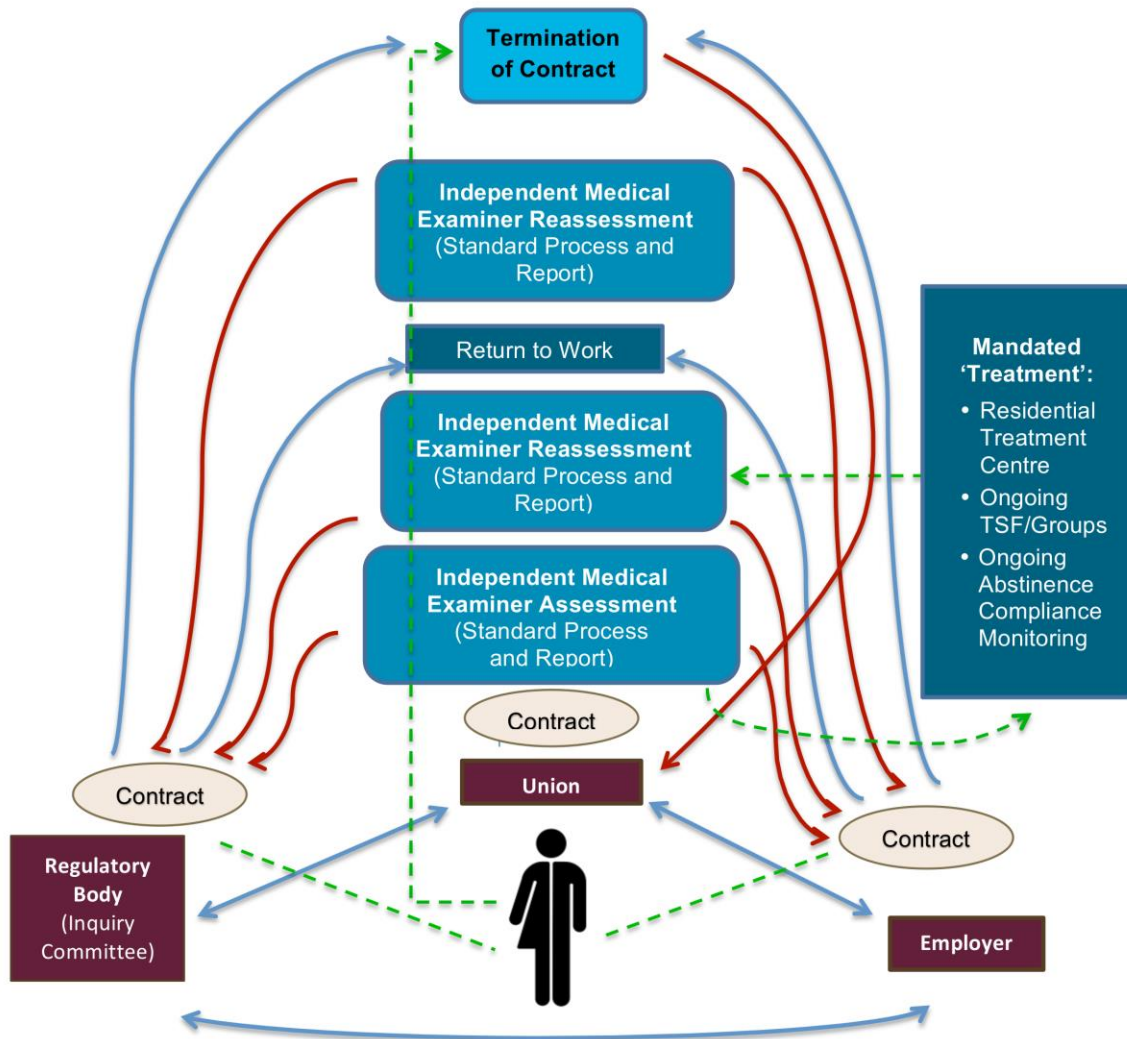
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# Appendix A.

## The Nurse in The Program



Adapted from Smith, 2006, p. 3

**Key**

- Nurse's activities = - - - - ->
- Independent Medical Examiner's Processes = - - - - ->
- Regulatory Body/Employer's Processes = - - - - ->

## Appendix B.

### Description of The Program

	<b>Entry Points into <i>The Process</i></b>
<b><u>I. Regulatory Body (RB)</u></b>	<p><b><u>Mandate:</u></b> To ensure “that nurses who require assistance attend addiction treatment and engage in ongoing relapse prevention; promote public protection; ensure nurses are practicing only when fit to do so; and meet statutory reporting requirements in accordance with sections 32.2 and 32.3 of the Health Professions Act” (CRNBC, 2012).</p> <p><b><u>By Self-Report:</u></b> A nurse may self-report to the RB if they identify that they have a problem with substances that is affecting their practice, or if they have been encouraged to report by others (generally their employer or the union). The RB would then ask them whether they are currently working, if their employer knows, or if they have had treatment. They would “encourage” them to 1) contact the Union’s Program Administrator to facilitate the process of their obtaining treatment and 2) inform their employer if they have not already done so. They are asked to voluntarily convert their license to non-practicing and remove themselves from actively practicing. This non-practicing licensure status is <u>not</u> noted on the RB’s Registry as disciplinary.</p> <p><b><u>Reporting by Others:</u></b> Another health professional, the employer, or a member of the public may contact the RB if they believe that a nurse is impaired by substance use, or if theft of drugs has occurred. The complaint will be directed to an RB administrator who will provide them with information as to what constitutes sufficient “specific and objective” information to make a complaint. The complaint must be submitted in writing (hard copy, email, fax) to the RB and be about a person who is (or was when the incident occurred) registered with the RB. The RB will inform the nurse of the complaint. They will be offered the opportunity to enter the same process as self-reporting.</p> <p><b><u>RB Inquiry Committee:</u></b> The RB will take this information to their Inquiry Committee (IC) for adjudication. While the nurse is in the IME assessment/treatment process, the IC will engage the services of a ‘Professional Conduct Review Consultant’ to undertake an investigation of the nurse on behalf of the IC. They will investigate by gathering information from the employer (what was the impact on patients? Any</p>

	<p>practice/behavioural concerns? Diversion of drugs?), medical information (IME and treatment recommendations), and any other information seen as relevant to determine if there has been a breach of Standards of Practice. The results of the investigation are compiled into a report, which is forwarded to the IC for review.</p> <p><u>IC Composition/Qualifications:</u> The IC meets in panels of 3 to review new files. A panel is always comprised of a mix of volunteer RB registrants and members of public. The RB's Governance Coordinator vets applications via their previous background and professional competencies. It is not a requirement for them to have clinical or educational background in substance-use problems; they rely on the IME for expert opinion.</p>
<p><b><u>II. The Union</u></b></p>	<p><b><u>Stated Aims:</u></b> Advocacy, representation and support with any complaints and the return-to-work (RTW) processes; facilitating referrals for medical assessments and treatment.</p> <p>When a nurse contacts the Union, they are offered entry into The Program for treatment and support in their return to practice. They sign a contract to enter The Program and begin the treatment process.</p> <p>The Union directs the nurse to self-report to the RB and their employer if they have not already done so. The Union will provide advocacy when the nurse has any involvement with the employer or the RB. The Union facilitates treatment referrals (see A-F below).</p>
<p><b><u>III. Employer</u></b></p>	<p>Reports nurse to the RB if they do not self-report. Refers nurse to the Union for representation in employer/employee discussions and for treatment referrals.</p> <p>If theft of drugs is involved, the employer investigates records with their Pharmacy Department. Depending on the specific employing facility, the nurse may be linked with a Human Resources designate (usually Disability Manager [DM] or Work Ability Advisor [WAA]) and will interact with their Manager in employment matters.</p> <p>The employer (via the Manager, DM or other designated individual) assists the nurse to organize their source of income while they are off work for treatment until their designated RTW date. This may involve accessing their sick time, vacation, medical Employment Insurance, or after 4 months, Long-Term Disability.</p>



	<b><u>Mandated Treatment Process: [The Union facilitates referrals]</u></b>
<b>A) Assessment by an Independent Medical Examiner (IME)</b>	The nurse is referred for an IME, who is considered to be an ‘addiction physician.’ This is a private service that costs \$2500. Canadian dollars (CDN) Some employers pay for this; if not, it is covered by the Union. The IME assesses the nurse and completes a report that includes a diagnosis and treatment recommendations. If the nurse is diagnosed with a substance use disorder, the initial recommendations without exception include monitoring, attendance at a specific in-patient treatment program and Twelve-Step Facilitation (TSF) group meetings (see below), followed by a reassessment by this IME. The IME report is forwarded to the Union, who will forward it to the RB.
<b>B) Monitoring</b>	Random biological (urine) testing is ordered to determine if 100% abstinence from <u>all</u> psychoactive substances, except nicotine and caffeine, is achieved and maintained. The nurse is assigned to use the services of a specific approved monitoring company (there are several, all private) by the Union or the employer, whichever is paying. Some Health Authorities pay for monitoring for full-time employees; if not, the Union sets this up and pays the first year. The monitoring companies are all private businesses and are not covered by the public-pay system. If the nurse is on Long-Term Disability benefits, the insurer pays. The required services cost from \$400-1000 CDN/month. The public labs are not considered adequate by the RB because they do not meet their ‘chain of custody’ standards. Program participants are required to log-in online daily and be available 7 days/week to provide a random urine sample for testing within the following 12-24 hours. There are typically 24-28 random tests/year. This frequency decreases as the contract progresses. The monitoring contracts generally last 2-3 years. Testing frequency may be increased at the IME’s discretion if the nurse relapses or is deemed to be in a “more vulnerable” state (i.e. on return to work, following use of post-operative opioid medications, etc.). Monitoring requirements also involve regularly meeting with an employee of the monitoring company (a ‘Monitor’). Depending on the specific company’s procedures, this takes place either on-line, by telephone, or in person. The monitor will “check-in” with them to assess the participant’s compliance with the program by ‘ticking-off’ whether the nurse has met the contractual requirements for urine screening and attendance at TSF meetings. They “confirm” attendance at these meetings by asking the nurse what dates and where they attended meetings and asking them questions about their progress with the 12 steps (see

	below). The monitoring company provides regular monthly reports to the Union's program administrator, the employer (Disability Manager), and the RB.
<b>C) In-Patient Treatment</b>	The IME will recommend that the nurse attend one of two private treatment centres in Ontario that offer a 30-45-day in-patient treatment program specifically for health care professionals for a cost of approximately \$20,000 CDN. The Union organizes the admission and transportation to the facility. A report is sent to the IME.
<b>D) Attendance at TSF/Group meetings</b>	Participants in the program are always required to attend a specific number of TSF-based peer support group meetings per week. Attendance at Caduceus groups (peer support group specifically for health care professionals) are generally required, either included as part of the TSF meeting requirements, or separately. The frequency is ordered by the IME, which may decrease as the contract progresses, or increase if the nurse relapses. According to program administrators, nurses who are personally opposed to the religious basis of the TSF format and who self-advocate <u>may</u> be offered a choice of a secular support group (Life Ring or SMART), at the IME's discretion, although some participants refuted this.
<b>E) IME Reassessment</b>	Following in-patient treatment and after at least 4 weeks' compliance with treatment recommendations, the IME will review the report from the treatment centre, reassess the nurse and make treatment recommendations for the period of their contract with the RB. This reassessment costs \$800–1500 CDN (paid by the Union). The treatment recommendations will include continuation of complete abstinence from <u>all</u> psychoactive substances except nicotine and caffeine, ongoing monitoring, attendance at TSF and/or Caduceus programs, any other required individual treatments, return to work (RTW) date, length of the contract with the RB, any conditions and/or limits on practice (i.e. no carrying narcotic keys or handling of controlled substances), and limits on work schedules (i.e. shiftwork, hours of work, or a program of gradual RTW). The IME reassessment report is forwarded to the Union, who will forward it to the RB. The contract typically lasts for 2-3 years but is often longer.
<b>F) Ongoing Counselling/ treatment modalities</b>	Ongoing supportive counselling is not included in the standard IME recommendations. In certain isolated cases, the IME may request psychiatric treatment or 1:1 psychotherapy for reasons specific to the individual. Private counselling is not covered unless the nurse is on long-term disability benefits

	<p>(LTD); if so, the insurer may pay for some if it is specifically recommended by the IME.</p> <p>All nurses under the Union’s collective agreement (whether the nurse is in The Program or not) includes extended health benefits that cover \$900 CDN/year (approx. 6 or fewer sessions) for a clinical counsellor or registered psychologist. If the employer offers an Employee and Family Assistance Program (EFAP), all of their employees can access this service for short-term solution-focused counselling.</p>
<p><b>RB RTW/Follow-up</b></p>	<p>The RB receives the IME’s report via the Union. If the IME determines that a nexus existed between a disability (i.e. a ‘substance use disorder’ [SUD]) and the nurse’s transgressions of standards of nursing practice, then the RB will seek to resolve the matter by entering an individual agreement (contract) with the nurse to ensure their safety to practice. In this case, disciplinary action does not take place. If a disability or a nexus are not present, then disciplinary action may be taken.</p> <p>When the IC completes its review, they communicate their findings and decision to the nurse via a formal report, which is sent to the Union. The nurse is asked to respond to this document. If the nurse agrees with the report, they will sign a contract with the RB when the IME clears them for RTW. If they disagree, they will enter into a separate dispute process with the Union acting as their advocate.</p> <p>The RTW contract is based upon the IME’s recommendations for the nurses’ treatment plan, practice restrictions and RTW conditions. If conditions/limits are imposed on the nurse’s practice, these will be posted on the RB’s public website, stating that the nurse has ‘limits on practice’ and directing employers to call the RB for more information. This RTW contract is sent to the Union and the employer. The RB will receive a quarterly report from the employer (see Employer) regarding their nursing practice. While under the contract, the nurse must inform the RB if they change jobs, take a leave from work, or relapse. If they change jobs, the RB will report information about the limits/conditions on practice to the new employer’s HR department.</p>
<p><b>Return to Work: Employer</b></p>	<p>In cases of theft of drugs, the employer may elect to proceed with pressing criminal charges. In these cases, the IME will determine if the thefts were a result of a disability (‘SUD’) and if so, then no criminal charges generally result. If no nexus was determined, then the employer may initiate a disciplinary</p>

	<p>process and/or press legal charges and the Union would then be involved to advocate for the nurse.</p> <p>The employer completes a RTW contract with the nurse that stipulates their adherence to the IME's recommendations. If the nurse is deemed by the IME to have a disability ('SUD'), the Human Rights Code states that an employer has a legal duty to accommodate any workplace requirements per the IME's treatment and RTW recommendations.</p> <p>Accommodations may include; stable schedules, no night shifts, limited workloads, restricted or no access to narcotics, and the nurse's need to attend monitoring appointments when called to do so. The nurse may need to be accommodated to a different position if the current position cannot be changed to meet their IME-stipulated limits/conditions. The Union facilitates this accommodation in conjunction with the employer.</p> <p>The employer (usually the DM, WAA, or other designate) completes a quarterly report for the RB by obtaining information from the nurse's manager. This includes: concerns with the nurse's functioning in the workplace; any changes in the nurse's behaviour; attendance issues; ability to meet professional standards; and, if there are identified concerns, whether these have been discussed with the nurse. The individual completing the report may or may not meet with the nurse to collect this information.</p>
<p><b>End of Contract</b></p>	<p>The length of the contract will be determined by the IME. When that designated period of time ends, the nurse submits a written request to the RB to conclude the contract. The nurse is required to provide information as outlined on a specific RB text and include reports from the IME, employer, and Monitoring Co. This information will be forwarded to the IC for adjudication. The IC may either conclude the contract or determine that further action is required. When the terms of the agreement are complete, the nurse's license is then unencumbered by conditions/limits, but the fact that there has been a practice agreement remains permanently on the nurse's file.</p>

**Source**

College of Registered Nurses of British Columbia. (2012). *Early intervention program*.  
<https://www.crnbc.ca/crnbc/Announcements/2012/Pages/EIP.aspx>

## Appendix C.

### Primary Participant Invitation

**Nurses' Substance Use Study Invitation Notice to be posted in the [Union's e-newsletter] and on the [Union's] closed group Facebook social media site**

**Invitation to Participate in a Research Study:  
Substance Use among Nurses in [a Western Canadian Province]: An  
Institutional Ethnography Study**

My name is Charlotte Ross and I am a nurse who is conducting research on substance use among nurses [in a western Canadian province] as part of my doctoral studies in the Faculty of Health Sciences at Simon Fraser University.

You are being invited to take part in this research study because we want to learn more about the experience of nurses in [a western Canadian province] who are now or have previously been participants in [The Program]. This study will help us learn more about how nurses' substance use might be linked to their professional culture and the context and conditions of their day-to-day work. Ultimately, we hope to develop knowledge that can be used for the creation of effective prevention strategies, treatment programs, regulatory policies and relevant nursing education.

If you would like to learn more about participating in this study, please contact me by email at: [email address].

With kind regards,

Charlotte Ross, RN, RPN, BSN, MA, PhD(c)  
Doctoral Student, Faculty of Health Sciences, Simon Fraser University

## Appendix D.

### Secondary Participant Invitation

**Subject Line: Invitation to Participate in a Research Study: Substance Use among Nurses**

**Invitation to Participate in a Research Study:  
Substance Use among Nurses in [a western Canadian province]: An  
Institutional Ethnography Study**

My name is Charlotte Ross and I am a nurse who is conducting a research study on substance use among nurses [in a western Canadian province] as part of my doctoral studies in the Faculty of Health Sciences at Simon Fraser University.

At this stage in our research, we are interviewing people who have worked with nurses who are in the [The Program], such as; workplace managers, program administrators, HR/LR personnel, consulting physicians, regulatory bodies' administrators, among others.

This study will help us learn more about how nurses' substance use might be linked to their professional culture and the context and conditions of their day-to-day work. Ultimately, we hope to develop knowledge that can be used for the creation of effective prevention strategies, treatment programs, regulatory policies and relevant nursing education.

I would like to invite you to take part in this research study by participating in an interview (approximately 60-90 minutes), that could take place in your office if you work in the Lower Mainland, on the SFU Burnaby campus, or via Skype.

If you would be interesting in participating, or would like to learn more about this study, please contact me via email at [email address].

With kind regards,

Charlotte Ross RN, RPN, BSN, MA, PhD(c)  
Doctoral Student, Faculty of Health Sciences, Simon Fraser University

## Appendix E.

# Primary Participant Consent Form



SIMON FRASER UNIVERSITY  
ENGAGING THE WORLD

### Participation in a Research Study:

#### Substance Use among Nurses in [a western Canadian province]: An Institutional Ethnography Study

#### WHO IS CONDUCTING THE STUDY?

##### Research Team:

Principal Investigator (PI): Charlotte Ross, RN, RPN, BSN, MA, PhD(c) Doctoral Student, Faculty of Health Sciences, Simon Fraser University Contact Information: Email: [email address] Telephone: [telephone number]

This study is part of my doctoral studies in the Faculty of Health Sciences at Simon Fraser University. My senior academic supervisor is: Contact information: Dr. Nicole Berry, email: [email address]

The other members of my supervisory committee are: Dr. Victoria Smye, email: [email address]; Dr. Will Small, email: [email address]; Dr. Sonya Jakubec, email: [email address].

There are no organizational, institutional or corporate sponsors or partners in this study. The study is being funded by the primary researcher's private resources and by scholarships and grants.

This study is not affiliated with the [The Program], [The Regulatory Body], [the Nurses' Union], any health care employers, or any other organizations. The only contact with the [The Program] has been to request their assistance in recruiting participants into this study. No organization, employer or agency has any influence in this study, nor will any external parties know who did or did not participate in this study or have access to any of this study's data.

#### WHY ARE WE DOING THIS STUDY?

You are being invited to take part in this research study because we want to learn more about the experience of nurses in [a western Canadian province] who are now or have previously participated in [The Program] because of their problems with substance use. This study will help us learn more about how nurses' substance use might be linked to their professional culture and the context and conditions of their day to day work. Ultimately, we hope to develop knowledge that can be used for the creation of effective prevention strategies, treatment programs, regulatory policies and relevant nursing education.

## **YOUR PARTICIPATION IS VOLUNTARY**

Your participation is entirely voluntary. You have the right to refuse to participate in this study. If you decide to participate, you do not have to answer any questions you do not wish to answer, and you may terminate your participation in an interview or focus group at any time without giving reasons. You may also choose to withdraw entirely from the study at any time without any negative consequences to your employment, professional status, involvement in [The Program], or other services to which you are entitled or are presently receiving. If you choose to enter the study and then decide to withdraw at a later time, all data collected about you during your enrolment in the study will be destroyed.

## **WHAT WILL YOU BE ASKED TO DO IF YOU AGREE TO PARTICIPATE IN THE STUDY?**

Participants will be asked to take part in private, in- person or computer Skype-to-Skype interviews with me, or in focus groups of 3-- 4 other participants that are led by me. You are free to choose to participate in the interview only, a focus group only, both an interview and a focus group, or none of these activities. Each interview or focus group will take place at a mutually agreed-upon time and be located on one of the SFU campuses (Burnaby or downtown Vancouver) or via computer Skype-to-Skype format. The interviews and focus groups will last approximately 60 to 90 minutes. Participants may also be asked to participate in a follow- up interview by phone, Skype, or in person. Please note the phone is not considered to be a confidential method of communication, should you choose to follow- up by phone.

## **WHAT ARE THE POTENTIAL RISKS OF PARTICIPATING IN THIS STUDY?**

### **Emotional/Psychological Risk**

You are free to decline to answer any question or discuss any matters that you do not want to; however, a potential risk exists that reflecting upon and discussing sensitive and emotional material may lead to strong emotional reactions. If you consent to participate in this study, it is important that you believe that you have achieved a level of emotional stability that would allow you to tolerate discussing this material. As well, you will need to have an established source of emotional support in place during and after the study that you can access should you require support.

### **Risks of Breach of Confidentiality**

Your confidentiality will be respected. Participant's identities or records will not be shared with any agencies, organizations, or government departments. Information that discloses your identity will not be released without your consent unless required by law.

We will be taking the following measures to maintain your confidentiality in the study:

- Interviews and focus groups will be audio-- recorded. In these recordings, participants will be referred to by a mutually agreed-- upon pseudonym that only the participant and I will know.
- Participants' identities and pseudonyms will be coded with a file number. A hard copy log linking identities to codes will be kept in a locked cabinet in an office on SFU campus or in a locked cabinet in my locked home office. I will be the only



person who will be able to link the participants' identities, files, codes and pseudonyms.

- A clerical research assistant will transcribe the audiotapes to written documents, but will only be aware of the clients' pseudonyms and file numbers. The clerical research assistant will also be required to sign a confidentiality agreement.
- Audio recordings will be erased following my review of transcribed documents. Electronic files of transcriptions will be retained on a password protected encrypted memory stick. This memory stick, as well as interview audiotapes, signed consent forms, researcher journals, the master log linking participants with pseudonyms and hard copies of transcriptions will all be kept in a locked cabinet.
- The hard copy log linking participants with pseudonyms will be maintained until the researcher has had an opportunity to validate the accuracy of transcribed interview material with the participant. It will then be destroyed per the planned data destruction procedures listed below.
- I will keep all data and files for a minimum of 2 years following completion of the study and completion of my doctoral degree. They will then be disposed of by confidential shredding of hard copies and destruction of electronic records and memory sticks. This destruction will be completed using SFU's confidential paper shredding and data destruction services.
- Data from participants who choose to withdraw from the study will be destroyed as noted above, promptly upon their withdrawing their consent to participate in the study.
- The information gathered in the interviews and focus groups will be used in the writing based on this research. It is anticipated that this writing will result in documents available to the public, such as a doctoral thesis and/or journal articles. Participants will not be identified by name in any reports of the completed study and all information and quotes will be written in such a way that identities of participants, other people, and organizations are concealed.

#### Legal Limits to the Confidentiality of your Information:

Please be advised that, if at any point in the study, participants reveal a circumstance that involves direct and current risk to themselves, any others, or to the general public, the researcher is professionally and legally obligated to report this information to the appropriate authorities.

#### Limits to the Confidentiality of Your Information in Focus Groups:

Although we strongly encourage participants not to discuss the content of the focus group with people outside the group, we can't control what participants do with the information discussed. As such, if you choose to participate in focus groups, only limited confidentiality can be offered.

#### Limits to the Confidentiality of Your Information When Communicating over the Internet:

Please be aware that confidentiality cannot be guaranteed when communicating over the internet.

## **FIRST AND SECOND PHASES OF THE STUDY**

If you choose to participate, you and other nurses will be involved in the first phase of this study. Once we complete the phase one interviews and focus groups with nurse participants, interviews with a second group of people will take place. This second phase of interviews will be carried out with people who work in other positions in the health care system. Although these people will likely include workplace managers, program administrators, and/or regulatory bodies' administrators, we do not yet know who we will wish to recruit for the secondary phase. The purpose of the second phase interviews is to gather information on institutional/organizational programs and processes that are involved in addressing nurses' problematic substance use.

We will not be purposefully selecting any secondary participants who have had any direct contact with you or any of the other nurse participants. But, because we do not yet know who we will be recruiting, there is a potential that secondary informants who work with you could possibly be recruited into this study.

At no time will any information that could potentially identify you or any other participants be disclosed or discussed in any way with any other study participants, any other people external to the study, or in the written reporting. Nevertheless, a small concern exists that participants or readers of the research could connect information from the two research phases, or mistakenly think that they could.

## **WHAT ARE THE BENEFITS OF PARTICIPATING?**

It is hoped that you will find participating in an interview and/or focus group to be a rewarding experience; however, if you agree to participate in this study, there may or may not be a direct benefit to you personally. Nevertheless, the information gained from this study may contribute to a better understanding of the experience of nurses who have problems with substance use and make a contribution that is useful to the nursing profession.

## **WILL I RECEIVE PAYMENT FOR PARTICIPATING, OR WILL I HAVE TO PAY FOR ANYTHING?**

There is no cost to you for participation in this study. You will not be paid to participate in this research; however, public transit or parking costs incurred for your attendance at interviews or

focus groups will be reimbursed. A small gift of appreciation for your participation in the study may also be provided.

## **WHAT WILL BE DONE WITH THE STUDY DATA AND RESULTS?**

There are no plans for secondary uses of the recordings or other data for any other research purposes. The results of this study will be reported in a graduate thesis and may also be published in academic journal articles, books, or at academic conferences.

## **WHO CAN YOU CONTACT IF YOU HAVE QUESTIONS ABOUT THE STUDY?**

If you have any questions about the study or the procedures involved, please contact me via the contact information at the top of this form.

**WHO CAN YOU CONTACT IF YOU HAVE COMPLAINTS OR CONCERNS ABOUT THE STUDY?**

Concerns and/or complaints should be addressed to Dr. Jeff Toward, Director, Office of Research Ethics, [email address], [telephone number].

## PARTICIPANT CONSENT AND SIGNATURE

### Participation in a Research Study: Substance Use among Nurses in [a western Canadian province]: An Institutional Ethnography Study

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason and without any negative impact on your employment, professional status, involvement in the [The Program], or other services to which you are entitled or are presently receiving.

- Your signature below indicates that you have kept a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

---

Participant Signature

---

Date: YYYY/MM/DD

---

Printed Name of the Participant signing above

I am choosing to participate in interviews for this study. YES/NO (Circle one)

I am choosing to participate in focus groups for this study. YES/NO (Circle one)

I have established supports in place that I can access during and after the study should I experience any emotional distress. YES/NO (Circle one)

I consent to being contacted following my participation in the interview and/or focus group, should the researcher require clarification or more information. YES/NO (Circle one)

I would like to be contacted to participate in other, future studies by this researcher. YES/NO (Circle one)

I would like to have the final written report of the study's findings mailed to me. YES/NO (Circle one)

If yes, please provide a mailing address \_\_\_\_\_

# Appendix F.

## Secondary Participant Consent Form



SIMON FRASER UNIVERSITY  
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### **Participation in a Research Study: Substance Use among Nurses in [a western Canadian province]: An Institutional Ethnography Study**

#### **WHO IS CONDUCTING THE STUDY?**

##### **Research Team:**

Principal Investigator (PI): Charlotte Ross, RN, RPN, BSN, MA, PhD(c) Doctoral Student, Faculty of Health Sciences, Simon Fraser University Contact Information: Email: [email address] Telephone: [telephone number]

This study is part of my doctoral studies in the Faculty of Health Sciences at Simon Fraser University.

My senior academic supervisor is: Dr. Nicole Berry, email: [email address]

The other members of my supervisory committee are: Dr. Victoria Smye, email: [email address]; Dr. Will Small, email: [email address]; Dr. Sonya Jakubec, email: [email address]

There are no organizational, institutional or corporate sponsors or partners in this study. The study is being funded by the primary researcher's private resources and by scholarships and grants.

This study is not affiliated with the [The Program], [the Regulatory Body], [the Nurses' Union], any health care employers, or any other organizations. No organization, employer or agency has any influence in this study, nor will any external parties know who did or did not participate in this study or have access to any of this study's data.

#### **WHY ARE WE DOING THIS STUDY?**

You are being invited to take part in this research study because we want to learn more about the experience of nurses in [a western Canadian province] who are now or have previously had problems with substance use. This study will help us learn more about how nurses' substance use might be linked to their professional culture and the context and conditions of their day to day work. Ultimately, we hope to develop knowledge that can be used for the creation of effective prevention strategies, treatment programs, regulatory policies and relevant nursing education.

#### **YOUR PARTICIPATION IS VOLUNTARY**

Your participation is entirely voluntary. You have the right to refuse to participate in this study. If you decide to participate, you do not have to answer any questions you do not wish to answer, and you may terminate your participation in an interview at any time without giving reasons. You may also choose to withdraw entirely from the study at any time. If you choose to enter the study and then decide to withdraw at a later time, all data collected about you during your enrolment in the study will be destroyed.

### **WHAT WILL YOU BE ASKED TO DO IF YOU AGREE TO PARTICIPATE IN THE STUDY?**

Participants will be asked to take part in private, in- person interviews with me. Each interview will take place at a mutually agreed-upon time and be located on the SFU campus in Burnaby, via computer Skype-to-Skype interviews, or in your workplace. The interviews will last approximately 60 to 90 minutes. Participants may also be asked to participate in a follow- up interview in person, via Skype-to-Skype or by phone. Please note that the phone is not considered to be a confidential method of communication, should you choose to follow- up by phone.

### **WHAT ARE THE POTENTIAL RISKS OF PARTICIPATING IN THIS STUDY?**

#### **Risks of Breach of Confidentiality**

Your confidentiality will be respected. Participants' identities or records will not be shared with any agencies, organizations, or government departments. Information that discloses your identity will not be released without your consent unless required by law.

#### **We will be taking the following measures to maintain your confidentiality in the study:**

- Interviews will be audio recorded. In these recordings, participants will be referred to by a mutually agreed upon pseudonym that only the participant and I will know.
- Participants' identities and pseudonyms will be coded with a file number. A hard copy log linking identities to codes will be kept in a locked cabinet in an office on SFU campus or in a locked cabinet in my locked home office. I will be the only person who will be able to link the participants' identities, files, codes and pseudonyms.
- A clerical research assistant will transcribe the audiotapes to written documents, but will only be aware of the clients' pseudonyms and file numbers. The clerical research assistant will also be required to sign a confidentiality agreement.
- Audio recordings will be erased following my review of transcribed documents. Electronic files of transcriptions will be retained on a password protected encrypted memory stick. This memory stick, as well as interview audiotapes, signed consent forms, researcher journals, the master log linking participants with pseudonyms and hard copies of transcriptions will all be kept in a locked cabinet.
- The hard copy log linking participants with pseudonyms will be maintained until the researcher has had an opportunity to validate the accuracy of transcribed interview material with the participant. It will then be destroyed per the planned data destruction procedures listed below.
- I will keep all data and files for a minimum of 2 years following completion of the study and completion of my doctoral degree. They will then be disposed of by

confidential shredding of hard copies and destruction of electronic records and memory sticks. This destruction will be completed using SFU's confidential paper shredding and data destruction services.

- Data from participants who choose to withdraw from the study will be destroyed as noted above, promptly upon their withdrawing their consent to participate in the study.
- The information gathered in the interviews and focus groups will be used in the writing based on this research. It is anticipated that this writing will result in documents available to the public, such as a doctoral thesis and/or journal articles. Participants will not be identified by name in any reports of the completed study and all information and quotes will be written in such a way that identities of participants, other people, and organizations are concealed.

### **FIRST AND SECOND PHASES OF THE STUDY**

If you choose to participate, you will be involved in the second phase of this study. This second phase of interviews will be carried out with people who will likely include workplace managers, program administrators, regulatory bodies' administrators, and others associated with nurses who have had problems with substances. The purpose of the second phase interviews is to gather information on institutional/organizational programs and processes that are involved in addressing nurses' problematic substance use.

### **WHAT ARE THE BENEFITS OF PARTICIPATING?**

It is hoped that you will find participating in an interview to be a rewarding experience; however, if you agree to participate in this study, there may or may not be a direct benefit to you personally. Nevertheless, the information gained from this study may contribute to a better understanding of the experience of nurses who have problems with substance use and make a contribution that is useful to the nursing profession.

### **WILL I RECEIVE PAYMENT FOR PARTICIPATING, OR WILL I HAVE TO PAY FOR ANYTHING?**

There is no cost to you for participation in this study. You will not be paid to participate in this research; however, public transit or parking costs incurred for your attendance at interviews will be reimbursed. A small gift of appreciation for your participation in the study may also be provided.

### **WHAT WILL BE DONE WITH THE STUDY DATA AND RESULTS?**

There are no plans for secondary uses of the recordings or other data for any other research purposes. The results of this study will be reported in a graduate thesis and may also be published in academic journal articles, books, or at academic conferences.

### **WHO CAN YOU CONTACT IF YOU HAVE QUESTIONS ABOUT THE STUDY?**

If you have any questions about the study or the procedures involved, please contact me via the contact information at the top of this form.

**WHO CAN YOU CONTACT IF YOU HAVE COMPLAINTS OR CONCERNS ABOUT THE STUDY?**

Concerns and/or complaints should be addressed to Dr. Jeff Toward, Director, Office of Research Ethics, [email address], [telephone number].



## PARTICIPANT CONSENT AND SIGNATURE

### Participation in a Research Study: Substance Use among Nurses in [a western Canadian province]: An Institutional Ethnography Study

Taking part in this study is entirely up to you. You have the right to refuse to participate in this study. If you decide to take part, you may choose to pull out of the study at any time without giving a reason.

- Your signature below indicates that you have kept a copy of this consent form for your own records.
- Your signature indicates that you consent to participate in this study.

---

Participant Signature

---

Date: YYYY/MM/DD

---

Printed Name of the Participant signing above

I am choosing to participate in interviews for this study. YES/NO (Circle one)

I consent to being contacted following my participation in the interview, should the researcher require clarification or more information. YES/NO (Circle one)

I would like to be contacted to participate in other, future studies by this researcher. YES/NO (Circle one)

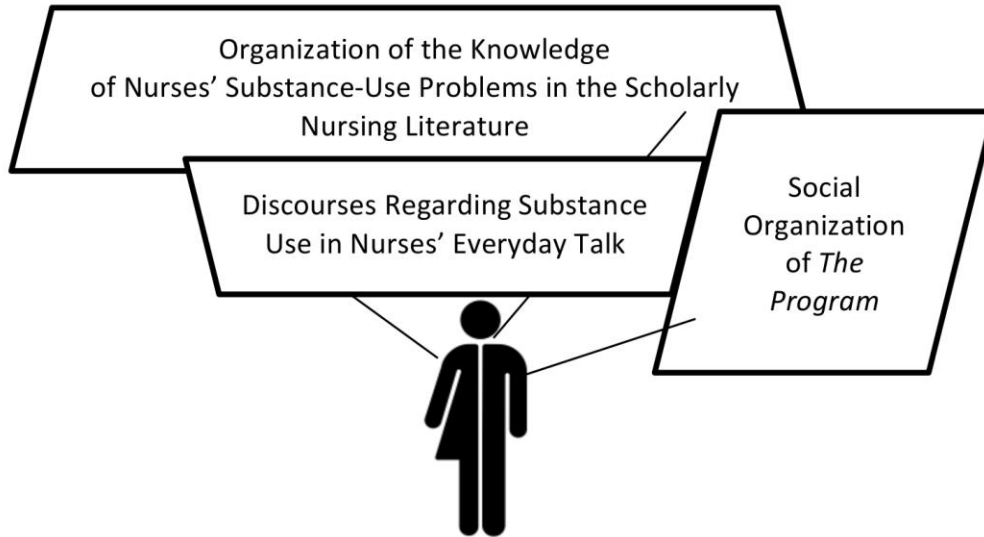
I would like to have the final written report of the study's findings mailed to me. YES/NO (Circle one)

If yes, please provide a mailing address \_\_\_\_\_

---

## Appendix G.

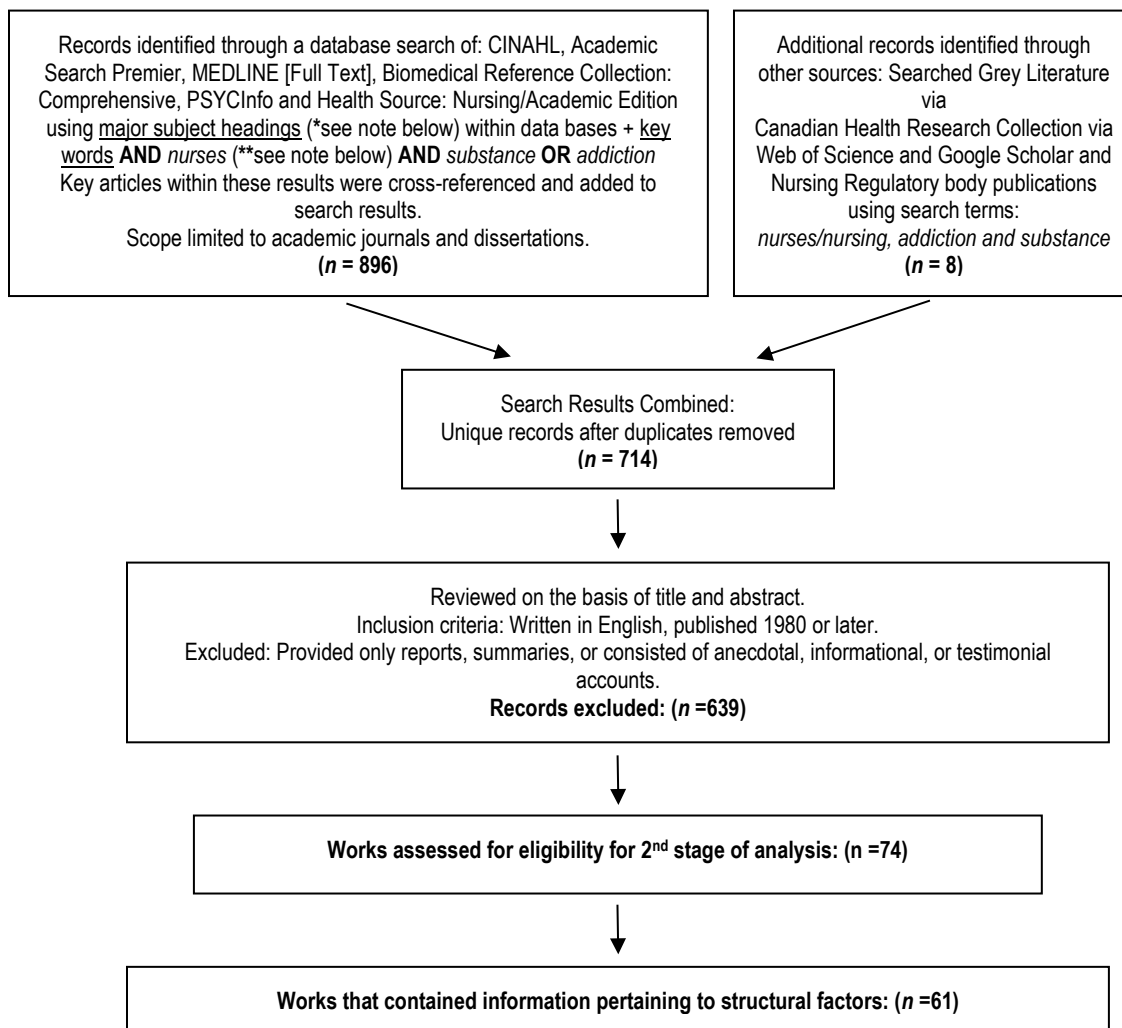
### A Diagram of the 'Small Nurse Hero'



*Note.* Adapted from *Institutional Ethnography as Practice* (p. 3), by D. E. Smith, 2006, Lanham, MD: Rowman & Littlefield. Copyright 2006 by Smith. Adapted with permission.

## Appendix H.

# Flow Diagram Depicting the Literature Search and Selection Process



*Note.* \*Major Subject Headings: CINAHL: keyword nurs\* + (SU) impairment, health professionals.

Academic Search Premier: (SU) impaired AND medical personnel + (select field) nurses  
MEDLINE [Full Text]: MESH - nurses (exact SU heading) AND professional impairment AND substance

Biomedical Reference Collection: Comprehensive: SU impaired, medical personnel AND (select field) nurses

PSYCInfo: SU impaired professionals + nurses

Health Source: Nursing/Academic Edition: SU impaired medical personnel + (select field) nurses

\*\* Nurses: In this search, the term 'nurses' included the professional categories of nursing students, registered nurses, registered psychiatric nurses and licensed practical nurses.

## Appendix I. Literature Sources Containing Information on Structural Factors by Thematic Category

<u>Author(s) and Publication Date</u>	Thematic Category				
	Access	Stress	Attitude	Treatment Policies	Nursing Culture
American Nurses Association (2015)					X
Beckstead (2002)					X
Bowen, Taylor, Marcus-Aiyeku, and Krause-Parello (2012)					X
Bozimowski, Groh, Rouen, and Dosch (2014)	X				
Breslin (1992)		X			X
Brewer and Nelms (1998)					X
Bugle (1996)	X		X		
Canadian Nurses Association (2009)					X
Clark and Farnsworth (2006)	X				
College of Registered Nurses of British Columbia (2012)				X	
College of Registered Nurses of British Columbia (2014)				X	
College of Registered Nurses of Nova Scotia (2008)	X				X
Collins, Gollnisch, and Morsheimer (1999)	X		X		
Darbro (2005)	X	X	X		X
Darbro (2011)					X
Darbro and Malliarakis (2012)					X

<u>Author(s) and Publication Date</u>	<u>Thematic Category</u>				
	<u>Access</u>	<u>Stress</u>	<u>Attitude</u>	<u>Treatment Policies</u>	<u>Nursing Culture</u>
Dittman (2008)	X	X			
Dossey (2010)				X	
Grover and Floyd (1998)					X
Haack (1988)		X			
Heise (2002)				X	
Heise (2003)				X	
Howard and Chung (2000a)					X
Howard and Chung (2000b)					X
Howard and Chung (2000c)					X
Hutchinson (1986)			X		
Kelly and Mynatt (1990)		X			X
Kenna and Lewis (2008)			X		
Kenna and Wood (2004)	X				
Kunyk (2013)	X				
Kunyk and Austin (2011)				X	X
Lillibridge, Cox, and Cross (2002)	X	X	X		X
Malloch (2013)					X
Monroe (2009)				X	
Monroe and Kenaga (2010)				X	X
Monroe, Kenaga, Dietrich, Carter, and Cowan (2013)				X	
Monroe and Pearson (2009)				X	
Monroe, Pearson, and Kenaga (2008)				X	
Monroe, Vendor, and Smith (2011)				X	X

<u>Author(s) and Publication Date</u>	<u>Thematic Category</u>				
	<u>Access</u>	<u>Stress</u>	<u>Attitude</u>	<u>Treatment Policies</u>	<u>Nursing Culture</u>
Patrick (2010)			X		
Pullen and Green (1997)					X
National Council of State Boards of Nursing (2011)			X	X	X
Ramer (2008)				X	
Rojas, Jeon-Slaughter, Brand, and Koos (2013)	X				
Shaw, McGovern, Angres, and Rawal (2004)				X	X
Shields and Wilkins (2006)			X		
Sidlinger and Hornberger (2008)	X				
Smith, Krinkle, and Barnett, (2013)				X	
Solari-Twadell (1988)			X		
Stammer (1988)		X			
Storr, Trinkoff, and Anthony (1999)		X			
Strom-Paikin (1996)					X
Sullivan (1987b)	X				
Sullivan, Bissell, and Leffler (1990)	X				
Tipliski (1993)	X		X		
Trinkoff and Storr (1998a)	X				
Trinkoff and Storr (1998b)		X			
Trinkoff, Storr, and Lipscomb (2001)			X		
Trinkoff, Storr, and Wall (1999)	X		X		

<u>Author(s) and Publication Date</u>	Thematic Category				
	Access	Stress	Attitude	Treatment Policies	Nursing Culture
Trinkoff, Zhou, Storr, and Soeken (2000)		X			
Trossman (2003)				X	