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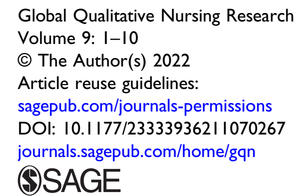
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The Concepts of Social Space and Social Value: An Interpretation of Clinical Nursing Practice in Vietnam

Các khái niệm về không gian xã hội và giá trị xã hội: diễn giải về thực hành điều dưỡng lâm sàng ở Việt Nam

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Abstract

This research draws on broader inquiry that explores the construction of the spatial positioning of nurses in Vietnam and how power structures sustained that positioning. Observations and individual interviews were undertaken with 32 registered nurses. Analysis of participant data and relevant policy documents moved beyond coding to theorising and thus to the abstraction of key concepts. Social space and social value were significant concepts developed in the research. The concept of space reflected the ways in which nurses constantly engaged in processes of negotiation to embed a sense of control over their practice. The related concept of social value brought focus to a power structure whereby the fiscal priorities of health care managers reinforced a disconnect between the use and exchange values of nurses. An interpretation of power relations that underpinned the material and symbolic spaces in which nurses worked was framed within the historical context of Vietnam.

Tóm lược

Bài báo này da trên nghiên cứu với qui mô lớn hơn nhằm tìm hiểu v thế của nghành điu dng tại Vit Nam. Phơng pháp quan sát và phỏng vấn cá nhân đc thc hin với 32 nhân viên điu dng làm vic tại tám khoa của mt bnh vin Vit Nam. Vic phân tích dữ liu của ngời tham gia và các tài liu v chính sách liên quan đã vt ra khỏi phạm vi mã hóa dữ liu đơn thuần, m rng sang học thuyết và chuyển sang trừu tng hóa các khái nim chính. Không gian xã hi và giá tr xã hi là những khái nim quan trọng đc phát triển trong nghiên cứu này. Khái nim v không gian phn ánh cách thức mà các nhân viên điu dng liên tục tham gia vào các quá trình thơng lng để kiểm soát đc vic thc hành của họ. Khái nim liên quan v giá tr xã hi tập trung vào cơ cấu quyn lc, theo đó u tiên tài chính của các nhà qun lý chăm sóc sức khỏe góp phần làm gián đoạn mối liên kết giữa giá tr s dụng và giá tr trao đổi mà ngành điu dng mang lại. Lý gii v các mối quan h quyn lc đã đc củng cố trong không gian thc và không gian mang tính biểu tng nơi các điu dng làm vic, đc đnh hình trong bối cnh lch s của Vit Nam.

Keywords

nursing practice, space, social values, power relations, qualitative research, Ho Chi Minh City, Vietnam,

Từ khóa

Thc hành điu dng, không gian, giá tr xã hi, mối quan h quyn lc, nghiên cứu đnh tính, Thành phố Hồ Chí Minh, Vit Nam

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Background

As is the case elsewhere, nurses and midwives combined constitute the largest proportion of the Vietnamese healthcare workforce. According to the General Statistics Office of Vietnam (GSOV, 2021), in 2011, there were approximately 141,494 registered nurses (RNs), across all educational qualifications, and 44,104 doctors working in the health care system. Vietnamese nursing is also shaped by the legacy of the complex historical development of the country. Up until the mid 1980s,. there were no regulatory structures or working policies that underpinned the development of nursing as a profession. Nursing practice was not recognised as an autonomous area of practice until formally acknowledged in 1990 through the establishment of the Vietnamese Nursing Association (VNA). Nursing was subsequently legally endorsed by the Vietnamese government in 1992 through the institution of the nursing office in the department overviewing national treatment and caring.

In Vietnam, physicians and medical assistants have historically had significant roles in overseeing nursing activities. It is not surprising, therefore, that an enduring view in Vietnamese society was of nurses as assistants to physicians rather than autonomous practitioners (Jones et al., 2000). For example and despite the efforts of the VNA, government policy documents from 1993 to 2007 continued to categorise the nursing role as 'medical assistant'. These documents explicitly stated that nurses were to follow the orders of physicians (MOH, 2011, 2015).

Since 2007, there has been a greater emphasis on the independence of the nursing role in health care services in Vietnam. This shift coincided with the development of Vietnamese Nursing Competency Standards (VNA, 2012) curricula as an outcome of the Atlantic Philanthropies funded series of projects undertaken, from 2007 to 2016, in partnership with an Australian university. There was, however, an ongoing separation of the higher education and health care labour markets in Vietnam, the result of competing strategic policy reforms. While the Vietnamese health education sector looked to internationalisation as strategic to the development of human health resources (Nguyen & Tran, 2018; Tran & Marginson, 2018), the Vietnamese clinical health care sector focused on the fiscal autonomy and efficiency of public hospitals (Nguyen, 2018; Võ & Löfgren, 2019). The local circumstances of the autonomisation of Vietnamese health care meant that policies were based on the interests and preferences of clinical health care management rather than the education of health workers (Võ & Löfgren, 2019). Thus, the context of this research was one where the space and value of nursing clinical practice were the products of the localisation of clinical health care reform policies in contrast to the greater professionalisation of nursing through the internationalisation of nursing education.

In this research, space was not conceived of as an inert thing but as relational in the sense that space both constructs and is constructed by human actions. The concept of space developed as a significant analytical concept within broader research that explored structural tensions between nursing education and nursing practice in Vietnam. The focus of the research was the interrelationship of the specific spatial form of nursing practice and its imposed social value within a clinical context in Vietnam. The aim was to explore the construction of the spatial positioning of nurses in practice and how power structures sustained that positioning.

Methods

Theoretical framework

The research drew on the works of Lefebvre (1991) and Harvey (1996) and was informed by the key assumption that the conditions of nursing work are shaped by social processes that produce and reproduce structures of power and knowledge and thus particular interests. A further assumption was that social processes and associated actions always happen within a space (Lefebvre, 1991; Harvey, 1996) and hence an understanding of nursing practice and its complexities extends to the spatial forms within which practices take place). Space is integral to hierarchies, divisions of labour and organisational power and functions which embed and/or constrain social actions (Giddens, 1984; Sjoberg et al., 2003).

The interrelationships among these issues were analysed to explain the processes underpinning social actions within nursing practice. This focus allowed for an exploration of the context wherein human actions around nursing work were constructed within a hierarchy and associated division of labour. Thus, the works of Lefebvre (1991) and Harvey (1973) provided the tools of analysis to explore the construction of nursing practice within space and the implications of the configuration of a particular spatial form.

Lefebvre's early work (1991) focuses on how meanings attributed to everyday life, rather than knowledge of everyday life, transform actions. As such, Lefebvre (1991) dialectically depicts space as both a product and determinant of social interactive actions. In the research, the concept of space allowed for an examination of how social relationships both reflected and were constitutive of the organisation of nursing practice. Lefebvre also (1991) argued that the role of space was central to social and historical processes where conflict and tensions exist around the constructed meanings of social actions.

Harvey's work (1973) also addresses the production of space but places greater emphasis on the political and economic interests of spatial forms. Thus, in addition to social interactions, there are political and economic issues which constitute space and these interrelated elements were considered in explaining how Vietnamese nursing practice was formed and performed. Harvey (1990, 1996) was also interested in the accumulation and circulation of surplus value where use value and exchange value become elements in the production of space.

Setting

The research was conducted in a primary tertiary referral hospital that serviced 37 provinces in the south of Vietnam and a hospital population in of more than 2544 inpatients and 3500 outpatients per day. The hospital had 2000 beds and consisted of four centres and 38 clinical, 12 subclinical and 11 functional departments and employed 1349 RNs across these settings.

Participants and recruitment

Purposeful sampling guided participant recruitment. The research focused on RNs as key stakeholders in the research organisation. Inclusion criteria were RNs with bachelor education qualifications, at least 3 years clinical experience, and who were providing direct care to patients. RNs who worked in specialist departments such as Intensive Care, Cardiology Intensive Care, Surgical Neurology Intensive Care, Cancer Departments and Palliative Care Department were not considered potential participants. Data generation was focused on nursing decision-making and actions around patient care. Based on the inclusion and exclusion criteria, eight departments were selected for recruitment (Table 1).

The researcher contacted the nursing Heads of Departments of the eight identified areas to obtain approval for recruitment and subsequently collaborated with each departmental head nurse to organise two research information sessions to ensure all nurses had an opportunity to attend. Research posters were displayed in all eight departments and information flyers were distributed to all nurses working in those areas. Nurses who were interested in participating in the research contacted the researcher through a contact number and/or email address included on the flyer and posters.

At the time of data generation, there were approximately 60 RNs across the eight departments who met the inclusion criteria and of these 32 RNs agreed to participate in the research. Table 1 presents participant demographic data.

Table 1. Participant Demographic Data.

		Sex	
Department	Number	Female	Male
Surgical Neurology	3	1	2
Surgical Gastrointestinal	7	6	1
Internal Cardiology	6	5	1
Internal Respiratory	5	3	2
Oncology	1	1	0
Endocrinology	4	4	0
Internal Neurology	4	3	1
Haematology	2	2	0
Total	32	25	7

Data generation

Observations, individual semi-structured interviews and a range of policy documents constituted research data.

Observations. Observations were undertaken to explore the clinical practice of RNs and the social and cultural contexts in which the RNs worked. The researcher undertook two-hours of observation of each recruited RN at varying times between 7:30a.m. to 7:30p.m. in the eight departments of the hospital. The result was 58 hours of observational data. The timing of a period of observation was negotiated between the researcher and each participant to ensure that the participant was comfortable and able to work freely. A note taking chart, informed by the research theoretical perspective and the work of Spradley (2016), was used to record the observed dimensions of the social situations in initial general observations as demonstrated in Table 2 below. The observations were tested out against other data sources including interviews, documents, literature and theory throughout the analysis process.

Interviews. Semi-structured individual interviews, each of approximately one-hour duration, were also undertaken. The interviews took place outside working hours and in private spaces in the relevant departments to ensure convenience and confidentiality for participants. Of the 32 participants, 29 agreed to be interviewed following a period of observation and three RNs agreed to be observed but not to participate in an interview. Each interview was broadly informed by the theoretical perspective in exploring how nurses self-interpreted their work, how they described their interactions with physicians, patients and family carers; and how structural and social contexts shaped nursing practice (Table 3).

The interview content was constructed and co-constructed through an iterative process of data generation, data analysis and back to data generation. The concept of theoretical sampling (Charmaz, 2014) played an important role in this phase as ongoing analysis informed subsequent interviews. The process ensured that interviews became more focused and condensed as the research progressed.

Documents. An additional data source was government and legal documents relevant to nursing in Vietnam. These sources were government or legal policies that had previously been implemented, or were currently active policies, in Vietnam. The document sample expanded throughout the analysis process to capture relevant issues and perspectives on clinical practice. The number of documents increased from five to 50 during the analysis process and provided broad insight into the political, social and economic contexts of Vietnamese nursing practice (Table 4)

Table 2. Observations Recording Template.

Dimensions	What to observe
Space	Description of the department and how it works ✓ Organisation: location of physician room, nursing room, Patient room ✓ Positioning of physicians, nurses and patients ✓ Arrangement: instruments, documents, work shifts, work responsibilities
Activities	What was being done by the observed participant
Act	Acts carried out by other people in the observed setting including physicians, nurses and patients.
Event	What was happening in relation to the observed participant's activities
Creation	The responses and responding processes of the observed participant to situations The responses and responding processes of people in the setting, including physicians, nurses and patients, to the observed participant's activities and/or responses
Interactions	The interactions between the observed participants and other people in the setting, including physicians, nurses and patients
Time	The sequences and length of the observed activities
Emotion	The expressed feelings of the observed participant toward the situations and other people in the setting and how he/she expressed these feelings The expressed feelings of other people in the setting, including physicians, nurses and patients, and how they expressed those feelings
Object	The material objects in the settings

Table 3. Semi-Structured Interview Guide.

Contents	Questions*
How nurses perceived their interactions with physicians, patients and family carers.	• Can you talk about your interactions with physicians? Can you describe your professional relationships with physicians in the clinical setting? • How do you perceive your relationships with patients and family carers? • What most influences those relationships?
How structural and social contexts shaped nursing practice.	• Could you explain what was happening in the situation I observed? • What did you think about that situation and what was happening? • What did other people related to your work think about your nursing practice? How did you respond? • What factors influence your decision-making around your nursing practice? How and why? • Can you describe the physical setting in this ward? I am interested to know where nurses, physicians, patients and family members are usually situated. What is acceptable for nurses in moving into different areas in this ward. What is not acceptable?

(*) Additional questions were added, as informed by the direction of each interview, for further exploration and clarification.

Table 4. Categories of Selected Documents.

Categories	Health	Education	Others
Resolution	1	3	1
Law	0	3	
Decision	6	9	
Decree	2	5	
Circular	2	2	
Joint Circular	1	0	
Reports, Agreement, Standards	14	1	
Total	26	23	1

Data generated from documents were used to support or challenge outcomes of the analysis of observational and interview data. The researcher adopted the method of Charmaz (2014) who proposed that the examination of documents be organised around three comparative pairs: (1) form and content; (2) audience and author and (3) production and presentation. Hence, data generation considered the context of Vietnamese healthcare within which the documents were constructed.

Data analysis

The method of data analysis, in the early phase, drew on the work of Charmaz (2014, 2017) as a guideline to explain rather than describe the studied phenomena. Hence, the researcher actively engaged with open and focused coding of data to reach a level of abstraction and conceptualisation rather than a description of themes. This active engagement was expected to achieve a theoretical sensitivity defined as the researcher's

ability to understand and extract abstract and analytical concepts (Charmaz, 2014).

In its evolution, however, the analysis became 'non-technique and non-method' (St. Pierre & Jackson, 2014, p. 7171) as the process of theorising broadened to include the unanticipated such as, in this case, the concept of space which appeared significant in the positioning of nurses and nursing practice. Reflexivity was thus important in the analytical process in '…bringing in issues of alternative paradigms… (and) rebalancing and reframing of voices in order to interrogate and vary data in a fundamental way' (Alvesson & Sköldberg, 2009, p. 313). The result was a dialectic process of analysis where all data sources including literature, theoretical concepts, interview and observational data and documents acted as sensitising material for interpretation.

Ethical considerations

Ethical approval was obtained from the relevant universities in Vietnam, the University of Medicine and Pharmacy at Ho Chi Minh City (UMP) (ethics number 243/ĐHYD-HĐ) and Australia, the Queensland University of Technology (ethics number 1,500,001,042). The processes of these institutions were strictly followed to identify all possible ethical risks in relation to participants.

Ethical considerations in the research were judged to be of low risk. The four ethical principles of autonomy, non-maleficence, beneficence and justice were adhered to in the research (Holloway & Galvin, 2016). Posters were situated in the eight departments to inform physicians, nursing staff, patients and families about the research. Where participants were to be observed while caring for patients consent from patients and/or families was first secured.

Findings

The social space of nursing practice

The working spaces occupied by the nurse participants both reflected and constructed social practice. The following description depicts the physical arrangement of functional rooms in the research space;

> Observation 1: […] Basically, every department has one staff room located between two corridors of patient rooms, one staff meeting room used for hand over before the morning shift located outside the department, one resting room for physicians opposite the staff meeting room, one resting room for nurses inside the department, one storage room for medical equipment and one room for minor medical procedures. In surgical departments, the corridor to the right is usually used for patients who are waiting for scheduled operations while post-operative patients are situated along the left corridor. In the medical surgical department, patients are located in rooms…with the most severe patients located nearest the staff room and the nurses' room.

A focus on space thus begins with how interrelationships within the physical work domains of the nurse participants were integral to the broader structuring of practice. The two key work environments for nursing practice were the staff room and patient rooms.

Nursing practice in each space differed according to the functions of those spaces. The majority of documentation of patient information was carried out in the nurse staff room and nursing practice took place at the bedside. The nature of these spaces appeared as physical and thus as 'things', or immobile containers, within which nursing as a neutral practice was performed (Harvey, 1973). Yet, nursing practice was also a social product of processes of negotiations (Strauss, 1978) and hence these spaces were beyond 'things' (Harvey, 1973) and existed as relational. Harvey (2006, p. 121) asserts that relational space 'be understood as a relationship between objects which exist only because objects exist and relate to each other. There is another sense in which space can be viewed as relative and I choose to call this relational space'.

There were differences in the physical realms of the staff room and bedside areas that reflected contradictory notions of nursing practice; closed versus opened and individual versus interactional. The staff room was a closed space and positioned occupants within a hierarchy.

> Observation 1: The staff room is divided into two small rooms, one for nurses and one for physicians and the rooms are separated by a partition. Nurses sit with nurses and physicians sit with physicians. Only the head nurse sits in the physician's room presumably as an information source. The staff room has closed doors with two-way windows and patients and family carers stand outside if waiting for a nurse or physician. Patients and family carers are allowed into the room when physicians want to talk with them.

The spatial formation of the research context physically separated nurses, physicians, patients and family members and thus functioned as a barrier to greater collaboration and interaction. Patients and family carers were treated as outsiders by nurses and physicians and nurses were perceived as strangers when entering the space of physicians.

There were also well defined and detached spaces occupied by the two professional groups. For example, the partition located in the medical and nurse staff rooms created visible physical territories and the closed doors and two-way windows separated professional staff from patients and family carers.

> Observation 8: One group of physician sits in the medical staff room writing patient reports, prescriptions and medical orders. Nurses sit together in their staff room writing up nursing notes.

> Nurses sometimes come to the medical staff room to collect completed charts or to check medication and nursing orders. Sometime, a doctor briefly comes to chat with nurses and then quickly moves away.
>
> Mostly family carers and sometimes patients come to the staff room with requests. When patients and family carers come, they stand outside the room, in front of the windows. They knock on the two-way window. A nurse comes to open the window and asks them what they want.

The staff room was shared by nurses and physicians and yet the space was organised into discrete areas as though the appearance of nurses in the physicians' area might signify an encroachment on space. Both nurses and physicians avoided going into the respective space of the others.

> RN11: We don't sit together… It would be strange for nurses and physicians to sit together and discuss patients. If you do sit there (in the physician's room) they move away…. Or they sit there but don't talk I mean talk about patients. You can sit there and listen to them but I don't know what to talk about. It is strange. I don't think physicians like it. I don't like it either.

Furthermore, the area allocated to patients and family members reduced the engagement of this group with health care professionals. Indeed, the spatial form supported individual rather than interactive social actions. Any infringement on the space of physicians by nurses risked being attributed to an individual or individuals. Furthermore, the separation was publicly visible and thus the material reality of this spatial form limited the space in which nursing practice could be renegotiated.

In the above examples, social space was realised through an ordered co-existence of inhabitants as agents and material properties. The location of barriers, such as partitions or closed doors and two-way windows, constructed a social space that reflected a class stratification in the broader social realm. Nurses had limited access to space understood as the domain of physicians, and patients and family carers had to gain permission to enter hospital spaces outside patient rooms. The physical arrangement of space ordered routine work in such a way that reflected the dynamic social relationships between the groups.

> Observation 1: There are rest rooms, one for nurses and one for physicians. The rest room for physicians is located outside the department entrance. The rest room for nurses is inside the department next to the room set up for the most severely ill patients. When something unexpected occurs, patients and family carers come to the staff room to call the nurses. Nurses then come to a patient room to assess the patient. If the problem is not acute the nurses provide treatment. If the nurses determine that patients are deteriorating or are severely ill one nurse will call the physicians while the other nurses will start emergency procedures.

The construction of space by social interaction and, in turn, the reproduction of social relations in that space (Harvey, 1990), was more overtly demonstrated in the shift from patient-centred to physician-centred spatial forms at a patient's bedside.

> Observation 18: (The patient had respiratory failure that needed emergency intervention). Three nurses were involved in preparing equipment needed for patient treatment. They stood around the patient with equipment ready. When a physician appeared, the three nurses stepped back and waited for the physician to assess the patient. During this time (a very short time), one nurse prepared equipment, one nurse prepared emergency medication and the third took vital signs again. The physician asked for information about the patient (vital signs etc) and gave orders. The nurses carried out the orders while the physician observed and re-assessed the patient. …. The patient's wife was asked to **stand outside** the room and wait.

The actions of the three nurses brought the physician, rather than the patient, to the centre of activity. The patient focused actions of the nurses were then re-established once the physician had left the room. The interrelationships were interpreted in the following conversation with one of the observed nurses;

> Researcher: To me, it looks as though the actions of you and your colleagues changed when the physicians appeared. You were more autonomous in your work and you worked with the patient more than when the physician was there. Is that right?
>
> RN18: Well… I can understand what you saw. It is like the rule. When there is a physician present, we should… usually have to… wait… although we know what to do. Of course when there is no physician we have to act first and report later (because) the patient can't wait. In some very acute situations, we have to call and wait for physicians. Because we have to wait, we try to manage the time, what we call "golden time" in an emergency, by preparing equipment, medications, so that we can do orders right at the time they are given… Because of this, you saw that we, but not really, it looked as though we stepped back from the patient.

Nursing was limited in form and content as shaped by the norms and power relations that produced a narrow spatial form of practice. Underpinning form and content were the interpretations of nurses which confirmed practice as dependent upon, or subservient to, the medical profession. In reflecting Lefebvre (1991), within the spatial form some actions were ensured, others highly desired and yet others were limited. Hence, nurses who adhered to the contextual norms of patient care practiced within confined boundaries. In so doing, nurses reproduced a spatial form that entrenched

those boundaries and ensured that interactions with other health professionals were minimal.

It appeared that the constraints of symbolic power shaped nursing practice in minimising spatial access and thus the movements of nurses within the broader space. Spaces were not equally accessible to nurses where some, such as the medical staff room, medical treatment room and staff meeting room, were understood to be primarily the domains of physicians unless invitations to nurses were forthcoming. The spatial constraints underpinned the identity of nurses and functioned as, what Sauer (2015) referred to, a classifying device.

Yet, there was also the paradox of the spatial movements of nurses. Nurses had a broad scope of practice that required them to transverse a range of spaces around various departments in circumstances of patient transfer, sample delivery, medical instruments, administrative documents and formalities of health insurance. Nonetheless, the social spaces were linked to power relations at the centre of ongoing processes of negotiation around nursing practice. All social actors simultaneously belonged to a social space which was constantly changing because of a need to transcend, and then retreat once more within, the constructed professional boundaries.

Power was clearly embodied within the spatial forms of nursing practice where relationships among nurses, physicians, patients and family carers produced a 'front of objectivity' (Bourdieu & Wacquant, 1992, p. 258) which obscured the ways in which rhetorical and other strategies created symbolic power to legitimise a particular order. The positioning of the head nurse in the same room as physicians was symbolic of a division between two groups, one obviously more powerful. There were no physicians situated in the nursing staff room which reinforced the prevailing hierarchy. Thus, the relationship of space materialised as physical distance between nurses and physicians and secured a social order where geographical space was not simply a determinant in the formation of the social space but was constantly reproduced through the ways in which everyday lives were enacted within that space (Beyes & Steyaert, 2012; Wapshott & Mallett, 2012). Space was, therefore, produced by both geographically designed structures and the daily practices of members (Lefebvre, 1991). Daily practice was significant to the ongoing production of social space.

> Observation 12: One nurse carrying patient records comes into the physician's staff room and sits down with a group of four physicians who are writing prescriptions and medical orders. The nurse focuses on writing patient notes. Sometimes, the nurse listens to conversations among physicians and contributes one or two comments. Not long after (approximately 5 minutes) one physician stands up and goes away. The next physician goes away after 2–3 minutes. The third physician stands up after 2–3 minutes with the final physician following. The nurse sits alone and continues to write patient reports. After 1–2 minutes, another nurse comes and sits down.

Nursing practice and commodity values

The social distancing between nurses and physicians cannot simply be understood as an issue of status but as a power relation reinforced through a regulated division of labour. Nursing practice is subject to a commodification process (Goodman, 2016) where social and economic processes bring nursing work to the market to be bought and sold based on economic and political interests. In reflecting the work of Harvey (2014), nursing practice as a commodity has a use value which is its utility in providing patients and family carers with services that meet their fundamental human needs. The utility of nursing reflected the ability of nurses to address the needs of those groups and thus, in the terms of Harvey (2014, p. 34), the use value of nursing was 'myriad, seemingly infinite and very often purely idiosyncratic' due to the multiple and variable needs of patients and family carers. Nursing practice was also valued based on its worth when traded as a commodity in the health industry. The exchange value is the monetary expression which is described as 'uniform and qualitatively identical' (Harvey, 2014, p. 33). In other words, money underpinned the exchange value of nursing practice in the marketplace of health care.

An example of the contradictory tension between the use and exchange values of nursing practice was the way in which the workloads of physicians and nurses were defined. According to the MOH (2015) (Circular 2922/QD-BYT, The Development of the HealthCare Workforce, 2015 to 2020), the standard physician-patient ratio in tertiary hospitals was one physician for every five patients to be increased, by 2020, to one physician for every three patients. This meant that the workload of physicians was calculated in terms of numbers of patients. The nurse-patient ratio was not so clearly defined. The nurse-patient ratio was deduced from the nurse-doctor ratio of one physician per two nurses (WHO, 2016). As such it appeared, on paper, that nurses would normally care for five patients. Nonetheless, with a bed usage of over 200% in tertiary hospitals in Vietnam (MOH, 2015), nurses routinely cared for more than 10 patients per shift. The use value of nursing practice was clearly far higher than the exchange value and nursing practice was thus appraised as having a lesser monetary value in the healthcare industry more generally. The disparity between use and exchange value rendered nursing practice and its value invisible in terms of remuneration.

> RN9: There are many moments where I think about my job. It is about a balance between life and work but mostly about money. We (nurses) are so poor. Our salary is so low. We do not have extra money like physicians. They get money for small operations (these operations are done in departments not in theatres)

and lots of extra sources (a sensitive topic related to ethical issues so information is not reported in detail). Our labour is so cheap. It makes me feel sad about my work. It makes me think a lot about where to go with this job.

Money is the material representation of the social value of nursing practice or the value of 'how much' the practice is worth in the form of wages. As Harvey (2014) points out, there is most often a gap between a representation of an activity and the social reality that is represented. This means that money paid as the exchange value of nursing practice reflected only some aspects of practice. The MOH (2015) and MHA (2015) had established criteria for the value of Vietnamese nursing practice which was materially expressed in the salaries of nurses. The criteria defined a set of nursing skills to legitimise the salary levels. Yet, nursing practice in clinical contexts involved far more than a range of discrete skills:

RN13: The payment is not worthy to our work. We do a lot which they don't see. They only see that we have a wound for dressing but they do not see how big the wound is. It is different between a small clean wound and a big infectious wound with complications. They don't care and they pay us for dressing one wound. They count the work of nurses as one wound dressing, doing medications twice a day… but we do more than that.

Hence, nursing wages concealed the value of nursing practice. On this point, in a more abstract explanation, Harvey (2014) noted;

Money, we can say at the outset, is inseparable but also distinct from the social labour that constitutes value. Money hides the immateriality of social labour (value) behinds its material form. It is all too easy to mistake the representation for the reality it seeks to represent, and to the degree that the representation falsifies (as to some degree it always does) we end up believing in and acting upon something that is false. In the same way we cannot see the social labour in any commodity, so we are particularly blinded to the nature of social labour by the money that represents it. (p. 49: 50)

Thus, the political system devalued nursing practice through the development of criteria that was inadequate in materialising the social (or use) value of nursing practice as money. Since use values are largely invisible, society judges nursing and nurses in terms of the wages that the profession attracts. Society, therefore, devalues nursing practice or, as Harvey (2014) would note, is blinded by money.

Nurses were also positioned in precarious employment because of individual bargaining relationships with employers, low wages, and a dearth of workplace rights and social protection (Benach et al., 2016)

RN22: Don't ask for a higher salary. We (nurses) have to accept the salary because there is nowhere to go. Can you ask for more? No. So why do we think about asking for more? Why do you keep it in your mind all the time and then become disgruntled? You can't do anything so why not just accept it and make things easier?

Researcher: Do you think about changing jobs?

RN22: Lots of my colleagues complain about the low salary and compare the salary with other hospitals. But I think they pay you more because they require you to do more. You are paid for what you do here. So don't compare.

Wages in nursing are based on work evaluation and inferior wages reflect the historical and social factors that determine how nursing work is evaluated and exchange value established Exchange value in this research reflected economic and political interests that both sustained, and were sustained by, a spatial-economic hierarchy in the form of the dominance of medicine over nursing and a capacity to exploit the use value of nursing practice over the exchange value of that practice.

Discussion

The concept of space, following on from Lefebvre (1991), has become the focus of an increasing literature and particularly in organisational studies (Taylor & Spicer, 2007). From the mid-1990s on, a small body of work has developed in nursing in, what Andrews (2003) refers to as, health geography that variously addresses the changing geography of healthcare (Liaschenko, 1996, 2001), the shifting spatial dynamics of the relationship between patient and nurse (e.g. Malone, 2003) and consideration of socio-spatial factors that structure nursing practice (e.g. Halford & Leonard, 2003; Purkis, 1996).

Our research extends nursing work in this area to consider the materialisation of both power and economic relations in the spaces of nursing work. We drew on Lefebvre's theoretical concern with the materiality of power relations in organisations and Harvey's work on economic space. The study concludes that the spatial formation of the Vietnamese research context physically separated nurses, physicians, patients and family members and thus functioned to restrain greater collaboration and interaction. Patients and family carers were positioned as outsiders by nurses who were themselves perceived as intruders when entering the space of physicians. Thus, nursing practice appeared as a product of processes of negotiations that continually sought to mitigate tension that occurred in physical, social and economic spaces. Yet space, in turn, was integral to the production and reproduction of material economic relations that subordinated nursing and reinforced the exploitation of the social and economic value of nursing practice.

Limitations

A limitation of this research is the absence of the concept of gender as a critical concept in explaining the spatial formations of the clinical areas in healthcare in Vietnam and the use and exchange values of nursing work in that region. Yet, in a sense, gender is a taken for granted factor, certainly important, in the positioning of nursing within healthcare globally (Allan et al., 2016; Azocar & Ferree, 2016; Clayton-Hathway et al., 2020; Nelson & Gordon, 2006). There is, therefore, a shared understanding of the political implications of nursing work as gendered.

Semi-structured interviews are limited in several ways one of which is that they do not readily capture the context in which interactions and performances occur (Holloway & Galvin, 2016). Interviews are, moreover, products of co-constructions of interviewees and interviewers. Hence, and in this research, both the researcher and participants were engaged in interpretive processes whereby all made choices about expectations and responses. If interviews constitute layers of interpretations by the interviewer and interviewees an expectation that a reality can be captured is problematic. These issues were pre-empted and other data sources included to mitigate the limitations of the interview method. Observations and government policies also provided insight into the positioning of nurses and nursing in the research space.

Data analysis commenced with the initial coding method proposed by Charmaz (2014). The application of a systematic, predefined, set of techniques, however, risked confining the analysis to the abstraction of discrete codes and categories that would obscure context (St. Pierre & Jackson, 2014). Indeed, Charmaz (2017) has shifted significantly on this very issue in recent times in arguing the compatibility of theorising and applying a broader set of sensitising concepts along with her 'box of tools'. Thus, a strength of the current research was the move away from an imposed frame of predefined techniques in data analysis to a more flexible analytical stance that allowed for a fuller exploration of the complexities of the research situation.

Conclusion

The social and geographical spaces in this research symbolised the dominant cultural and economic convictions of the existing social order in health care in Vietnam. Based on the priority of the accumulation of surplus value, the spatial environment, as the physical architecture of hospital departments, was arranged in a particular geographical form. The spatial configuration appeared as an important mechanism of control that normalised (or legitimised) the extraction of surplus value from nursing practice. The contradictions between use and exchange values in the health care setting manifested in the inequitable distribution of monies across health professional work, a situation produced and reproduced by the spatial form of the work environment and the broader social context.

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