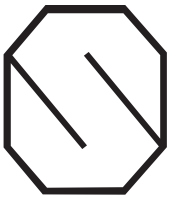

Systemic Exchange: Responsibility for Angst

Ian Brooks

Abstract

This paper reports on research that tells the story of nurse managers' attempts to provide a 24-hour service. Although research was contextualized within the National Health Service in the United Kingdom, the outcomes are not merely *about* the NHS. It is argued that middle managers, possessing delegated responsibility, are considered to be empowered. Such empowerment is accompanied by widely experienced anxiety. An escalatory and contagious process is observed which exaggerates 'normal' stress and challenge among middle managers into a state of self-perceived angst. It is argued that anxiety is, in effect, delegated, a process which serves to partially relieve superiors of anxiety-generating responsibilities. In contrast to arguments that players in bureaucracy 'conspire' to ensure that responsibility and consequent anxieties are largely held by the organizational elite, this paper argues that this traditional Weberian notion is worthy of challenge. Findings are based on qualitative data from an ethnographic research project that immersed itself in the minutiae of middle managers' organizational lives.

Keywords: anxiety, National Health Service, delegation, emotion

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Introduction

This paper reports on research which tells the story of nurse managers' attempts to provide a 24-hour service. Although research was contextualized within five National Health Service general hospital trusts in the United Kingdom, the outcomes are not merely *about* the NHS. It is argued that ward and directorate general management (referred to as middle managers), possessing delegated responsibility, are considered to be empowered. Such empowerment is accompanied by widely experienced anxiety. As if by exchange, anxiety is the price of empowerment. An escalatory and contagious process is observed which exaggerates 'normal' stress and challenge among middle managers into a state of self-perceived angst. In delegating responsibilities to middle managers for achieving both cost and quality improvements in an environment of acute nurse shortage, senior managers, tacitly at least, devolve anxiety. As responsibilities move between actors so do sources and subsequent feelings of anxiety. In this way, managers partially relieve themselves of angst from this source. This contrasts with the Weberian argument that players in bureaucracy 'conspire' to ensure that

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responsibility and consequent anxieties are largely held by the organizational elite.

This paper draws on data to demonstrate the delegation process, the often contradictory and demanding nature of responsibilities and the consequent signs of self-perceived angst. It will illustrate that responsibility is in effect exchanged for anxiety. This systemic process is observed within each NHS unit examined.

In this paper there is a departure from the psychoanalytical concept of anxiety as a clinically defined human state. The interpretative nature of this research is less concerned with the definition of the state of mind or clinical symptoms than it is with the respondent-espoused and collective acknowledgement of its symptoms in the context of organization as an emotional arena (Fineman 2000). Anxiety is considered to be socially constructed, hence its definition is grounded in the data. It is a state where stresses at work encourage discourse and emotional behaviours indicative of, and frequently referred to by respondents as, anxiety. Unlike the clinically defined and experienced condition, and its clear differentiation from stress, anxiety is used here in a broader sense to encompass a range of emotional behaviours and expressions which may or may not partly result from stress. Behavioural symptoms, noted in the data, include tearfulness, agitated movements and facial expressions indicating, for example, anger and worry. Espoused feelings of hopelessness and resignation, isolation and neglect, frustration and bitterness are noted in this emotionally charged arena.

Sociologists and anthropologists have shown vigorous interest in emotions (see Hochschild 1983; Harre and Jones 1986; Kemper 1990) for some time, although it is only recently that their thoughts have influenced organizational theory. That said, the study of emotions in organization has, more recently, proceeded apace (Van Maanen and Kunda 1989; Albrow 1992; Fineman 1993; Pinder 1998; Ashkenasy et al. 2000) with psychoanalytical perspectives having been eclipsed by social constructionist approaches. It is within the latter school that this research is located. As such it examines interrelationships between social groups, mediated through power, in aiming to explain and observe behaviours of an 'emotion-cluster'. As emotional meaning is negotiated interpersonally between middle managers, through conversational rituals and power (Gibson 1997), contagion, although not inevitable, is facilitated. This 'catching' and passing on of emotion has recently been explored (Doherty 1998; Verbeke 1997), raising the spectre of collective or shared emotional experiences in the workplace. This paper emphasizes the interrelationship between hierarchical levels and suggests that middle managers in ward-based hospital environments represent an emotion-cluster or set. As such they negotiate meaning and, it is argued, endure a shared experience of anxiety. Hence, the emotion-cluster is defined by structural parameters, and anxiety is exchanged between structurally defined social groups, thereby placing emphasis on both the social and relational contexts of anxiety.

Whereas the theoretical frame for this research is largely provided within

the emotional arena of organizations, brief consideration of structure and change is considered appropriate. Empowerment, the delegation of coherent responsibilities to an appropriate level, accompanied by adequate support, is widely considered in management literatures to lead to favourable outcomes for individuals, groups and organizations. Participative styles of management are said to engender loyalty and commitment and to increase job satisfaction and productivity (Drucker 1954; Likert 1961) and delegation is believed to negate many of the human problems resulting from mechanistic organization (see Argyris 1957). What is more, new public management (Dunleavy 1991; Dunleavy and Hood 1994; Ferlie et al. 1996) has stressed the adoption of 'private sector concepts', such as flatter hierarchies, the application of explicit standards and measures of performance, and emphasis on managerialism and change. Emphasis is placed on 'resistant' managers, said to be particularly common in public sector bureaucracies, who fear delegating budgets, responsibilities and decision making (Kanter 1997; Knapp 1998; Manz 1990; Weisbord 1988). Competent senior managers, it is argued, are moving their focus from one of control to the creation of appropriate conditions enabling employees to make optimum contributions (Bartlett and Ghoshal 1997). These changes are said to create a 'post bureaucratic paradigm', a gargantuan shift from bureaucratic to entrepreneurial behaviours (Aucoin 1990; Gray and Jenkins 1996; Kernaghan 1993; Osborne and Gaebler 1993). Little, if any, emphasis is placed on the adverse consequences of delegation for immediate recipients or groups further down the hierarchy, or on understanding its impact on emotions in organizations.

Context

Ward managers, most of whom are registered and practising nurses, manage day-to-day activities on a hospital ward, often containing around 10–30 beds, and report to a general or assistant directorate manager, themselves often experienced nurses or members of a profession allied to medicine. Collectively, those holding these ward and general management positions are responsible for operational activity. As middle managers they have considerable responsibility, and consequent accountability, for staffing, the achievement of continuous cost improvement, maintenance of quality standards and innovation in clinical practice. What is more, they are required to be 'flexible' in response to demand for their services and increasingly to accommodate nurse flexibility, particularly with regard to shift and temporal aspects of working. As the data presented in this paper illustrate, many middle mangers consider their responsibilities and challenging objectives impossible to achieve and contradictory in nature. They harbour considerable uncertainty of outcome and operate within an internal and external environment of scrutiny, ever-increasing expectations and empowered nurses and patients.

Research Method

The proposed thesis arose during research in five NHS general hospital trusts which sought empirical explanations for observed patterns of nurse shiftwork. It focused on identifying 'good practice' case studies and on establishing the adverse consequences of denial of nurse choice over temporal aspects of their working lives. Its transparent aim was to identify mechanisms to improve nurse retention and satisfaction. Hence, research was not *about* anxiety and the researcher did not enter the field intent on exploring emotional experiences. Therefore this paper reports unintended findings, those which emerged from the research experience and data analysis processes.

Ethnographic research was undertaken in an NHS trust general hospital in the Midlands of England and supplemented, concurrently, by a phenomenological research exercise encompassing four other NHS units in the south, east and Midlands of England and in Northern Ireland. Close examination of often intimate discourse was used in this research to surface anxious states of mind. Ward and directorate operational managers have similar experiences; hence, they were identified as an 'affective set' for analysis. Fineman (2000) acknowledges that the socially interrelated nature of emotions, such as anxiety, suggests that they are exchanged or shared among colleagues and superiors. It is the vertical, or hierarchical, delegation of angst that focuses attention here.

The researcher's intention was to explicate the emic or 'native's point of view' (Malinowski 1922). It was considered important to explore how participants made sense of their working environment. Clinical diagnosis or other 'measures' of anxiety levels were deemed unnecessary; instead, it was the participants' discourse and behaviours, articulated and displayed, that informed 'diagnosis'. As such, the primary source of data was spoken language, 'the main symbolic offering of culture' (Bate 1984: 48), an approach consistent with Barley's (1983: 393) contention that 'organizations are speech communities sharing socially-constructed systems of meaning'.

The ethnographic fieldwork took place over a four-month period within a broader year-long exercise. The researcher observed actors at work and engaged in informal discourse about workplace issues. Time was spent in the hospital environment around the clock, on wards and meeting rooms, observing rituals and routines and chatting with staff largely about hospital, healthcare and shiftwork issues. Wherever possible notes were taken on-site, enabling the immediate recording of actors' work experiences, although occasionally the researcher delayed recording data until a more opportune moment. As the ethnography progressed, stories merged into a contextualized, relational narrative.

The ethnography conducted in one hospital was supplemented by a grounded theory approach using data collected in a further four units in which data incidents were categorized and properties of these categories identified; these were given descriptive labels to aid data analysis. As

categories developed, they were recorded on cards, and further evidence, mainly in the form of respondents' discourse, collated in support. A process of iteration or constant comparison (Glaser and Strauss 1967), the testing of categories and properties on subsequent interviewees, helped to confirm, qualify or reject the analysis. Thus data collection and coding were conducted in parallel as an ongoing, iterative process. This approach is largely consistent with Glaser & Strauss' (1967) grounded theory, characterized as it was by inductive, interpretative analysis of rich data. The substantive theory set out in this paper emerged from the data.

Thirty middle managers, with operational responsibility for staffing, quality assurance, clinical innovation and cost improvement in ward-based environments, and 12 senior managers, were interviewed in five hospitals in England and Northern Ireland. The interviews served to enrich the data gathered by observation and other 'ethnographic' means, and enabled the researcher to explore some of the assumptions and observations made and to confirm or clarify understandings. Two long-serving respondents were interviewed initially, serving as invaluable 'key informants'. Researcher-generated stimuli were minimized, even when conducting the semi-structured interviews, by attempting to remain largely passive (Spradley 1979), unthreatening, interested and concerned. In the main, the language and content of the interview were dictated by the respondent and focused on workplace issues, such as the roles and responsibilities of managers and nurses and on the relationships between these groups. Over 60 hours of tape-recorded discourse resulted, which, together with field notes that recorded respondent behaviour and body language, contained ample evidence to support the analysis presented in this paper.

Initially, it was not easy for the researcher (me) to be motivated to conduct the primary research, particularly on the night shift, although respondents, often suspicious at first, warmed and welcomed my presence. On a number of occasions, individuals actually thanked me for listening to them and for researching 'them'; they appeared to respect my willingness 'to come to them' on 'their territory'. These highly personal encounters provided useful data and memorable experiences. As time passed and the actors' confidence in me grew, they recognized that the researcher was not a medium for communication outwards, but rather an interested and concerned party. As the relationship matured the data became enriched. Some is now used to help tell the story of anxiety on the ground.

Findings

Data, in the form of discourse and description of emotional behaviour, are now presented. They illustrate both the respondent-experienced sources and the symptoms of angst, the accumulation of angst, and the mechanisms that encourage it, together with how anxiety is expressed at middle management levels.

Manager's Experiences: 'Balancing Plates, Living Dangerously'

Middle managers spoke freely about sources of frustration and anxiety in their working lives including the introduction of flexible working contracts, acute nurse shortages and increasing levels of demand for services, the outcomes of strategic reviews, sources and reliability of funding and performance, workload and risk management measurement tools. These were often noted as irreconcilable demands, for example being required to offer greater working time flexibility to nurses while also required to offer a flexible service to patients. They suggested that senior management expectations were unachievable. Nurse managers frequently referred to the 'contradictions' inherent in their roles and shared their concerns at being required to 'square the circle' and 'satisfy all these masters'. They felt, as one articulated while discussing nurse flexibility,

'unsure how to take individual preferences into consideration, [especially as many nurses now] jump on the government band-wagon of family friendly rhetoric.'

Another middle manager confided that

'when the off duty [rota] goes up on the board within about a minute there is knocking on the door saying "this is appalling can we change it?" It comes across as very selfish, "I want this, I want that." If we met these needs we simply couldn't staff the ward, if we don't meet these needs we're told they'll leave and that looks bad. We can't win.'

Middle managers see themselves as squeezed between the very real and frequently articulated concerns of nurses, and managerial and operational imperatives to increase nurse retention while providing a flexible 24-hour service. What has changed is the level of empowerment increasingly 'felt' by nurses, due to prevailing labour market conditions and major political support to nurses from government. The middle manager's reaction is typically an emotional, angst-ridden and resigned tone in discourse, displayed, for example, as 'we can't win', or expressions of frustration accompanied by behaviours, such as, shaking the head, looking to the floor or tensing of muscles and facial expressions depicting worry or fear and sometimes barely suppressed anger, bitterness or helplessness.

Individual nurses exert pressures on their managers frequently and openly, expressing firmly articulated views about balancing work and social and domestic responsibilities, showing particular concern about being required to work nights when they would not choose to do so. One nurse referred to night work as 'a crushing responsibility', while others complained of the 'unsociableness' of nights and their inability to sleep and to adjust. Nurses spoke of the 'ever-present difficulties of balancing work and home responsibilities' and of being 'Jeckyll and Hyde' characters having to cope with the 'lack of fit between work shifts and the needs of families'. Many nurses referred to lifestyle considerations as influencing their shift preferences.

Middle managers, while generally recognizing these sentiments, appeared under increasing pressure to relieve them of such experienced difficulty. Frequently, they articulated concerns that the limits to flexibility had been

reached and that attempts to further accommodate twilight working, school hours, term time and other employee-friendly working time arrangements would bring with them significant negative safety and cost implications. Hence, one manager suggested that

'there is a limit to how many people you can have on a flexible working pattern. The problem is, we are flexible about them and they are not being flexible about what they can do.'

This comment was expressed with obvious frustration and worry and a degree of bitterness. Another middle manager argued:

'You do have to balance it. At the moment I would not accept anybody else [who required] rigid hours. I couldn't. I've got an imbalance in the 24-hour service. But they [an HR manager attempting to place a potential nurse recruit] label me as inflexible, not a good manager. I don't have any answers.'

This perceived lack of reciprocity was a commonly articulated concern among middle managers. One, attempting to staff a ward, expressed her dilemmas:

'[We have] two senior sisters, one is a single parent and works 8.30–4.30, the other works four days a week because she has a husband who travels and she has the babies — because we're so specialized you can't afford not to be flexible,'

A manager of a renal ward suggested:

'When the girls return from maternity they say "I want to work these days and these hours." Then I have the mutiny — they all want to do earlies, they all won't work weekends. Who is going to be there from 5 in the afternoon to midnight in dialysis? Dialysis is the sort of thing if you don't have it you die. I have to deal with this. It's tough actually.'

Another middle manager felt trapped by forces beyond her control:

'It's difficult to get the expertise, it's like a brain drain; there's so many jobs in the *Nursing Times* it's frightening.'

Another manager with a similar story to tell concluded:

'I feel that the full timers do get punished and it's me who has to carry that off. But, with such a shortage of trained nurses what can you do? The fact that I think they [those demanding further flexibility] are selfish, they want their cake and eat it, is something I have to keep quiet [meanwhile] you have a hard core who end up doing all the lates and weekends. I have different rules for different people [the respondent paused and shook her head]. It takes a lot of skill as a manager.'

A manager from the same unit confided that when attempting to provide absence cover many nurses were only prepared to work if they were paid at the overtime rate, even if they had not fulfilled their contractual hours in the given time period. She concluded:

'We're short of staff, there's nothing I can do about it but it makes me depressed. Some of them earn more than me.'

And about prospects for the future, she reflected, with an expression of worry, 'I dread to think.'

Some of these and other comments illustrate the worry felt about a highly uncertain future. The researcher was often surprised by the articulation of emotions, in both expression or behaviour, suggesting that managers' coping mechanisms are threatened.

The impact of national nurse shortages is considerable, as one manager reflected:

'People are leaving. In Neurosciences we lost two E grades. They were getting fed up with work flow and nursing levels. Of course leaving made nursing levels worse. When I qualified I could take charge of the ward. I was confident. Now [a pause] what are we going to do?'

A middle manager in another trust made a similar observation:

'... as soon as you get a retention and recruitment problem you are working with very low establishments and that makes it worse. It's hard to get out of that and build up confidence.'

Another manager expressed her view of the dilemma which she faced when attempting to provide staffing cover 24 hours a day:

'We have to have it [weekend, late and night work], it keeps us on the road. It *is* unfriendly, of course, but there's a shortage of trained nurses and you cannot accommodate them, otherwise *people will die*.' [italic reflects respondent emphasis]

She continued by explaining the lengths to which she had attempted to resolve this problem:

'I've tried recruiting from abroad. We are like the League of Nations: me being an Australian, we've got Spanish, German, just employed a Philippino, an Aussi, a Kiwi and they're all willing to do full time and they don't care what shifts they do. I dread to think that a quarter of my staff are foreigners. What happens when they all want to go home? We have to keep the show on the road.'

Keeping 'the show on the road' 24 hours a day, 365 days a week, under such circumstances lies at the core of managers' raison d'être, yet is perceived by them to be an operational imperative which is constantly under threat. The uncertainty that this creates is omnipresent and a major cause of concern for middle managers. Their anxious state appears to derive not merely from this daily imperative but from apparently genuine fears for the future. This is, for them, a major source of worry.

Understandably, flexibility is often discussed and working patterns agreed at nurse interviews. This is consistent with HR and senior management advice. Nevertheless, one manager's story revealed another reality.

'A junior sister said at interview, "Oh, I'll be all right, I can be flexible." She is starting next week and we've had a phone call to say, "I can only do these shifts and I can't do weekends." I can't have a sister who needs to be team leader telling me she can't do weekends. I'm trying to sort it out, it's going to be tough, but if she doesn't come ... [she raised her hands to the sky and did not complete the sentence]. It's so difficult because they keep saying "We've got a flexible policy," even Mr Blair is on about it. You can go too far and have nobody to do the out of hours, then the good ones leave, then what do you do? So you've got to get a balance. It's difficult.'

This was not an unemotional account. The manager was faced with real dilemmas and ambiguities, the resolution of which she believed to be 'difficult', itself a euphemism for 'I don't know how this is going to be achieved.'

It was not uncommon for managers to openly express emotions during interviews and when being observed at work. A number were tearful, one asking:

'What is being done for me? I have children, I have to balance work with home and fill in for nurses and manage and cope. What about me?'

Very many suggested that they often found it difficult to cope and saw no end to these difficult conditions. A middle manager argued that she was, 'caught between nurses who everyone thinks get a raw deal and managers who want results' and, holding her hands wide apart, as if to illustrate the distance between the conflicting positions, she reflected: 'Where am I?'. After a brief silence, the respondent gathered herself before continuing,

'The buck stops. I'm the one who has to keep the show on the road, I'm the one who misses my kids at Christmas [and, as if aimed at convincing herself] you just have to do it.'

Being confronted by forces beyond their control, yet experiencing little perceived recognition of this, appears to stimulate feelings of helplessness and signs of angst.

Delegated Accountabilities and Prescriptive Controls: 'Heads You Win, Tales I Lose'

It is apparent that middle managers in ward-based operational areas hold considerable responsibility. So significant is that responsibility that many senior managers often directly seek to 'support' subordinates, as an assistant chief nurse from a large NHS trust hospital suggested:

'We ran a whole day for managers to look at different ways of rostering. The Chief Executive opened it and summed up just to show them how important this was.'

'On the ground' a manager suggested that

'now they've told us how good managers do it, we've got to follow suit or we're not up to the job. They don't have to do it of course and none of them ever have under these circumstances.'

Middle managers 'feel' the distance between their senior colleagues' expectations and the realities they face on the ground, leading to articulated feelings of isolation and threat. Another middle manager, who attended the same 'support event', commented,

'although it was all common sense, every time we said, "well this and that won't work" they looked annoyed and said "we never said that this was easy".'

She continued,

'What they were really saying is "this is what we want, now do it and be accountable

for the consequences if it doesn't work." Maybe that's a bit harsh but underneath a lot of us felt that way. They were washing their hands of the problem.'

The responsibility for improving nurse retention and accommodating flexibility was being delegated by senior managers and received by an anxious group of middle managers. Less directly, but no less potently, the articulated vision or ambitions of senior managers placed similar emphasis on the middle manager. A senior HR manager outlined his vision for the nursing 'culture' at ward level as

'the sort of culture where staff do feel that they are valued and that the unit is theirs, where they are listened to and their needs taken into consideration'

and he added that at ward level many managers will argue 'we can't do that'. Whereas the initial sentiment is admirable, for managers having to achieve such utopia it further adds to their sense of helplessness, frustration and isolation.

A director of nursing from one of the research sites confided:

'I see a lot of disempowered nurses. Leadership is an issue at ward level.'

She identified a series of common attitudinal and motivational problems experienced by nurses, suggesting that middle management generally failed to tackle these concerns. Although there was recognition of some of the problems 'on the ground', the prevailing assumption was that these could all be overcome given sound operational management. Another senior manager reflected:

'It's the reality that has hit managers: they have been forced to do something.'

The 'distance' between senior managers' ambitions and middle managers' construction of the expectations placed upon them further contributes to the anxiety of the latter.

Middle managers have increasingly taken responsibility for risk management from their senior colleagues, as one suggested:

'It's so hot these days. They've got all these databases, all the drug errors are recorded. We know where they occur. I guess it's like a score.'

This delegation process was viewed as adding further accountability: the respondents suggesting that senior managers monitor their performance judgementally. In addition to prescription, and both implicit and explicit admonishment from senior managers, an increasing array of tools are employed to measure performance. In addition to the recording of drug errors, extensive use is made of workload measurements at ward levels which aim to identify patterns of workload demand and thus prescribe 'ideal' shift patterns. Such 'scientific' data carry considerable weight in a 'clinical' organization, even though the data are usually collected by compiling nurses' self-completed workload timesheets. It is widely viewed as reliable, robust information while working time arrangements employed by managers are often considered by senior managers as less rational, and inertia driven. Delegation of responsibility and accountability becomes

de-personalized by such measurement, yet the impact is highly 'personal' for these managers, reflecting, as it does, on their performance. This led one manager to comment:

'[because] my staffing pattern doesn't match the [measured] workload I now have to lose one nurse from lates [but] it's not as simple as that. Doing that will depress everyone; we'll lose others and if they go the assumption is you're not a good manager.'

Another manager, commenting on the use of workload measures and patient complaints procedures, suggested, in rather rapid speech as if chanting:

'... it becomes destructive if it says you need eight nurses and you've only got five [because of prevailing labour market conditions]. Nurses start that shift with a bad attitude. In this hospital they won't shut beds, you have to admit people. Then of course the [patient] complaints go up. The best and the worst thing we ever did was having the complaints procedure introduced. It tells us we need more staff to avoid problems, we can't get more staff so we can't stop the complaints so do we now listen to the complaints? [a sceptical look] What do you think?'

A manager, reflecting on his predicament, provides an apt contribution:

'We do the work but don't get the recognition, but you can be sure when things go wrong we're told about it.'

And, tossing an imaginary coin at the researcher, he added,

'It's like heads you win, tails I lose.'

Managers often articulated comments like this to illustrate their feelings of isolation and their self-perceived pariah status.
Emotionally expressed concern over uncertainties oozed from the data. A manager commented that

'the introduction of budgets and budget holders confines me. If you have such staff responsibilities you can't do the job you used to. You can't give the quality of care you would like. You are always balancing plates, living dangerously.' [accompanied by agitated body movements and an expression of worry or serious concern]

On the same theme another manager suggested that

'we need to lead by example but heavy workload and the added management tasks makes us too busy to do that.'

Again, much of this discourse was delivered with what appeared to be genuine concern and regret. A feeling of helplessness, even personal inadequacy, was apparent.

Rising Angst: The 'Narrowing Path'

Managers' discourse revealed considerable anxiety about workloads, insufficient staffing levels and ever-increasing expectations in terms of both productivity and skills. They referred to increasingly vocal patients and relatives who know and exercise their rights, who are less patient and accepting and who demand quality care and attention. Senior nurses, including

ward managers, are having to learn new skills in order to relieve junior doctors of some responsibilities currently hampering attempts to reduce their hours in line with government and BMA requirements. Managers view the increasing pressure, in addition to the 'normal' emotional, mental and physical demands of the role, as having to 'deal with problems that don't belong to us: relatives, angry patients, cost constraints'.

Many middle managers, some on temporary contracts, spoke of lack of job security, having to meet objectives for 'cost improvement' and 'quality of care', having to 'move mountains' and 'overcome obstacles' to achieve this. An experienced middle manager argued that her options were few; she was traversing

'a narrowing path' [her hands moved together until they touched]

There was obvious emotional theatre at this moment: the respondent could not bear to articulate the next scene, preferring not to think about the future and the uncertainties it held.

Some of the coping mechanisms employed by middle managers, such as frequent unwillingness or inability to discuss the future, create further dilemmas. When asked how apparently irreconcilable demands upon them were going to be met, many respondents simply shook their heads and a number looked to the sky, as if searching for divine intervention. One manager replied, 'I simply don't know', slowly and deliberately emphasizing each word and revealing her anxious state of mind to the researcher. While one practical way to compensate for acute nurse shortage has its associated problems, as a manager suggested:

'I increased my number of healthcare assistants. A third of my staff are that. At least the patients get fed and washed but it's the barest minimum [quality of care] really. They can't give drugs and, I know it sounds silly, but patients are so sick these days [due to reduced length of recuperative stays and non-hospitalization for less severe cases] and need more trained care. There's a big turnover of healthcare assistants, something like 30%, so even if they are there you haven't got such great skills and that sort of trust you like to think you have with a registered nurse.'

It is also worthy of note how, not untypically, she refers to *'my'* people. This highly personalized approach reflects a significant degree of emotional engagement with the work which itself tends to heighten consequent anxieties when apparently insurmountable problems, such as that articulated above, occur.

Finally, Menzies (1960) and others have already noted that healthcare professionals, particularly in operational areas, suffer anxiety resulting from their core role of caring for seriously ill and often dying patients; but one manager's story put that into perspective:

'Most of us know we are in a life and death profession. We don't take it for granted and everyone has a cry now and then, you expect it, but I'm in no doubt that staffing causes most stress these days.'

Discussion

The data presented above provided support to the argument that anxiety is, in effect, delegated, a process which serves to partly relieve more senior managers of what might otherwise be an overwhelming degree of anxiety (and it is recognized that this might itself be a 'necessary' coping mechanism for them). As a result, middle managers are faced with having to maintain or improve quality of care on wards in acute hospital trusts in an environment of cost constraint, nurse shortage and 'encouragement' to embrace nurse-initiated flexible working practices. The data illustrate that this responsibility harbours many unknowns, such as the availability of nursing staff at all times of the day, week and year at the appropriate grade and skill levels.

Middle managers' anxiety is deeply woven into how they enact their roles, exercise power and make decisions. Furthermore, as the appraisal of a situation is likely to be linked to respondent's current emotional state (Lewis 1995), anxiety can act as a mediator ensuring an escalatory process. For example, it is quite feasible that anxious individuals and groups are especially vigilant for threats and danger (Eysenck 1992; MacLeod and Matthews 1988) and may have a heightened sense of worry and vulnerability; in a sense, then, middle managers' anxious state may be self-reinforcing.

Whereas evidence presented elsewhere (Brooks 2000) suggests that nurses themselves bear considerable burdens of power imbalance, as their influence increases, reinforced by government employee-friendly rhetoric (see for example Department of Health 1999) and an acute nurse shortage, data suggest that a further burden is being placed on the already beleaguered middle manager. The delegation process that had manifested itself in increased, often enforced, temporal flexibility for nurses appears to have been checked, leading to further accumulation of anxiety at middle manager levels. It appears that a combination of formal legitimate or position power (French and Raven 1959) from superiors, and collective, formal and informal influence from below, leaves operational managers facing grim prospects. As such, power is a dynamic: it is not fixed in either location or extent, but fluctuates given the interplay between formal and informal processes. Power lubricates the anxiety-delegating process, acting as the mediating force. It is the power to delegate responsibilities laden with ambiguity and complexity, or the collective power of nurses to resist its acquisition, which is of central significance. There is what Lukes (1974: 24) refers to, in his three-dimensional view of power, as '*latent conflict*, which consists in a contradiction between the interests of those exercising power and the *real interests* of those they exclude'.

Many respondents acknowledged that any further accommodation of nurses' demands for temporal flexibility in rostering would not, on their part, be considered if it were not for the current difficult labour market conditions. They had not internalized the requirement for temporal flexibility; its achievement could not be further accommodated along with other conflicting

objectives. The power of nurses in this regard may, however, prove ephemeral for they have struggled with professionalization (Caplow 1954; Johnson 1972; Wilensky 1964) and consequent attempts to gain occupational control or equity of treatment with 'competing' professions (e.g. medicine) and with mediating processes, such as bureaucratization or managerialism. Salvage (1988: 517) refers to nursing as that 'stunted occupational subspecies', a reflection on their relatively powerless position. Nurse power appears vulnerable, perhaps giving hollow consolation to middle managers.

Conclusions

In contrast to the argument that players in bureaucracy 'conspire' to ensure that responsibility and consequent anxieties are largely held by the organizational elite, this paper argues that this traditional Weberian notion is worthy of challenge. It has been argued that delegating responsibility serves to share angst with the less powerful. As such it could be considered as a coping mechanism: a process initiated to even out what would otherwise be an overwhelming level of anxiety borne by a few. Delegation may not entirely relieve the manager of responsibility, or indeed control, but both appear to be shared, with the likely consequence that the 'superior' is at least partially relieved of ensuing anxieties. While this paper is written from an anxiety perspective and, as such, focuses on the negative aspects of the delegation process, most literature has stressed the positive associations of that process. Therefore, it presents a fresh perspective from which to view delegation, empowerment and participative management.

It is, however, important to reflect on the approach taken in conducting this research. Much of the data were elicited from an ethnographic study in an NHS general hospital trust. As ethnography this is an individual's perception of the respondents' observed reality. If another ethnographer entered the same cultural territory, she or he might view aspects of that world differently (Agar 1980). The grounded theory research conducted in a further four units did, however, serve to support and modify understandings elicited in the focal unit.

In this research, anxiety is a grounded concept. From a psychoanalytical perspective what was articulated, expressed and enacted by respondents would require further validation. Similarly, from that perspective, the relationship between stress and anxiety is not clarified. Nevertheless, the interpretative nature of this research is less concerned with defining the state of mind of respondents than it is with acknowledging respondent-espoused and 'lived' symptoms in the context of their emotional arena. As such the data are enriched with highly emotional behaviours and expressions from members of the 'emotion-cluster'. The author has attempted to illustrate this by telling their stories, but acknowledges the ensuing struggle experienced in relating their true anxieties. Furthermore, I am aware that the outcome of this research will be evaluated in terms of its persuasiveness, credibility and its power to persuade and to stimulate its audience.

What is more, research in this area is far from complete. Research is required to further develop this argument, to evaluate its applicability and relevance in other contexts and to examine this process as part of the demise of traditional or Weberian notions of bureaucracy and the further embedding of postmodern organization. For example, it is quite feasible to consider the anxiety-delegating process as operating in a wider arena, similar to what Trist (1981) refers to as a 'domain' or, more recently, what Bain (1998) labelled a 'system domain', something which is shared across organizations. Additionally, research could establish the consequences of this process for middle managers' social and domestic lives, for their performance, well-being and retention. Certainly the data were enriched by pleas from respondents for this to be considered. It might also examine the potential positive effects of anxiety delegation, such as a potential capacity to stimulate and challenge (Geare 1989), including an examination of the process of employee involvement in decisions regarding the delegation of tasks and responsibilities and of the degree of acceptance of collective responsibilities.

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