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The social construction of the definition of nursing.

Eve T. Keenan
University of Massachusetts Amherst

THE SOCIAL CONSTRUCTION OF THE DEFINITION OF NURSING

A Dissertation Presented

By

EVE TUCKER KEENAN

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Approved as to style and content by:

Sheryl Riechmann-Hruska

Sheryl Riechmann-Hruska, Chairperson

Donald K. Carew

Donald Carew, Member

Ellan Cole

Ellan Cole, Member

Mario D. Fantini

Mario D. Fantini, Dean School of Education

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ABSTRACT

THE SOCIAL CONSTRUCTION OF THE DEFINITION OF NURSING

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Eve Tucker Keenan, B.S. Medical College of Virginia

M.S., Ed.D. University of Massachusetts

Directed by: Professor Sheryl Riechmann Hruska

This study presents an ethnographic perspective of a nursing unit, focused on the creation of the definition of nursing. Participant observation was used as the main data gathering resource. Analysis of documents and a questioonaire supplemented data collection.

The purposes of this study were to (1) discover the process by which the definition of nursing became known to the staff members on a selected unit and, (2) describe the unit's definition of nursing and how it was practiced. The motivation for this research was a search for a way for the nurse manager to understand how nursing comes to be known on a nursing unit, so the manager would be in a stronger position to support a collaborative process for the development of a "new" vision of professional nursing.

The definition of nursing discovered was a complex mixture of the old and new cultures discussed in nursing literature today. The traditional culture of nursing was dominated by the language and values of medicine and bureaucracy. The medical perspective dominated the way the

nurses viewed and cared for their patients. The assessment forms, teaching curriculums, language and ritual of shift report and patient progress notes all reinforced the medical pathology . The departmental structure and lack of problem solving between specialties served to exhaust the nursing resources in time consuming systems and routines (e. g. medication and laboratory systems). The emphasis on rules and task assignments by way of policies, memos and job descriptions, focused nursing care in such a way that there was little room to be creative and use autonomous nursing judgment.

The behaviors in the "new culture" in nursing was characterized by an emphasis on professional development. There was a beginning by nurses to identify domains that were unique for nursing. The new standards for documenting care provided the method and process for nurses to begin to use a new exclusive framework for assessing their patients and planning their care. The new culture's nurses were beginning to recognize and use the power within themselves to establish new values and directions.

Implications for nursing education, management and further research were discussed.

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INTRODUCTION

Background of the Study

The days of the snoopy nursing supervisor are over. The autonomous practice expectations for today's nurse require that we take a new look at the old ideas of controlling, directing, and managing the nursing staff. The new vision promoted in the field is for the nursing leader to become known as an advocate for professional nursing practice rather than an adversary (Hegyvary, 1983). Professional nursing charachterized by a practice that is autonomous, wholistic in approach, and theory based is needed both for improved patient care and advanvcement of the field of nursing. The nurse manager stands in an excellent position to facilitate such developments if she is aware of the opportunity created by her position.

In the past, the nursing profession has relied on nursing education as the means to develop new cultures in nursing. This has meant relying primarily on contexts outside of the hospital (i. e. community health clinics or educational institutions) to provide the environment to develop the professional components of nursing. The current study complements and extends this view. It supports the position that the nurse manager, within the context of the hospital environment, can support and encourage the new

definition of professional nursing practice.

This research will examine those processes which contribute to the social construction of what nursing means, and how it comes to be practiced in a given setting. The role of the nurse manager on the practiced and perceived vision of nursing will be considered as a part of this research. Information from this study can help a nurse manager in the process of operationalizing her vision and advance understanding in the social sciences of emergent socially defined "realities".

In this study the reader is asked to shift his thinking to the perspective of the actors involved; to understand how the practice of professional nursing in a given context becomes known to and delivered by the nurse. This perspective provides the key to unlocking the door of implicit assumptions, beliefs, and values that have been accepted or condoned and passed along by nurses and nursing managers and which have then guided nursing practice and administration.

The new approach to be considered here is called the "interpretive" approach. Originally Burrell and Morgan (1979) coined this term to characterize those organizational development theories that emphasized the subjective view of the actors within an organization. The interpretive paradigm's emphasis on understanding process and the creation of meaning and other aspects of definition

formation beyond the manager will be particularly useful here in the study of the role of the nursing manager in shaping a view of and actual practice of professional nursing. It is also useful in the field in helping nursing leadership focus their energies toward the development of a compelling professional vision for nurses. The nursing leader, because of her positional authority, is in a powerful position to facilitate the development of a positive, professional vision and to help a nursing group identify and enact the vision of nursing.

Purpose of the Study

It is the purpose of this study to explore the dynamic social process that creates the meaning of nursing on a hospital nursing unit today. More specifically, the purposes of this study are (1) to discover the process by which the definition of nursing becomes known to the staff members on a selected unit and, (2) to describe the unit's definition of nursing and to document how it is practiced.

Three types of data will be considered. The first of these will be the symbols, myths, rituals, and stereotypes that underpin the assumptions that are held by the unit's staff and are part of the culture of nursing on that particular unit. The second data source will be the communication process on the nursing unit in order to discover the implicit messages that create the definition of professional nursing within the context of that specific

nursing unit. Finally, the researcher will be looking at behavior patterns such as decision making, roles, norms and rules,from which can be infered a definition of nursing.

Assumptions Underlying the Study

It is assumed that nursing is part of a culture that is socially created. How nursing is conceived and practiced in a unit is a result of social interaction.

Definitions of nursing will be different, depending on the myths, values, assumptions and behaviors that have framed the definition for each individual. Although, the individual nurse has her own definition of nursing , it is assumed that a unit definition of nursing is a powerful shaper of her behavior on the unit.

Furthermore it is assumed that the shared, socially constructed definition, can be made explicit once the underlying assumptions, myths, values, symbols, communication processes and behaviors have been discovered and verified by the unit staff.

There are messages about nursing to be found in the behaviors of all the actors on the nursing unit. Questions and expectations of all involved serve to tell the nurse what nursing is.

Definition of Terms

"Nursing" as defined by the unit : Those perceptions and attitudes that form the concept of nursing and activities that the registered nurses on the unit engage in during

their eight hour shift. It also includes those activities outside of the nursing unit that they define as directly related to their nursing.

Communication Process: All methods either verbal or non-verbal of receiving and giving messages.

Implicit Messages: Those indirect sources of influence that are usually received by inference.

Professional Nursing: "A professional health care service whose practitioners ascertain the health of individuals and their response to deviations from it, also problems and needs related to maintenance of normal patterns or deviations secondary to illness or sequellae; who formulate and implement plans to help recipients determine and meet their own health goals; and who provide care and comfort as needed" (Official statement of the Massachusetts Nurses Association, 1976).

Professional Components of Nursing: Though each unit develops its own version or definition of "professional nursing", a list can be given of those behaviors identified by researchers in the field. "A high level of autonomy which distinguishes professions implies the assumption of commensurate moral and legal responsibilities. Among those of nursing are:

1. Commitment to recipient-centered, goal directed practice.
2. Defining and interpreting the nature, scope and role of nursing.
3. Managing and evaluating nursing practice.
4. Developing standards of nursing practice and nursing

education.
5. Continuing personal and professional development.
6. Accountability for nursing practice and its delegation.
7. Providing for basic and continuing education for its members.
8. Establishing conditions of practice and reward.
9. Collaborating with one another and with other groups to evaluate health care services.
10. Participating in social and political action related to the health needs of society.
11. Conducting and/or cooperating in research and its application to the improvement of care" (Statement of Professional Nursing, Massachusetts Nurses Association, 1976).

Staff Members: Those individuals (i.e. unit clerks, nurse aids, building service personnel) who are employed by the hospital to provide care and services to patients. This group will also include attending physicians, although not employees of the hospital, they contribute to the definition of nursing.

Interpretive Paradigm: An organizational theory perspective that has as its primary concern an understanding of the subjective experience of individuals. These theorists attempt to construct their perspective from the standpoint of the individual actor. To retain the integrity of the phenomenon the researcher attempts to get inside and to understand from within (Burrell and Morgan, 1979).

Participant Observation: "Research characterized by a period of intense social interaction between the researcher and the subjects, in the milieu of the latter. During this period, data are unobturusively and systematically collected" (Bogdan and Taylor, 1975, p. 5).

Ethnomethodology: Inquiry that tries to discover the methodology by which people make sense out of the situations in which they find themselves. The researcher's task is to examine the way people abstract rules and common sense understanding in situations in order to make them appear routine, explicable, and unambiguous. Meanings then are practical accomplishments on the part of members of a society (Bogdan and Taylor, 1975, p.16).

Significance of the Study

This ethnography concerning the influences on the definition of nursing as practiced on a nursing unit will provide a model for discovery. It will provide a new way for nurses to examine their practice and decide if it is actually what they want to be doing. Once this process of discovery has been documented, the model may be used by other nurses and researchers to identify the meaning of nursing within the unit they choose.

Over time as these experiences are reported, similar patterns of influence may appear throughout the nursing literature. These patterns may help the nurse manager begin to understand how the vision of nursing which she has identified compares with the vision as described for other settings. She may also better understand how the vision is enacted on her particular nursing unit, and perhaps more significantly, how it came to be that way.

With knowledge of elements of the process, the nursing

manager is in a stronger position to support a collaborative process for the development of a new vision of professional nursing. She may be able to encourge a process that will develop symbols, reward systems, nursing models, communication strategies and thinking systems that are more consistent with the professional and autonomous vision of the nursing staff.

If nursing management is able to clearly communicate their vision of professional nursing, and further develop that vision in collaboration with the nurses on the unit, nurses will be able to practice in a supportive environment. "Professional nursing" as described in the literature can perhaps be a reality in nursing practice. Ultimately, society stands to gain substantially, from the nursing potential that may be realized once a new vision of nursing is consistently operational.

C H A P T E R I I

REVIEW OF THE LITERATURE

The foundation for the interpretive approach to understanding nursing management is found in the school of sociological theory that values the subjective understanding of events (phenomenology). It is logical to use this foundation because nursing is a profession that identifies itself as humanistic, and adheres to a basic philosophy that focuses on individuality of each patient. There is a concern for the whole person and his relationship with his socio-historical contexts (Tinkle and Beaton, 1983). It has been said by one nursing leader that " each person is believed to have experienced his own 'reality'. The experience may be shared, but the individual is ultimately the one who interprets his own experience and gives meaning to it" (Munhall, 1981 p.176).

It is important to note that all actors are creating and interpreting visions or meanings on a day to day basis. This author is suggesting that the nurse leader make this process conscious by using selected sociolgical and organizational theories as a foundation. She must become aware how her meaning making and vision production is affecting and helping to create the meaning of nursing for the nursing staff and others within the hospital.

This literature review will demonstrate how selected sociological and organizational theories of provides the framework for examining the social construction of nursing. First it will be necessary to look at assumptions that are inherent in approaching any "scientific" study. Then a sociological approach to understanding everyday knowledge will be presented. The next section will demonstrate how current organizational theorists have used this foundation to form a new perspective to understand organizations. The last section of the literature review blends the previous theoretical perspectives and uses this perspective to examine pertinent nursing literature to build a new way of understanding nursing.

Burrell and Morgan (1979), organizational theorists, offer an invitation to examine the deep structure of assumptions which underlie different modes of theorizing about organizations. "Central to our thesis is the idea that all theories of organizations are based upon a philosophy of science and a theory of society" (p.1). Although scientists do not always make their assumptions explicit, they must make some decisions about the ontological and epistemological nature of their work. In particular, social scientists must decide if the reality they are to investigate is external to the individual (objective) or if reality is the product of the consciousness (subjective).

There are also assumptions to be made about the

epistemological nature of the work. One must decide what forms of knowledge can be obtained; what may be regarded as true or false. This has much to do with beliefs about the nature of knowledge. Is knowledge a hard objective fact that can be communicated through words, or is it more subjective, spiritual, or soft, based on experience of a very personal nature? In order to understand this perspective, a brief review of early phenomological sociologists is presented. These authors are selected for review because this study assumes that the definition of nursing is subjective and is best described by the beliefs and behaviors of the actors themselves.

Sociological Theory

Schutz (1967) reasoned that since social action was based on how people perceived social reality, sociology needed a phenomenonolgical basis to study social reality itself. He introduced the notion of reflexivity in understanding reality. Schutz posited that consciousness is an unbroken stream of lived experiences which hass no meaning in themselves. Meaning is dependent upon reflexivity--the process of turning back on one-self and looking at what is happening. This study will be searching or "turning back and examining" the messages that shape the roles of nurses on a specific unit and control their behavior. It will also identify symbols which legitimize how these nurses define nursing and subsequently how they

practice.

Schutz used the term typification to describe the organizing process of everyday life. Typifications are learned through our social context (Schutz, 1967). An example would be the word "nurse". It has meaning without a context. The typification process differs from context to context. As the actor moves from one to another, the person's perceived reality changes with the typification process and the context (i.e. the school nurse in contrast to the intensive care nurse).

Berger and Luckman (1967) further developed the foundations laid by Schutz by creating their treatice on the sociology of knowledge. This work emphasizes the role language plays in the social construction of reality. Language becomes the means actors use to objectivify and communicate or transfer their experiences. They show how through the habituation tendency in man, man institutionalizes the typifications in the social context to create reality on a day to day basis. They further develop the notion of institutions to demonstrate how man creates roles and controls behavior. Finally they demonstrate how symbols in a context can serve to legitimize a socially constructed reality. This study will be searching for the messages that create roles and control nursing behavior and the symbols which serve to legitimize them.

Garfinkel (1967) building on the work of Shutz, Berger,

and Luckman, reviewed above, used the term "indexcality" to refer to the contextual nature of perceptions of objects and events. He used the word "indexical" to note that expressions or words act as indices for the context required to make sense of those expressions (Leiter,1980). Garfinkel developed a methodology to analyze the accounting practices which people use to render objects and events observable, objective and rational (i.e. a "waiting room" becomes an emergency waiting room when one notices the nurses, physicians and ambulances coming and going).

Combining both reflexivity and indexicality with a prescription for understanding how people used rules to convey meaning, Garfinkel developed the study of "common sense knowledge" and labeled it ethnomethodology. By using reflexivity, indexicality, language, roles and typifications as data, a method can be applied for understanding common sense meaning. "The work of ethnomethodologists is very much concerned with identifying the taken-for-granted assumptions which characterize any social situation and the way in which the members evolved, through the use of everyday practices, make their activities 'rationally accountable'" (Burrell and Morgan, 1979, p.248). Many authors have suggested that the ethnomethodological approach to nursing research and theory development may be more congruent with the basic values in professional nursing (Gorenberg,1983; Munhall, 1981; Oiler, 1981; Omery,1983; Tinkle and Beaton,1983). It

will be used in this chapter to look at the concept of social construction of the meaning of nursing as it has been documented in the literature to date.

Weick (1979) a social psycologist, has further developed the notion of the social construction of reality by suggesting "organizations are more active in constructing the environment that impinge on them than is commonly recognized" (p.267). He suggests that "an organization's reality is simply one way that people try to make sense out of the stream of experiences that flow to them. These organizing acts are acts of invention rather than acts of discovery, they involve a superimposed order rather than underlying order, and they are based on the assumption that cognition follows the trail of action" (p.278). For example, the increase in nurse midwives may be seen by obstetricians as a threat to adequate health care and his pocketbook in contrast to the view of the child bearing population who see this circumstance as an opportunity for more choice in their maternity options. This flow of data that enters the organization is punctuated in a rather random and arbitrary fashion. This punctuation and bracketing of the stream of events entering the organization or the manager's mind is called <u>enactment</u>. Because the sensemaking is an invention from the "facts" that flow into the organization; it is characterized by reasonableness rather than accuracy. Weick posits that reasonableness is the standard because there is

no underlying order to be discovered. It is the unique interpretation by that organization which may be influenced by the retained wisdom from previous enactment experiences. This retained wisdom may serve as a constraint on the possible interpretations of reality that the organization may invent. "Enactment drives everything else in the organization. How enactment is done shapes what the organization will know"(p.277). This way of viewing the environment offers a new way of looking at "restraint" and "limitation" that is prominent in the business policy literature today. Weick states:

> "Limitations are deceptive conclusions but, unfortunatly, people don't realize this. What they don't realize is that limitations are based on presumptions rather than action. Knowledge of limitations are not based on tests of skills but avoidance of testing.
>
> On the basis of avoided tests, people conclude that constraints exist in the environment and that limits exist in their repetoire of responses. Inaction is justified by the implantation, in fantasy, of contraints and barriers that make action 'impossible'. These constraints, barriers, prohibitions, then become prominent 'things' in the environment. They also become self-imposed restrictions on the options that managers consider and exercise when confronted with problems. Finally, these presumed constaints, when breached by someone who is more doubting, naive or uniformed, often generate sizable advantages for the breacher" (Weick,1979:149-150).

With a different but related view to Weick, Davis (1982) focuses on the context of an organization as a means of both transformation and strategic goals. Davis suggests that the

context of the organization is the unquestioned assumptions through which all organizations members filter their experiences. If the manager behaves as if the context exists, then the content will follow through the employees. Managers who spend their energy on managing the context of the organization will see their strategic goals accomplished because the employees begin to see the context as real and the strategies as happening.

"In one sense the difference is simply in the perspective you take; in another sense the difference in perspective makes all the difference" (Davis,1982,p.76). Davis' argument is that the organization will be in a much stronger and effective position if one consciously manages the perspectives of contexts in organizational and strategic planning.

Smircich and Stubbart (1983) encourage the enactment of many diverse environments for the organization. Indeed, they implore researchers to study and document the process of enactment to see if one can identify those assumptions, beliefs, and myths that have framed the current understanding. This diversity of perspectives will provide novel and creative interpretations of reality. By testing and experimenting with these multiple perspectives, the organization is in a much more powerful position to develop its potential from base assumptions that have been fully explored.

"The challenge to our mode of organization is to see whether we can develop our capacities to actively choose our logics of action, or whether our lot is simply to be guided by them"(Morgan,1981,p.21). Following the advice of Weick, Stubbart and Smircich and Morgan, to actively choose our logic of action, it will be helpful to review one of the most influential ideologies that has been part of the enactment process in nursing today; paternalism and oppression.

Oppression and Nursing

Jo Ann Ashley's landmark book, Hospitals, Paternalism, and the Role of the Nurse(1976) has encouraged authors (Muff,1982; Roberts,1983; Torres,1981) to write about the affects of oppression and paternalism on the role of nursing.

> "The study of nursing development in the United States is a study of overwhelming obstacles and lack of progress, of discrimination and exploitation. . . .The oppression of women in the nation's hospitals has not been an historical accident or a necessity based on rational justification--either morally, socially, or economically. Women's servitude in American hospitals and the economic utility of young women in these institutions was an outgrowth of prejudice against the female sex. Mythical notions and accompanying social misconceptions about women supported their servitude, keeping nurses subservient to physicians and preventing the full development of their potential contributions in the field of health care"(Ashley,1976, p.x).

Similarly to the work of Friere(1978) and Jackson (1976), Muff (1982) and Roberts (1983) demonstrate how the

oppressed group (nurses) are socialized to the belief that the dominant group's (physicians' and administrators') values and norms are the "right" ones for society. This attribution of values, over time, contributes to the lack of questioning the status quo. The tendency is for the the oppressed as well as the opppressor, to internalize these norms and to believe that to be like the oppressor will lead to power and control. While striving to be more like the dominate group, the oppressed reject their own values and beliefs. This rejection is the pathway to self-hatred and a marginal position between the two groups (Baker-Miller, 1976).

Roberts (1983) identifies three mechanisms that maintain the myth of dominant superiority. (1) Education that is controlled by the powerful and limited to curricula that support their values. (2) Reward for behavior that is preferred by the oppressor. "Members of the oppressed group who desire to be powerful may be rewarded for proclaiming that the values of the dominant culture are correct, even though it means degrading their own characteristics"(p.24). This collusion encourages the continuation of a subordinate status for the oppressed. (3) When there may finally be a revolt the oppressor gives token appeasment of rights or rewards to the oppressed.

The articulation of this theory forces the nursing manager to reflect on her position, behavior, values and

beliefs as they are a determinant and integral part of the nursing service department. Questions she can ask to see how much she has adopted beliefs of the dominant group might be: Why was she chosen for the position? Have the dominate values of the bureauacracy become her way of seeing and understanding the hospital institution? Can she find within herself an affinity for the values of humanism, autonomy, and caring that were so internalized when she was a new graduate? Does she encourage the new graduate to enter the department as an autonomous professional with her own unique contributions for patients? Or, does she require that all new employees participate in an orientation program that is designed to have all behave the same for ease of management?

It is clear that the nursing leader is in a critical, yet a very vulnerable position. She will be judged by her staff according to the way she provides the environment and resources for them to care for patients in a manner that meets their nursing values. The dominant and most powerful group (adminstrators and physicians) have the expectation that the nursing leader stay within her budget, follow the policies of the hospital and do everything in her power to maintain the status quo (i. e. nurse do as told, exert little influence, always respect the authority of the physician in regard to patient care and have no conflicting innovations). This dilemma causes the thoughtful nursing leader to examine her values and forces her to make a

decision, i.e. to maintain the oppressive status of the nursing staff or to actively seek strategies to reinforce the values and beliefs that will allow the nursing staff to reach their full potential. The initial step to liberation from the oppressed status is the recognition that domination exists and revealing it for what it is. Although it is not without risk, once this ideology has been revealed the leader has great resource within the nursing staff and its culture.

If one understands how the culture of nursing is created, one is in a stronger position to use the symbols, language and myths to support the founding values of the profession. "One of our first tasks in nursing is to motivate nurses not only to image the unimagined, but also to become aware how their social conditioning has affected them [and their leaders]" (Roberts, 1983, p. 29). The next section will look at the current literature which has developed the notion of culture in the nursing profession.

Culture as a Root Metaphor in Nursing

One could not review the interpretive literature today without considering the concepts of culture and symbols. However, as one begins to sift through the articles that speak to these concepts, the reader comes to appreciate the many ontological and epistemological assumptions various authors have taken.

> "Mostly the people have been inspired to use the term culture as an attribute, a quality internal to a group,

> so that reference is made to an organizational culture or subculture.... A consistent message coming from many [authors] writing about organizational culture is that managers need to be aware of their group's/organization's culture because it will make a difference" (Smircich,1984, p.4).

The interpretive perspective looks at the concept of culture as a root metapahor-an epistemological device that serves as a basis for theory development in organizations. Smircich argues for an interpretive view of culture that would speak about culture as a root metaphor, or organizations as culture that is characterized by "webs of meanings, organized in terms of symbols and representations.....[to] see human beings as maker of meaning, creating their social worlds through symbols" (p.8). This perspective requires that the researcher stand back from the organization and ask, "what is happening here?" "How did these symbols and signs get to be meaningful?"

> "Research from this perspective would center on the symbols that make organizational life possible. What are the ideas, [what are the] constructs that impel legitimate, coordinate, [and] realize, [the] organized activity in specific settings? How do they accomplish this task" (p.13)?

When the nursing administrator examines her nursing organization, there are two aspects of culture to think about. i.e. nursing and bureaucracy. Both perspectives offer an important viewpoint for the nursing administrator to reflect upon the processes that make nursing service assume the shape it does. Nursing culture will be examined first,

then how bureaucracy influences nursing will be reviewed.

Nursing Culture

In order to answer the question of" what is going on here that creates the meaning of nursing?", there must be some agreement on what this problematic called "nursing" is. Therein lies the challenge. Nurses have defined, categorized, departmentalized, and credentialed themselves until no one is sure of the nature of nursing, including nurses themselves (Weiss,1983).

Brooks(1983) much the same as Schutz's did with his reflexivity notion, suggests that we identify with the mythical Killyloo bird: "Whenever it took off on a new flight it would fly backword first because it could not tell where it was going until it had seen where it had been" (p.52). Although each nurse rarely looks back, as each nurse cares for her patient, she will be defining for herself what nursing really is. The meaning of nursing for each practitioner is a result of a social process and experience that has imparted various messages to the nurse actor. This meaning is then reflected in behavior. It is important to establish some of the myths and assumptions that have influenced this meaning of nursing as they have impact on the stereotypes that have confounded the definition of nursing.

Myths and Stereotypes. Several authors (Brooks,1983; Hughs,1980; Kalisch, et al. 1981; Muff,1982) have recently

undertaken comprehensive reviews of the rich history of nursing. The Kalisches (1980, 1981) have demonstrated the significant role that the news media both video and paper, have played in the structuring of the nursing image. They revealed that the " images conveyed by clinical nursing articles were positive and yielded sympathy from the audiences. . . . confusion between the role of the nurse and the physician was high"(1981 p. 137). The prime time television analysis was not positive:

> "The findings showed that nurses were depicted as working in acute care settings, entering nursing for altruistic reasons, primarily acting as a resource to other health professionals, not using problem- solving and evaluation skills, deficient in administrative abilities, and remiss in providing physical comforting, engaging in expanded role activities . . .Since the 1960s the trend in the quality of nurse portrayals has been downward" (Kalisch et al. 1981, p.358).

One worries over the impact this image will have on future generations making a career choice. Or more immediately, what do these messages convey to the practicing nurse, her patient, and the physician today?

Muff (1982) suggests that stereotypes are similar to the typifications extolled by Schutz (1967);

> "to obviate the need for men to understand each nurse as an individual by providing categories within which to 'file' the nurse, and to transform the nurse into his ideal . . . . Stereotypes are seductive. Once their use becomes habitual [Berger and Luckman's, (1967) institutionalized], the conformity of nurses becomes imperative. No longer merely shortcuts for the lazy, these stereotypes are standards by which all nurses are measured and thus are tools of oppression" (p.121).

Muff has reviewed everyday fiction to discover the

prevalent stereotypes of nurses today. Again, it is important to reveal the stereotypes that have come from mythology surrounding women and nursing's past so that they unveil the hidden assumptions that have had a part in creating meaning for nurses today. Muff divides the images into positive and negative;

NEGATIVE	POSITIVE
sex-symbol	angel of mercy
battle-ax	handmaiden
token torturer	women in white

Recognition is the first step. These stereotypes will be encountered again and again. Even the labels and division of terms that Muff has chosen to use above, might lead one to ask if she has bought the values of paternalism! One wonders how a handmaiden image is positive? Perhaps they have influenced the nurse or nurse-managers meaning of nursing. If so, each has a choice of continuing with the stereotype or substituting another meaning more congruent with a view that is closer to the professional model that many in the nursing currently support (Massachusetts Nurses Association, 1976).

Hughs (1980) has uncovered a series of myths concerning nursing described in secular magazines from 1896 to 1976 . She demonstrates how the literature portrays the notion that nursing is women's work, peculiarly suited to dainty, delicate-minded women. The Victorian norms dictated that womens' actions had to be consistent with moral sensibility,

purity and maternal affection. These expectations embodied the virtuous nurse. Nurses were equated with true womenhood. "Long standing social beliefs about women and their role in society became the foundation for several mythical beliefs that were associated with the nursing profession"(p.62). Some of these myths were:

1. If a nurse had a pleasing personality, then her mental capabilities were of secondary importance; implying that education could not compensate for the absence of pleasing personality characteristics and intelligence was not valued.

2. Emphasis in terms in the performance of rote repetitive tasks; failure to recognize intellectual abilities and a sound knowledge base as necessary requirements for excellence in nursing practice.

3. Nursing as a calling; any attempt to elevate the economic and professional status of the nurse was judged as being selfish, self-centered, and failing to live up to the religious instincts that were felt to be natural to their calling.

4. The nurse was born not made. 'Your ability to like people depends on your basic personality; love and concern are God-given not handed out with a college degree.'

5. Becoming a nurse would improve one's chances for marriage; a fringe benefit for nursing was marrying a doctor.

6. Nurses function only under physician supervision; any action by a nurse that had not been approved by a physician could result in harm to the patient (Hughs, pp.58-69).

These myths need to be set forth for the profession and public because they are insidious in American society.

Myths are powerful and influential. Although the word myth implies imaginary or false beliefs; they are not assumed to be false. Indeed, they are assumed to be true because they reflect values that society holds to be important either consciously or unconsciously.

Emerging new culture. Madeleine Leninger (1970) a nurse anthropologist, studied the nursing culture across the United States and found many of these same myths and stereotypes flourishing. She added an additional description of nursing norms to her scholarly research. At that time in nursing, she documented two distinct cultures which she called the traditional and the emerging new culture. These cultures appeared to reflect the opposite of each other. Nursing was moving from an "other-directed" profession guided by norms of an outside reference group to a dimension of creating its own body of knowledge, values and norms.

She contrasted the traditional with the emerging as moving from qualities of paternalism and self- sacrifice to the recognition that the nurse's needs, interests, and goals are receiving much recognition. "The successful nurse in the new culture is being recognized as the nurse who can articulate and knowledgeably communicate her problems and needs to others so effective care can be given" (p.70).

Tension described the shift from authoritarian to democratic values. The traditional nurse was secure with

clear lines of communication and supervision. The nurses were unable to deal directly with their concerns about authority; they continued to play the game and not step on the wrong toes. This problem was compounded by the traditional nurse's view that a democratic style was weak and vague, not providing the direction they required (Leninger, 1970). This represents nurses accepting the oppressive values and nursing managers gaining their power by accepting the values of the oppressor.

The emerging culture nurses are well described by Winslow (1984). He documents the transition of the metaphor for nursing from loyalty to advocacy. The old expectation of loyalty to physician and hospital at all costs has slowly changed to that of nurse as courageous advocate. Acceptance of the advocacy role entailed a readiness to enter disputes (p. 36). This change is also seen in the 1976 revision of the ANA code. The revised code requires nurses to protect the client from the "incompetent, unethical, or illegal practice of any person" (p.37).

The evolution from an apprenticeship method of educational preparation to collegiate preparation fostered a division between the advocates of doing and intellectual norms. The intellectual emphasis heralded attention to the emotional, and psychosocial aspects of the patient. There seemed to be a merging of an expressive and instrumental role behavior as masters prepared nurses modeled

comprehensive patient care. The anti-intellectual, non-scientific nurses were sorely missed by those who required handmaidens to function in their daily practice (physicians and adminisrtators).

The continuing debate about what is professional nursing and what are the basic educational requirments to be a professional continue to fill the pages of nursing literature. Reed (1984) in an essay based upon data from actual programs, documents the five kinds of education that lead to the Registered Nurse Licence. She outlines significant differences in education and goals of each program. Yet, nurses and hospitals and other health centers are continuing to prolong the debate by refusing to acknowledge a difference in expectation and reward for differences in potential performance, i.e. all RNs comply with the same job description even though their education prepares them to perform differently. Nevertheless, we are again witness to real confusion on the the meaning of nursing. This issue is important because it underscores an avenue where the nursing administrator can exert influence to use the various levels of education as they were intended.

Signs and symbols. Smircich and Stubbart (1983) discuss the importance of organizational symbols that relay values that are less than obvious. These values play a significant formative role in the reality the organization

enacts. They suggest that managing these symbols is a powerful way to produce the reality that is helpful to the organization.

The symbols and signs that represented the old values and norms of nursing were changing at the same time as the educational preparation. The traditional nurse's cap, white uniform, stockings and shoes, were traded in for a therapeutic relationship, based upon scientific principles without any clear signs to make them visible. In fact, Szaz (1982) has demonstrated how the white uniform actually served to encourage a comparison of rank and to foster the notions of obedience, servitude, and humility. The uniform may actually impede the nurses' definition of her role as she thinks: "I look like a nurse therefore, I am a nurse" [in the old definition of nursing].

Hardin and Benton (1984) have looked further at the ambivalence nursing is expressing towards its symbols. They suggest as nursing is becoming more diverse "that the term 'nursing' means such disparate things to nurses themselves, that our common (traditional) symbols are now obsolete"(p. 164). They examined the use of nursing caps and school pins for the state of Illinois. Their survey showed that "virtually every nursing program (including two newer collegiate programs who have decided against the capping) has maintained the pin" (p.166). Some of their responders suggested that a new set of symbols is emerging: Caps and

uniforms for ADs, Diplomas and Baccalaureates: white lab coats, beepers, and stethescopes for MSs; and tailored suits for Ph.Ds" (p.166).

The same survey showed that nursing pins have begun to change, many using a modified caduceus combined with the original lamps or caps. While these authors began to address the issues in the demise of some symbols, they raise an interesting question: "Having gone from petticoats to lab coats, stethescopes and caducei, could it be that nursing is attempting to solve its identity crisis by identyfying with the aggressor [physicians] (p. 166)? If so, it fits very nicely with the oppression theory mentioned earlier and raises questions about the growth and autonomy of the new nurse.

Another possible explanation may be that the nurses are changing their symbols because of an ideological base spirited by the feminist movement that revolts against the traditional symbols. Either way, "if we wish to be different from our tradition, then we must first discriminate which aspects of the role we choose to change and then educate ourselves and the public regarding the meaning of these changes. Just as playing 'dress-up' when we were younger did not make us nurses, so now playing 'dress-up other' will not make us 'other' unless we also change" (p.167).

Socialization. Smircich and Stubbart (1983) focus on the interpretive perspective for the manager and emphasize

the social processes that produce the concepts by which the organization is managed. They build on Weick's description of the process of enactment and suggest that the "art of management is the choice of frameworks and interpretation"(p.16). The limitations that managers "see" in the environment are a reflection of their assumptions and need to be tested. A process of self-reflection on the managers' enactment will allow the managers to rise above their assumptions and to begin to see other potentials for their organization.

Stein (1978) examined the socialization process of student nurses as they progressed thru their educational process. She traces a role definition for the student nurse that starts out in the freshman year as an image of nurturer for sick events. By graduation, the majority of students were emphasizing well- patient care and community health. It was the university faculty that took the role as value guardians for the practice of good nursing. By stressing ideals, the instructors hoped to teach "good" nursing or an expanded view of nursing that would endure throughout the students' careers.

In the role of socializer, the faculty attempt to find clinical cultures or contexts that support autonomous practice. Ada Jacox (1978) discusses how the nursing faculty meet with frustration when trying to find a clinical setting that supports autonomous nursing practice. The nursing

faculty, the most highly educated nurses, perhaps because they present a threat to staff, are not allowed to suggest new or alternative nursing interventions. They end up playing games to maintain their clinical position on the nursing unit. This is an unsatisfactory position that slows down the transition to a new kind of nursing and reflects the working of oppression and status lines in the hospital.

Dalme (1983) adds to the notion of nursing socialization by investigating the role the staff nurses and the nursing students' peers play in her role formation. The findings indicate "that the longer the nursing student is in the clinical arena, the more different groups of people significantly influence his or her attitude toward the profession. . . . It seems apparent that the student culture mediates how the values of nursing staff and faculty are transmitted" (p.140). Here we see how the clinical arena may have direct influence on the fledgling nursing students definition of nursing.

Even the Master's prepared clinical specialist has problems adapting to her new role as the "clinical expert" (Hamric, 1983). Hamric's essay discusses the real problems that clinical specialists face when trying to become "an expert practitioner, role model, patient advocate, change agent, consultant/resource person, clinical teacher, supervisor, researcher, liason and innovator," as the job description often says she should. Each of these job

functions require that the clinical specialist work from an influential power base and strong interpersonal communication skills which take considerable time and skill to develop. Unfortunately, the clinical specialists often adapts to the environment by becoming an "'organizational woman', . . . the individual accepted and integrated bureaucratic values but had minimal or no integration of professional values" (Hamric, p.48). Hamric notes this adaptation sequence is very similar to the cultural shock described by Krammer for new baccalaureate graduates. Again, the messages of the bureaucratic system are powerful influences on even some of the more educated nurse practitioners.

Queen (1984) demonstrates the importance of socialization process for RN students seeking a BSN. In her anaysis she refers to the socialization process as the development of a professional soul. "Within this professional soul, nurses will act in an ethical, accountable and collective and scholarly fashion"(p.135). Futhermore, she suggests one of the ways to encourage the professional soul is to remove these students from the hospital setting and assign them to community settings that reduce the reinforcment of traditional behaviors. Again the suggestion is that current hospital cultures are not the best place to develop a professional soul which reflects the new values and images of the professional nurse. It seems

clear that the clinical arena most often offers less than the ideal in terms of professional autonomous clinical practice. Changes are needed in hospital cultures if the new definition of professional nursing is to be realized.

Language. Pondy (1976) suggests that one of the least visible tools that influence behavior is the language we use. By talking about the experiences, the words begin to establish a shared meaning and serve to solidify the enacted context. The leader is

> "able to make activity meaningful for those in this role set not to change behavior but to give others a sense of understanding what they are doing and especially to articulate it so they can communicate about the meaning of behavior....If in addition the leader can put it into words, then the meaning of what the group is doing becomes a social fact....This dual capacity....to make sense of things and to put things into language meaningful to large numbers of people gives the person who has it enormous leverage" (p.94-95).

Many prior organizational theorists have forgotten that human beings with minds and language make up organizations. One important component of a change in this perspective would be to understand how these minds come to know causality. These beliefs are stored in the minds of the members and become objective perhaps by use of what Berger and Luckman call "signification". These signs may be in the form of myths, rules, policy, language or standard operating procedures. Of particular importance in understanding these beliefs is the role of language. Pondy and Mitroff (1979) state:

1. It controls our perceptions; it tends to filter out of conscious experience those events for which terms do not exist in the language.

2. It helps to define the meaning of our experience by categorizing streams of events.

3. It influences the ease of communication; one cannot exchange ideas, information, or meanings except as language permits.

4. It provides a channel of social influence (p.24).

The political and social roles of language have not received much attention in the nursing literature. Ashley (1980) reminds us that

> " . . . Language and ideas are alive, having constant effects and shaping the lives of individuals, nations and the human race. . . . To understand the politics of society, the living words and the language of the people are of primary importance" (p.12).

Indeed, it is the nurse's communication skills that are the basis for the therapeutic relationship that will be the catalyst for promoting patients' health. Likewise, it is the nursing managers' communication skills that provide the necessary resources for nurses to function through articulation of the new professional practice needs to key members of the hospital staff and administration.

Benner (1983) and Benner and Wrubel (1982) have explored the importance of a common language for nurses to document practical knowledge that is embedded in clinical practice. "There is much to learn and to appreciate as nurses uncover common meanings acquired as a result of helping, coaching, and intervening in the significantly human events that

compromise the art and science of nursing" (Benner,1983, p.41). These authors have emphasized the meaning of nursing interventions within the context of model cases. They point out that the context is what provides the meaning for the novice practitioner attempting to discriminate between possible nursing interventions. The model cases provide a means of synthesizing nursing knowledge. This is further evidenced by the growing movement to develop nursing diagnoses to provide a common language for addressing universal nursing problems.

Hutchinson (1984) comes the closest to an ethnographic understanding of meaning creation with her study in the Neonatal Intensive care Unit; "My purpose in writing those early field notes was to describe the culture. By analyzing the components, I will attempt to arrive at a meaning implicit in the culture"(p.88). She describes how the nurses "create meaning out of horror" by framing their daily activities in words that help them to adapt to an environment where the "grotesque is omnipresent, where human frailty is disguised by medical technique, and death masquerades as life"(p.86). She develops a framework that includes three kinds of meaning: "When a nurse creates meaning emotionally, she is closest to the baby; creating meaning technically, the nurse distances herself enough to function adequately; creating meaning rationally she is removed"(P.88). This is one of the few nursing studies that

attempts to understand how a meaning is created within a nursing unit and it provides powerful images of how nursing takes shape in that context.

From another perspective on the importance of language in the practice of nursing, Kasch (1983) who is not a nurse but a communication specialist, discusses the primary position for communication to nursing. She proposes that communication be viewed as a resource for accomplishing the instrumental and interpersonal goals of the nursing process. She suggests that

> "a theory of interpersonal competence suggests how systematic differences in the control over the resources of communication influence interpersonal effectiveness . . . . Interpersonal competence depends on the social cognitive, behavioral, and cultural resources of communication that underlie the individual's capacity to anticipate, control, and flexibly adapt to the demands of the social environment "(p.77).

Although Kasch has developed a communication theory for nursing interventions, it may also serve well as a model for nursing management. Because of its potential to help nurse managers for framing the meaning of nursing, it deserves further explanation.

There are two major components of this theory; social cognitive competence and strategic message competence. Social cognition refers to the way in which people

> "acquire, organize, and give meaning to the information they use to formulate beliefs, goals, and and plans that permit successful transactions with the environment and others. . . .All persons in varying degrees approach interaction with an egocentric orientation, and social competence is in part a

> function of an individual's capacity to escape the confines of personal perspective and to assume or construct the viewpoint of the other person" (p.77-78).

This ability to free oneself of blinding assumptions, opens up the alternatives perceived in the situation. A person must be able to manage differences in perspective in order to adapt communication effectively.

Kasch uses the term strategic message competence to refer to an

> "ability to use reflective control over the resource of language to influence another's beliefs and perceptions, adapt messages to different persons and situations, and control the outcomes of the interaction to facilitate the accomplishment of interactional objectives" (p.79).

In other words the nurse consciously develops a strategy such as inference patterns, schemes for framing ideas, or general lines of an argument for presenting ideas and alternatives. Competence is viewed from the standard of flexibility to develop an appropriate strategy for the situation.

Here we note the use of reflexivity to understand the impact of communication on the patient or the nurse. Moreover, nurses are actively encouraged to develop strategies to frame the communication in ways that are most instrumental. Herein lies the potential power of Kasch's work.

In summary then, this examination of nursing culture has demonstrated how the current negative image of nursing in

the press has been influenced by oppression, stereotypes, and bureaucratic principles. The signs and symbols of nursing are changing; either as a result of oppression or because the feminist spirit has captured the nursing profession.

Nursing has just begun to discover the importance of language and meaning for defining everyday reality to nurses. The beginning work has centered around the use of language to establish a common language for developing clinical knowledge. Kasch has done the most to develop the notion of communication as a resource for both the nurse and the nurse manager.

Bureaucracy's Impact on Nursing

Weber's "iron cage" has left its mark on the nursing profession. Just as positivist thinking runs counter to the wholistic approach of nursing, so does the bureaucratic method of control. Bureaucracy requires a division of labor and dependence on rules, regulations and close methods of control for survival. This structure is the antithesis of what professional nursing would require for a truly accountable and autonomous professional practice. Yet, with the exception of those few nurses who have sought employment outside the hospital, the majority of nurses have become enculturated to the ethic of organization so well depicted by Denhardt (1981). Nurses have become the rule and regulation keeper of the hospital's bureaucracy, being sure

that the physicians, nurses, auxillary service personnel all follow the guidelines and regulations established by the ubiquitous hospital committee. The nursing resource has been given over to the bureaucratic value of rule keeper.

Lewandowski and Kramer (1980) demonstrated through survey results that intensive care nurses had trends indicating a higher increase in bureaucratic role conception than non-intensive care nurses. Nurses within the specialized setting are rewarded for attention to and their knowledge of part-tasks. The structure is rewarding behavior that does not emphasize the whole patient. Thus, the nurse comes to emphasize "parts" of the patient.

The consequences of rewarding attention to "parts of the patient" are significant. This focus denies the emerging value of wholistic nursing. It says to other professionals in the context that nurses are not the ones to be concerned about the entire patient. Finally, the patient sees the nurse as one who is concerned more with his hourly statistics than the "person" who is present on the bed. All this reinforces the behaviors necessary for bureaucracy to flourish.

Early work (Drucker,1954) in the field of organization consultation pointed to the need for professional employees (gender not acknowledged) to have supervsion that emphasized a teacher, resource manager approach to professional employees. This was a shift from a belief that all workers

could fit into the bureaucratic system to a suggestion that professionals need a different framework in order to practice.

Yet, as late as 1969, the Simpsons in a discussion concerning "semi-professional" women and bureaucracy state: "because their work motives are more utilitarian and less intrinsically task oriented than those of men, they may require more control"(p.199). In the preface of this volume, the distinguished scholar Amitai Etzioni comments: "despite the effects of emancipation, women on the average are more ammenable to administrative control than men"(p.XV). It is hard to miss the patriarchal assumptions once one is made aware. Fortunately, the feminist perspective is being heard from the likes of Rigor (1980) and Kantor (1977) who suggest that the characteristics of the organizational situation, rather than the inner traits and skills, may shape and define women's behavior on the job.

Carol Gilligan"s (1982) recent research on the moral and psychological development of women adds to the feminist perspective on organizations. Her research has demonstrated the importance of relationships and interconnectedness for women. This view is contrasted with the male perspective of hierarchy of relationships which, by definition, has an inherent decision process for separation and relationship. Although it may be unsafe to generalize, the question we may ask is: How has the bureaucracy molded the nurses' behavior?

How have the nurses defined their role in this framework that demands a part-task approach to their daily activities for a "whole" patient. There must be some adaptation mechanism to relieve the tension between a need for connection and the beauracracy's requirment for attention to parts.

There has been some research by Clark and Lenburg (1980) that tries to discover those organizational conditions that encourage knowledge based nursing in contrast to rule-oriented nursing. They found "that if a high degree of information is exchanged and if nurses know how to receive and give information and win for themselves recognition; they are better able to apply knowledge . . . "(p.249). Support must be made available in hospital settings for nurses to operate in such a context of high information exchange. Nurses must be seen as an essential aspect of patient care/education; they must be valued more so they will be included in the information and decision process affecting clients.

This section of the chapter has focused on the two aspects of nursing cultures that have served to play a powerful influence on the nursing practice today. The history of nursing has been dominated with myths and stereotypes that have served to reinforce the oppression still felt by nurses today. Very little has been done in the way of understanding the importance of language and meaning

on the definition and practice of nursing. Finally, the bureaucratic form of management has been influential in blocking the wholistic approach to patient care that is basic to nursing philosophy.

Nursing Administration Literature and the Interpretive Paradigm

Now that we have some insight into the culture of nursing and the confounding impact of bureaucracy it is appropriate to search the relatively new field of nursing administration to look for clues for managing from the interpretive perspective. Although nurse managers have not overtly recognized their impact on defining nursing, some of their literature begins to address the importance of meaning, process, structure and consistency when managing a nursing service.

Barbara Stevens (1979, 1983) weighs the importance of a nursing theory framework for a nursing service.

> "The structures that are built to manage nursing care can either facilitate or inhibit application of any theory of nursing. . . Since she does impose theoretical structures, it is better that she recognize this fact and make informed choices concerning those structures she employs" (1979, p.104).

Stevens compares and contrasts the problematic and logistic approach to nursing. Because the former requires a thinking process that only looks at problems, its support system must be quite different than an approach which builds on the

strengths of a patient.

> "The greatest favor the nurse executive can do for her staff is to select and apply a single consistent methodology. . . . Implementation of a given structural approach to nursing requires thorough consideration of every document and every procedure used" (1979, p.105).

The policy for nurses' notes, assessment forms, verbal reports, and assignments all have direct bearing on the framework chosen to define nursing care. Stevens' attention to consistency infers that the underlying assumptions and beliefs for theory selection must be made explicit so that those values may be supported throughout all the nursing department's policies.

Stegman and Dison (1984) and Ford (1981) are among the nurse leaders who are advocating a nursing structure that incorporates both service and baccalaureate nursing education. This contingent of nurse managers seeks to influence nursing practice by allowing the culture of the educational system with its norm of intellectualism and autonomy to influence the bureaucratic norms of the hospital. The effort to support autonomy is further encouraged by the primary nursing assignment system. Primary nursing requires that the nurse attend to the whole patient. The nurse becomes accountable for the patients' care on a twenty four hour basis. The influence from the educational system helps to define those areas of patient care that are within the autonomous domain of nursing.

Two authors (Colavecchio,1982; Meyer,1984) have recently

acknowledged the meaning that reward systems have for nurses. Colavecchio investigated attitudes about direct patient care in order to determine those rewards that influence a desire for nurses to remain at the bedside. It appears that nurses practicing in hospitals derive their satisfaction from the content of their work.

> "The satisfying factors include challenging work, autonomy, a sense of accomplishment, harmonious working conditions, and [most importantly] the human connections they make with their patients. . . .its not the patient that makes the nurse want to leave nursing" (p.21).

It behooves the nurse manager to arrange the work of nursing in such a way that the nurse will receive these rewards. The manager must develop strategies to enhance the probability of the human connection between patient and nurse, not diminish it.

Meyer (1984) reminds the nurse manager to examine the rewards that are implicit in a performance situation. The point is, that nurse managers must examine the messages they are sending to the nursing staff either implicitly or explicitly. Is the structure providing negative sanctions for desired performance? For example; does the nurse receive 'flack' for taking on the role of patient advocate? Conversly, does the system reward non-performance? Are expected behaviors ignored on performance review evaluations? Are the norms of the group supporting non-compliance?

Conclusion

This literature review has discussed those myths, beliefs, socialization processes, and oppression that have been a part of the historical and social creation of today's ambiguous view of nursing. This background is helpful in three ways: (1) it provides a basis for approaching the current culture of nursing by supplying aspects of the rich heritage of nursing's past, (2) it shows the need for new supports to enhance the actual practice of professional nursing and, (3) it provides some clues for framing an ethnographic study of professional nursing today.

An ethnographic study of a nursing unit would focus on those patterns of behavior and communication on the nursing unit that would serve to display the themes, beliefs, and assumptions that form the definition of nursing for that unit. Specifically, the researcher would attend to the verbal and written communication between nurse peers and the nursing leaders. The interactions with other members of the units culture (physicians, social workers, dietitions, building services) would also provide valuble insights into to their participation in establishing expectations for nursing behavior. With this background, the following study has been designed.

CHAPTER III

DESIGN AND METHOD

This study developed an ethnographic perspective of a nursing unit focused on the creation of the definition of nursing. Because, an ethnography demands a flexible approach, only the general outline of the design was prescribed in advance (Bogdan and Taylor,1975). Nevertheless, there were parts of the process clearly established before the research began in order to set the appropriate tone for the participant observation and to insure a rigorous approach to the culture.

Research Site

A medical center in Western Massachusetts was approached. This hospital was chosen because of geographical convenience and preliminary interest of key hospital members in the research topic.

The particular nursing unit selected was a representative medical nursing unit in this teaching hospital. Important criteria for the selection were an interest and willingness on the part of the Nursing Director, the Unit Supervisor, and the Nursing Staff to be a part of this research.

Negotiations for the research included a flexible schedule to allow for the researcher's presence during important activities on the unit during any hour of the day.

The researcher also asked for a safe place to keep personal articles, (coat and purse) and permission to use an empty niche to do dictation of field notes as time and activity allowed.

Participant Observer's Role

Byerly (1976) discusses a continuum for the role of participant observer: (1) complete observer, (2) observer-as-participant, (3) participant-as-observer, and (4) complete participant. This researcher chose the paticipant-as-observer role because "it has the advantage of presenting a more detached image than complete participation and may result in the use of the observer as a 'sounding board' for feelings and opinions that might not be expressed to someone more intimatly involved in the immediate physical situation" (Byerly, 1976, p.145).

The researcher took the role of a graduate student in nursing management who was trying to learn about the nursing culture. The role was likened to that of an anthropologist (e.g. Margaret Mead) who was trying to identify the beliefs, rituals, values, language and traditions that make this unit unique and special. The foremost focus was on all those parts of the culture that help to make the definition of nursing clear.

There was little direct patient care by the nurse researcher in order to avoid becoming a model or influence for the nurses on the unit. Nevertheless, it was appropriate

to help with a few tasks such as helping to make a bed or to feed a patient in order to gain access to group membership. The researcher wore street clothes and a lab coat to help delineate the appropriate membership on the unit. This part of role establishment was handled very carefully to insure that the researcher was seen as someone who cared about the nurses, yet not as another pair of hands that was given to the unit.

Over time the researcher was viewed as the "resident anthropologist" and part of the ongoing membership of the nursing unit. Once the comment was made that the meetings did not seem complete if the researcher were not there. Interaction with the staff was characterized by support and interest in their concerns and beliefs. As time passed and questions were raised in the researcher's mind about the meaning of events, informants were asked for further explanation. However, in general the reseacher was not the one to initiate new topics of conversation and responded to direct questions in a non-committal way. The majority of the researcher's responses were reflective in an attempt to learn more about the members' viewpoint and not to become a part of the creation of nursing by her responses and opinions.

Consent Considerations

The anthropologist has a unique situation when it comes to informed consent because the membership or subjects of

observation vary from moment to moment, depending on whomever enters the nursing unit. It is suggested by Agar (1980) because the culture's members are at minimal risk, that a verbal consent be introduced to the unit members. The researcher included an explanation of the research design, a statement of risk and benefit, and assurance of anonymity. The only possible disclosure to nursing management was a case where patient safety was in question. It was clear that the write up of the research project would use pseudonyms and other techniques to disguise each of the units' members. The possible use of the research results was also discussed.

This information was shared with staff during staff meetings, that were part of the regular monthly meetings for employees assigned to that unit. Appendix A includes a script of the wording of this information. Each person had their questions answered at that time. A copy of the script was attached to the minutes of the staff meetings so that there is a permanent record of the information sharing.

As the research proceeded, there was reason to have more direct involvment with the unit members. This was in the form of shadowing staff nurses to gain an understanding the messages between nurse and patient. Also a sentence completion task was requested to verify and elaborate the messages that the researcher was receiving. The questionnaire was based on the first stages of the

observation. Each individual involved with the tool was individually approached by the researcher and requested to sign the informed consent. An example of the tool and the informed consent used at this time is found in Appendix B and C. The possibility of this encounter was mentioned as part of the initial information session.

Data Gathering

Jennie Keith's (1980) model of participant observation was followed. She divides the observation experience into three stages, each having its own goals and characteristic types of data.

Stage I: The first stages of observation served to map the nursing unit. This included the layout of the physical environment and a narrative of the key characteristics. A description of the cast of the actors, significant past events, and the major activities of the unit is included. All this information serve to describe the context for cultural activities. It also provides the baseline data that guided a sampling strategy for selection of staff, unit activities, and time frames that might provide the most opportunity for further observation.

During this time the researcher's role became established as the actors became more comfortable with her presence. It was an opportunity to frame the researcher's role as the individuals asked for clarification "now that she was actually there".

This information was gathered in field note form. The notes actually taken during the observation that served to jog the researcher's memory for a more complete descriptive narrative to be dictated on a taperecorder either during a quiet time on the unit or at home. As questions or hypothesies developed from the observation they were recorded as Observer Comment (OC) in the typed narrative (Bogdan and Taylor, 1975; Keith, 1980). As the researcher became more comfortable in the new culture, tentative patterns began to emerge. "As insights become reinforced into hypotheses about the way things work here, "key informants" can be asked to verify patterns" (Keith, 1980).

The key informants were those persons on the nursing unit who might have several reasons for talking to the researcher.

> "First, because I [the researcher] am a person who is genuinely interested in and repectful of another's point of view...Secondly because most people enjoy telling their story to an interested listener. . .You are a potential friend, though a peculiar sort. . . .the relationship is not really a friendship since the ethnographer is after all, 'doing research' and, once he leaves the group, he may have little or no further contact. The paradox of detached involvment appears again"(Agar, 1980 p. 88).

Stage II: During this time in participant observation, the observations became more focused due to the tentative patterns that were idenified in Stage I and the prepatory literature review. The focus included an emphasis on communication events, such as the patient reports, staff meetings, nursing care plans, informal interactions, nursing

department policy, memos, hiring interviews and orientation activities, all in order to document the language and messages that the nurses use to relay their meanings about nursing. The field notes became more specialized with an obvious concentration on those patterns and themes that seem to bear on the social creation of the definition of nursing. The field notes and documents from this Stage were again reviewed with an eye to confirming patterns that seemed to be emerging from the unit's culture.

Stage III: There was a pause in the data collection at this time in order to allow time for sense-making of the field notes, to search the literature for clarifying or supporting documentation, and to properly construct and pilot instruments for the final hypotheses testing. The instrument used to gather data is described below.

Questionnaire. The questionnaire was a sentence completion task similar to those suggested by Agar (1980). The key element in this stage was to provide mechanisms to prove the tentative hypotheses false (Agar, 1980; Ellen, 1984; Pelto and Pelto, 1978). The purpose of the tool was to encourage the nursing staff to freely suggest those aspects of professional nursing that were important to them and were part of their everyday practice. The stem for each sentence completion was suggested by the initial analysis of the observation data and the literature review.

The sentence completion task was piloted on a similar

medical nursing unit. The results of the pilot were evaluated for the "reasonableness" of theresponses. The researcher was looking to see if the stem brought forth the general form of response that indicated the nurse understood the question.

As a ressult of the pilot, the directions for completing the questionnaire were revised to leave open the number of responses to each stem. This approach was to encourage the nurse to state her priorities and not to force her to meet the expectations of the researcher. The tool and the responses can be found in Appendix C and D.

Twenty five nurses were individually approached within a week's time and asked to complete the sentences. They were each given a copy of the individual consent (Appendix B) and a copy of the completion task. They were asked to place their signed consents and completed tool in separate manilla envelopes that were hung on the confrence room bulletin board. They were given ten days to complete the task. Twelve nurses responded. Results from the questionnaire are presented in Chapter 4 as they support or elaborate the initial observation data.

Data Presentation and Analysis

The process of data analysis was on-going during the entire observation experience. Each tape of field notes was transcribed as it was completed, referenced with consecutive numbers for each page and was coded for time and place of

each observation. These notes were double spaced on 3/4 of the page, leaving ample margin space for many observer comments and classification codes. The notes permitted an opportunity to index and code the observations in various ways until a common-sense system emerged from the narrative. These notes were sorted to build a case for possible hypotheses. They were sorted several different ways as the observation continued and new insights were gained from the experience.

At the end of Stage II the coding system became more stable as themes were formed around various messages that were becoming clear from the communication process on the unit. There was supporting documentation from the field notes to build a case for the seeming definition of nursing for that unit.

The data gathered in Stage III was analyzed to look for confirmation or contradiction of the themes that evoned from Stage I and II. The criteria for analysis was systematic, public display, and opportunity to prove false, the tentative hypotheses (Agar, 1980). It must be remembered that the size of the sample for any instrument was necessarily small and non-parametric; "the purpose of hypotheses, as we use them, is to sensitize one to the nature of behavior in a setting and of social interaction in general: to help one understand phenomenon that were previously not understood" (Bogdan and Taylor, 1975, p. 80).

The data presented in chapters four and five are presented in three parts. The first discusses the process by which the definition of nursing for that unit became known to the researcher. The second portion of the data will be the researcher's best understanding of that units definition of nursing. Chapter five suggests those parts of the definition that are still unclear and leave the average staff nurse in a quandry. This section will also suggest some direct intervention that the nurse manager may consider to make the definition more toward the "New" culture. The field notes were used to build a case for all sections of the presentation.

C H A P T E R I V

ANALYSIS OF DATA

Overview of the Chapter

In this chapter the data (observations, questionnaire responses and written documents) have been organized so the reader may understand how the the observations were made, classified and interpreted. The background of the nursing unit provides the significant historical facts and presents characteristics of the unit that were important for establishing the tone and atmosphere of Baker 5.

The description of nursing on Baker 5 is divided into two sections; the traditional culture and the emerging new culture, similar to the distinctions made by Madeline Leninger in Chapter II. The data are organized according to the same topics as the literature review. The reader may want to refer to Chapter II for a more in depth discussion of the concepts presented. In order to facilitate return to Chapter II, the references for the articles mentioned in the analysis will be found on the page noted in the brackets [].

The author has used all the data sources to build a description of Baker 5's definition of nursing. The complexity of the data has required some extensive descriptions of the observations. The significant findings have been underlined.

Background of the Nursing Unit

Baker 5 is a medical nursing unit that has historically been one of the private (single room only) VIP units in Valley Medical Center. During the past few years it has seen several changes in contrast to its more stable early history. The changes included a unit renovation that made most of the private rooms into double accommodations, the arrival of medical housestaff with cardiac telemetry, and a series of three supervisors who have guided the the unit since the original supervisor retired after several years of service.

Cardiac telemetry is a technology that allows the patients' eclectrocardiogram (EKG, or heart rhythm) to be monitored by a small box that the patient wears. This box sends impulses to the nursing station where a receiver and a computer display the EKG for the nurses and physicians to see. The computer evaluates all the EKGs for their regularity and will send an audible alarm if the heart rhythm is questionable or if there is a mechanical problem with the equipment. A different alarm is sounded if the heart rhythm is life threatening. There are sixteen telemetry units available. The medical housestaff assign these to patients based on their assessment of patient priority. Four of the sixteen are reserved for surgical patients who may have a cardiac problem along with their surgical condition.

The addition of telemetry and the double accommodations

have changed the patient population on Baker 5. Previously, only patients who could afford "private" accommodations or those with rare medical cases that required a private room, were on this unit, often with their private duty nurses. Now patients are assigned to Baker 5 according to their admission diagnosis and the admitting schedule of the housestaff. The introduction of telemetry also required that the nursing staff become expert in reading electrocardiographic rhythms, and in the care of patient with cardiac disease. Telemetry also was the reason for a higher nursing-hour-per-patient-day allocation and a higher registered nurse ratio than the rest of the medical nursing units. In fact "telemetry" became the familar label for the unit.

The nurses on Baker 5 varied greatly in experience and educational preparation. Some had been working fultime in nursing for over ten years. Others had just graduated within the the year from nursing school and this was their first job. Many of the nurses with the most experience had graduated from diploma nursing programs, some of the younger nurses from baccalaureate programs and two of the three Clinical Nurse Managers (CNM) had completed their baccalaureate after their diploma education.

The tasks to be done for patients were divided according to job descriptions. The unit supervisor for this unit started her job the day I started my observations. She was

participating in a trial in Medical Nursing to see if one supervisor could manage two nursing units realistically. She was already responsible for the nursing unit directly below Baker 5. The Unit Supervisor had 24-hour responsibility for the nursing unit. This responsibity included management of all hospital systems and quality of nursing care. This meant she was accountable for the budget, the hiring, evaluation, and termination of employees, the development of nursing care programs, and staff morale! These duties were unit specific and were frequently overshadowed by her hospital committee responsibilites. But, the Clincal Nurse Managers (CNM) were the nurses reponsible for the three shifts, and they were the ones who managed the day to day activities of the unit. They were accountable to the supervisor for carrying out the programs and plans that were created at the CNM -Unit Supervisor meetings. As the coverage demanded, they took an assignment for patient care in one district. A district was a geographical area with specific beds always assigned to it.

The staff nurses were assigned to patients within one of four districts. This assignment was for the accountability of all the patients within their district which usually was between four and six patients. The assignment could include more patients, but during my observations it seldom did. These staff nurses would receive help for some of the tasks by the LPN or Aid who was assigned to patients throughout

the unit. The LPNs and Aids reported significant observations to the staff nurse responsible for the district.

The unit secretary provided the vital link between the physicians' orders and the nursing staff. She transcribed all the orders to the Kardex, and maintained the communication system of all information coming to the nursing station by telephone, by person or by mail to the appropriate nurse. These linkages were invaluable and were sorely missed when a unit secretary was not available. The CNM often was pulled from her management responsibilities to fulfill the the secretarial needs of the unit when the secretary was missing.

Methods for Discovering the Implicit Messages

The researcher took the perspective that asked the questions: "What is going on here? What seems to be important to the nursing staff? If I were to work here, what must I do to win approval and membership to this unit?" This perspective was used during the ten weeks of observations. The researcher was on the nursing unit or at nursing meetings around twenty hours a week. Quickly the nursing staff became comfortable with my presence and once remarked that the group did not seem complete if I were not there.

Initially the researcher tried to take an unobtrusive position in the nursing station to catch the varied activities and conversations that centered there. This

position yielded information about nurse-physician interaction, nurse-family interactions, nurse-nurse, and nurse-support staff interactions. All this conversation and discussion provided data for the researcher's conclusions regarding the unit's definition.

The Unit Supervisor and CNMs were very supportive of the research and actively sought me out to offer or confirm several opportunties for observation that would help in my "discovery." Some of the opportunities included; CNMs and Unit Supervisor planning and management sessions; Quality Assurance meetings; Staff meetings; and New Documentation Resource meetings. There were several workshops going on during this time which I was invited to attend at a reduced rate. They provided helpful insight into the New Documentation Package that had been in the planning stages for the past year. The Vice President for Nursing directed a workshop on survival skills for the CNMs. This workshop offered a unique opportunity to see and hear the top nursing manager discuss her views about nursing and specifically nursing management. The observations from these meetings are included in the description of the nursing culture on Baker 5.

A significant source of information was the shift-to-shift report given three times daily by all the nursing staff. It was my practice to arrive at the beginning of a shift so that I might listen to the reports and watch the

staff at this time. These messages, along with the written standard (which were predeveloped by a nursing committee) provided a framework for understanding how the nurses saw their responsibilities for patient care.

Towards the end of the observation period, I asked the nurses if they would allow me to shadow them while they were working directly with patients. This was done to hear the discourse between patient and nurse for any messages that I might have otherwise missed. Initially the nurses were a little hesitant, but they each agreed after a moment's thought.

The written documentation on the unit was available for analysis. This included numerous policy and procedure books. Some were specific for the unit and others were standards for the entire hospital. The bulletin boards in the nursing station and the conference room also provided helpful clues for verifying the important messages coming and going among the nursing staff members.

Finally, the staff members were asked to complete a questionnaire that would help to verify and elaborate the definition that the researcher had created from intial observations. The questionnaire was piloted on Baker 4 before implementation on Baker 5. After a few modifications, each staff member was approached for agreement to particapate in the questionnaire and to sign the necessary consent. Approximately 25 staff members were approached and

12 members actually completed the questionnaire.

Description of Baker 5: a Traditional Nursing Culture

Smircich (1983) has suggested that culture be used as a root-metaphor, an epistemological device, to see how human beings create their social world thru symbols. The observations on Baker 5 show how language, routines and models provide the symbols and create meaning for nursing.

The reader is reminded of Madeline Leninger's (1970) work in studying nursing culture throughout the United States [p.25]. She found many of the old beliefs and values flourishing. At the same time a new culture was emerging. Such was the case on Baker 5.

Oppression and collusion. Leninger (1970) described the traditional culture as other directed, guided by norms of an outside reference group [p. 25]. Ashley (1976) and others [p.16] have discussed how the oppressed group are socialized to the belief that the dominate group's values and norms are the "right" ones for society. This attribution of values, over time, contributes to the lack of questioning the status quo. The oppressed group unconsciously supports or colludes with the oppressor, by internalizing these values and by behavior that reinforces the perspective of the oppressor. Baker 5 was dominated by the values and language of medicine and bureaucracy. The staff spoke and lived the language and culture of the long standing, at times overpowering, world of medicine where the emphasis is

on disease and cure. This observation is not to diminish the amount of loving care that the nurses demonstrated for their patients, but it was done within the internalized values, norms and language of medicine and policy, not from the view of autonomous nursing practice. The following observations support this conclusion.

1. Patients were assigned to the nursing unit based on the patient's cardiac status and the housestaff's assignment system which rotated patient assignment to medical units according to who's turn it was to admit. When a patient no longer needed telemetry he was transferred to the medical nursing unit where his physician was assigned. This transfer ignored the relationship the patient may have established with their nurses and suggests that physician convienence was more important. This constant transferring of patients used valuable nursing time in accepting and sending patients back and forth from unit to unit, to say nothing of the energy patients must use to adapt and learn a new environment with each transfer.

2. Although the nursing staff initiated a teaching program for the telemetry patients, they developed curricula around three areas of medical concern: (1) anatomy and physiology of the cardiovacular system, (2) pathophysiology of the heart, and (3) medications. There were considerable resources given over for specific patient teaching, [24 hours of RN time per week] yet the subject matter chosen by the nursing staff reflected a concern for pathology, disease and cure, rather than concepts that might help the patients cope or adapt to their illness and that would reflect more closely the definition of a "professional" nurse (e.g. diet, life style, stress, excercise, family relations).

3. There was considerable energy allocated to measuring the quality of nursing care provided to patients through the Quality Assurance program carried out by the nursing staff. Baker 5 had the freedom to chose those aspects of nursing practice that they wished in order to measure the quality of their care. The aspects chosen for measuring "nursing" included compliance with the policies for (1) Intake and Output, [I+Os] (2) Telemetry

documentation, (3) Daily weights. Telemetry documentation represents an emphasis on the technology unique for that unit. The Intake and Output procedure and the daily weights are both medical orders that emphasize the dependent function of nursing practice. The message being: Technology and compliance with medical orders are key measures of our "nursing" care. Alternative items for quality assurance from a nursing perspective could have been patient education, effectiveness of nursing interventions, or nursing's attention to spiritual needs of patients.

4. The language used by the nurses to talk about their patients was that of medicine. The guide for giving shift to shift report was the Kardex; a concise way of organizing all the medical orders, laboratory tests, and diagnostic tests ordered for the patient by the physician. The form used by nurses to assess their patient's nursing needs was organized according to the medical model of physiological systems. Again, the language and model for looking at patients and describing their needs were the same as medicine.

5. The support systems for patient care were all dictated by bureaucratic guidelines and paperwork. The nursing staff had to fill out forms or telephone for all of the services that their patient required. This entailed a myriad of laboratory forms, forms for discharge, forms for nursing report, forms for the dietary department, requisitions for missing supplies, etc. Much of their day was spent meeting the needs of auxillary departments' system expectations so that their patients could recieve the care they needed. The bureauacracy dictated a large amount of their daily activities.

The examples described above show how Baker 5 was receiving, accepting and acting on clues from its environment about who they are and what they should be doing with their time. These examples also show how subliminal the use of language and activity can be in framing an oppressive situation, where those in the dominant position exert their influence, in a way that is seldom recognized by

the oppressors or the oppressed. In this case the norms and language of medicine and organizational policy became the most important influence.

Myths. Hughs (1980) discussed some myths about nursing in the secular literature. Briefly, they were concernd about nursing being a task oriented job rather than a profession guided by knowledge and science and, the necessity for physician supervision [p.22] These myths were in evidence on Baker 5 as described below:

> 1. The performance of repetitive tasks rather than using a sound knowledge base to dictate practice was demonstrated by the routine of vital signs, I+O's and daily weights. These were done routinely with little questioning of the contribution they were making to patient care. Patients were awaken from their night's sleep for questionable routines such as taking some vital signs and medications which were to relieve chest pain on exertion. A simple thing like bed making became such a routine task that the staff automatically changed all the sheets every day at least once and sometimes twice whether the patient needed it or not. There was a kind of feeling that it was a of way doing something "extra" for the patient. (Discusssions did not occur among the nurses or the patients about what helpful extras might be.)
>
> 2. Nurses function only under physician supervision. In one case a nurse did not feel comfortable in making the decision whether patient could take a shower or if she must have a bed bath. The RN had come to the conclusion that some drastic action was needed to improve the odor in the patient's room and suggest that the patient use a shower chair and have a complete bath. This autonomous decision was negated when the nurse went to the physician asked if it was OK. At an other time a patient wanted desparately to sleep in a cardiac chair and the nurse would not let him because he did not have an order from a his physician. Would not nursing judgement suggest that the patient was in greater stress with more strain on his heart, trying to sleep where he felt uncomfortable?
>
> At least three times during the observation period

> the nurses realized that they did not have a clear picture of what their standard for nursing care for cardiac patients at night was to be. There seemed to be a contradiction between the need for rest and some concern for frequent observation of the patient. The conclusion of the discussion was that they needed to ask the physicians what they thought about this matter. In contrast to the possibility of searching the nursing literature and coming up with their own recommendations about standards of nursing care for the cardiac patient at night and a strategy for working with the physicians to have them implemented.

These examples show how the nurses have fallen into the rituals of repetitive tasks and the myth of the necessity for a physician's order for every nursing action. The nurses on this unit have come to believe some of the myths discussed by Hughs.

Socialization

Smircich and Stubbart (1983) discuss the social processes that produce the concepts by which the organization is enacted. They also suggest that symbols and signs relay values that are less than obvious [p.28]. It is with this perspective that the researcher gathered the data about the socialization process that took place among the staff members on Baker 5. This process along with some significant symbols served to form useful messages about what was expected behavior among the unit members.

Nurse to nurse interactions. Frequently as nurses were going about their activities their interactions would be characterized by consultation with one another over many procedures. The norm seemed to be that it was acceptable to ask a peer about a nursing procedure, but peers did not

volunteer their expertise or advise on nursing issues unless they were asked. This norm required that the less experienced nurse recognize what she did not know and be able to ask for help. There was also a norm of asking a fellow member if she needed assistance in finishing up her assignment. But seldom was this help accepted. It appeared that each was to do her own work in a timely manner. The exception to this rule was a medical emergency which might put a staff member far behind in her schedule. Unit members quickly jumped in and helped the staff member catch up in such a circumstance. Another norm concerning work habits included keeping their break to the appropriate length and being on time for work, if not early in order to get organized for the next shift.

The questionnaire confirmed the value of being ready for the next shift (Appendix D #1). The members identified several expectations they had for themselves in preparing for the next nurse. They expected the patient to be clean, to have a bath done, lab reports received and reported, and the room and supplies ready for the next nurse.

The more informal conversation frequently focused on family, loved-ones and activities during leisure times. Once in a while there would be informal "gatherings" in the conference room. These were usually occasions to have some kind of food to celebrate the departure of a valued member. Food became the symbol for attachment and departure. The

unit members used this device to say good-bye to the nursing students assigned to the unit, to the unit supervisor who was transferred, and to a staff nurse who was going on a pregnancy leave of absence.

The general good feeling that the staff felt about working on their unit was symbolized by a little white button worn by many. This button affirmed their feelings with the words I Love (heart symbol) Baker 5. These buttons were given to the staff by the unit supervisor on Valentine's Day and were still worn by many members.

Patient nurse interaction. Nurses played an important role in bridging the barriers between the patient and their teaching hospital environment. They did this by interpreting for the patient medical language about tests and diagnosis and vital sign readings; interpreting for patients the hospital system; dietary, labs etc. and by interpreting for the patient physical signs and symptoms that caused concern to them. They were frequently giving reassurance about progress from day to day and assurance that the physician would be notified of their concerns. There were frequent questions about when the patient could go home. The nurse was in the position to explain to the patient what must happen before he would be able. Frequently the nurses were called to the phone to talk with a family member about the patient's status which usually included comfort level and mental status if previously it had been less than normal.

There was much time spent teaching the patients about procedures and tests they were going to have; stress tests, cardiac catheterization; angioplasty and cardiac-by-pass surgery. Each nurse had her own way of approaching the subject; not necessarily based on adult learning principles (i.e. the previous learning patterns and knowledge base, readiness to learn, etc.) but a sincere effort was made to let the patient know what was going to happen to him. A few diabetic patients on Baker 5 were instructed in the use of "Chem strips" to test their urine for sugar and acetone. The researcher looked for follow up on the educational activities in the progress note but found little. This made it difficult for all care givers to know each patient's knowledge level and how to continue the teaching program. Clearly there appeared to be a lack of messages emphasizing teaching as a constant value.

Sensitive sexuality issues were handled by nurses with aplomb. The nurses verbalized to me or another nurse their recognition that male patients had feelings about some things nurses were required to do; i.e. rectal temps, complete body shave, foley-cath care, diarrhea that needed to be cleaned up, examination of bed sore between buttocks. All of these examples nurses handled matter-of-factly, reassuringly and efficiently. They were just another part of the job that was handled discreetly and with care.

Patient comfort was frequently the topic of conversation

with the patient or those who were to care for the patient next. These measures usually focused on the effect of pain medication or nursing measures that might help the patient be more at ease emotionally, such as suggestions of reassurance. The questionnaire demonstrated that the nurses identified teaching, reassurance, and patient comfort measures as activities special to nursing (Appendix D #11). Yet, they were not communally valued as measures of quality assurance or as subjects for documentation.

Nurses were asking questions about how patients' managed at home; "Why did patient come in with such a high digoxin level? A wrong dose or did patient not take it correctly? How did patient manage his tracheostomy at home? Why are we giving patient his insulin here when he has been doing it at home for twenty years? Did the patient walk at home before her MI? Although the staff thought of the patient at home, their discharge planning was hit and miss. The nursing audit book demonstrated confusion among the nurses regarding who's role it was to initiate the referral for patients' discharge. Often social service was requested to provide follow up care either the day before or the day of discharge. One patient had cardiac rehab people with an excercise program, a physician with six prescriptions, and the dietitian trying to teach a low sodium diet to the patient, all at once before she was to go home at 11 AM. The behavior of nurses regarding discharge, home care and

prevention of reoccurnance, foreshadows the role for nursing with patients and their care at home. Many of these discussions are within the autonomous decision making domain of nursing if they would recognize this potential and use it.

A draft for the standard of discharge planning was on the bulletin board for staff comment. It addressed the need for nurses to assess patients' resources for discharge, but only addressed the medical; social; and financial needs of patients/families. There was no thought about a patient needing nursing care at home. Again, nursing has an important opportunity to establish its role in home care, but the opportunity needs to be recognized and taken.

At times it was clear that patients would not be going home. At these times the nurses were heard to ascertain from the physician the status for patients when their condition changed. They wanted to know if the patient was still a candidate for a full cardiac resuscitation if the patients heart stopped. There was considerable tolerance for "grey" areas in just what the resusitation status was i.e.(1) use of pediatric endo tube, but no chest compression, (2) everything but chest compression for another patient. Nurses were heard to be clarifying the status with the MD; but NOT PARTICIPATING in the decision as to whether or not a patient would be a full code (all possible interventions to reestablish heart rhythm if it should stop).

In stark contrast to the sudden death that usually occurs with a cardiovascular failure, during the observation period there were two examples of exceptional caring and emotional support for families and patients who went thru a period of 8--16 hours to die. There was Mrs. White, wife of a patient with Cancer of the thyroid who was slowly deteriorating. The nurse directly confronted in an empathetic, caring way, the wife with the issue of coping with stress of staying with her dying husband and how she might secure rest for herself. The nurses were with patient and his wife thru the entire experience of hemorraging and eventual death.

In a similar situation a patient with cancer was transferred to Baker 5 from the ICU so that he could be with his family in a more supportive environment during his last hours of life. The staff arranged special accommadations for this family unit so they could be together and yet have the privacy they needed. Again, a nurse was assigned to that patient exclusively to provide the comfort and care possible for a dignified death. Both of these occasions were symbolized by sincere thank you notes from the patient's family shortly after the death.

In contrast to emotional and psychological assessments involved in the verbal interactions, there were exceptional physical assessments that required immediate intervention to impede further deterioration in the patient's condition. Mr. Snow's cough was correctly assessed by auscultation as

increased fluid in his lungs and the physician was called in time to prevent pulmonary edema. Another patient showed EKG changes suggesting an evolving myocardial infarction. The nurse had to actually take the EKG to the physician in another unit to get her to act but in the end, they had the satisfaction of knowing they were right and made a difference. These examples provide strong reinforcement for the staffs' concern for physical assessment skills.

Relationship with student nurses. The tenor of the relationship between the nursing students and nurses might be described as partnership and consultant-teacher. There were many examples of staff nurses guiding the student step by step thru a new procedure or problem and mutual sharing of the student's success upon accomplishment. A student project included a class in adult learning theory for the staff of Baker 5. The students were responding to the expressed needs of the staff and were able to offer some new ways for the nurses to think about their patients. The warmth felt by the students toward the nursing staff was portrayed in their thank you note which was displayed proudly on the bulletin board. One of the students took a position on Baker 5 upon graduation. She stated she wanted to work on this floor because of the relationship she had developed as a student during the year.

Messages between physicians and nursing. One physician made a comment to the researcher about the staff's ability

to read the monitors, intimating that they were coming close to the practice of medicine and really how hard the professions were to separate at times. This underscored the lack of a developed separate practice of nursing.

The nurses told me of the controversy with some of the physicians over whether the nurses were spending enough time looking at the monitors. It was their feeling that the computer was programmed to alarm if a dangerous rhythm is present, and that they needed to respond to the alarms responsibly but the computer was there to save their time for other things.

The nurses were often supplying information to the physician about where the patients were if they were not on the floor. The conversation between doctors and nurses covered vital signs, rhythm strips, request for medication change or change in activity level for a patient. Once a nurse suggested a patient was not ready to go home because the patient did not understand her medications. This slowed her discharge a couple of hours while the intern checked with the attending physician, but the patient went home that Friday evening with some tenuous promise of follow up in the office. There were many calls initiated by nurses to secure medication orders; sleep, pain, or laxatives. The nurses regularly called both the attendings and the housestaff with abnormal lab results or results to secure potassium, insulin, coumadin or heparin orders. There was an

expectation that the nurse must be vigilent about all the laboratory results and it was their responsibility to get the physicians to respond to the abnormalities.

The questionnaire (Appendix D #3, #4) supports these observations and suggests that nursing's major role was in observing the physical status of the patient. Indeed, the discourse on the nursing unit centered on changes and interventions to improve the clinical pathology of the patient, not enhance the health and overall well being of the patient.

Clinical Nurse Managers [CNM] messages to staff. The CNMs were the shift delgates for the unit supervisor. They were vested with the major responsibilty of seeing to it that "the work was done," by daily assignments made by the CNMs. They juggled the staffing with the needs of patients, meetings, and special duties (code cart, telemetry, lunch and breaks, meetings or confrences for staff to attend). Once the assignment was made, there was rarely a question. I heard one or two comments by staff members but, they never voiced these to the CNM. The CNM would have to find her own mistakes and go back and correct them with the individual staff member. It seemes as if the the CNM was not to be questioned.

She spent most of her time coordinating the activities on the unit and trouble shooting problems brought to her by various personnel. She was the person to whom problems were

addressed and it was expected that the nurses communicate their affairs frequently to the CNM. Rarely did she go out looking for problems with the exception of nursing assessments. The questionnaires showed that the staff expect the CNMs to be checking to see if their assessments are done (Appendix D #8 #9). This may be due to recent emphasis by the nursing audit program. The CNMs had a major responsibility for carrying on the nursing quality assurance program for the unit and they used this information when forming their staff evaluations. The supervisor stated that she expected them to be used as both clinical and management resources for the shift because the supervisor did not have the time to fill that role.

Messages from unit supervisor. The unit supervisor devoted much of her energy and time on staffing issues (hiring interviews, arranging schedules, activity with payroll cards, following personnel guidlines).She had the responsibity for overseeing the staffing office's employee scheduling, being sure that there was enough staff for patient needs.

Role modeling of good time management was necessary because the unit supervisor was very active in hospital and nursing management committees (quality assurance, nursing research, documentation package). Much of her time was spent in these endeavors, as a result she was seldom on the nursing unit.

The supervisor arranged with potential job candidates for the researcher to observe job interviews with the understanding that I was to focus on the messages of the unit supervisor. Four interviews gave a composite of the supervisors values about her nursing unit. She was searching for continuity and trust for her patients as she described the monthly district assignment of staff. She described the nursing unit by the kinds of medical cases and age of the patient. She felt that honesty was important in portraying job characteristics to any potential candidate. She placed emphasis on the nursing process (how they learned it? what is the value of the care plan?). She used the term "integration" several times in summarizing her view of the applicants. She had the expectation for the new graduates to be reading professional journals. She was feeling the impact of DRG's [Diagnostic Related Groups as a method of reimbursement] and frequently brought this up in the interviews to examine the candidates knowledge. It was her view that it was going to change nursing practice.

The unit supervisor fulfilled the manager role for the unit as can be seen by many of her activities. Goal setting was an expected behavior of candidates in the form of career tracking. This was also expected of the nursing unit and each of the unit members at their annual evaluation. Goals for the unit had been established by the previous supervisor and the CNMs. There was a thorough review of progress to

date at the meeting to turn over the unit to the new supervisor. Meetings were the primary method for program and goal development for Baker 5.

The unit supervisor's approach to decision making took varied forms. There were directives: "The CNMs will work some weekends." (How and when is up to them). "The overage in pharmacy budget must be addressed. Tell me how you plan to do it within two weeks." Some decisions were laisez-faire. The nursing staff recognized thru nursing audit that they were lax in completing I+Os and it was up to them to solve the problem in the way they thought best.

The unit supervisor's behavior reflected the nursing department's value in evaluation. Besides being active in nursing audit and serving as the chairperson of nursing research, she participated in the original evaluation of the old documentation process by getting feedback from the people who were using it. This information was used to guide the development of the new package that the unit was to pilot. She awarded positive feedback to the nurses who had carefully reviewed the new forms and made significant suggestions for change. Also she encouraged them to speak up at the next medical documentation meeting to give their valuable perspective on the package. The unit was also going to participate in the evaluation of the new form that evaluates the housestaff.

The members of Baker 5 saw the Unit Supervisor as the

"purveyor" of policy and a resource person who cared about their success. They looked to her for answers that they could not find themselves. The questionnaire (Appendix D #8, #9) suggests that she was a source of support. She also provided creative ideas and affirmation of their new thoughts about programs or changes for the unit.

Messages from the director of medical nursing. The supervisor and staff initiated discussion with the Director about the following policy issues: unusual medical interventions new to the nursing unit (e.g. desensitizing a patient to an antibiotic); exception to usual staffing policy (e.g. sharing of day position by two nurses); a variation in a previous decision (keeping the old portable monitor on the unit as a backup). Each response by the Director seemed to take the framework of checking out with the intiator (unit supervisor) whether she had thought thru all the ramifications of the request. Once this was verfied, the initiator was allowed to go ahead with the request.

Norms

As the observations continued the researcher found that some behavior and interaction fell into patterns that were quite predictable. The most clearly defined are described below.

Defending the system. Many times auxillary departments did not fulfill their role in a timely manner and the nurses were left explaining to the patient why they were waiting;

the messenger for discharge, the television person for a TV contract, the dietition for discharge teaching, the pulmonary technician for an inhaltion therapy or why another nurse would not let a patient sleep in his coronary chair. Nursing was always expected to call again for the service or fix it. As the CNMs were told, "Dirty Laundry" (unhappiness with policy or troubles on the nursing unit) was to be discussed within the CNM group only; not with staff or the rest of the hospital.

Not confronting behavior that is troublesome. There was a seeming blindness or refusal to intiate potentially difficult or emotionally charged issues with patients or unit members. In the case of patients, examples of such issues were: fear of death, losing a home or loved one, a leg, sense of worth, or sexuality issues after a heart attack. Or in the case with peers examples included concern about staff who left med carts not stocked or meds not ordered, or staff who did not complete the I+O. There was some mumbling but no direct confrontation of the concern. Even the method of taping report did not allow face to face discussion with peers about difficult issues of each nurse's expectations of the other. The Quality Assurance results were used as the method of telling staff they are not meeting expectations in nursing practice rather than day to day guidence by unit members.

Continuity for patient care. This was a verbal

expectation but was rarely met. The coverage of districts was sporatic when the full time nurse was off. The CNM would fill in anywhere. Frequently some one was asked to float to another unit to provide coverage. This decision was made by names on a list; not by continuity needs for patient. It was more important to spread the unhappiness of floating justly among the nursing staff than to maintain patient continuity. Also, patients had a rather short stay on this unit. As soon as the patient was to have telemetry discontinued they were transferred back to their original teaching unit for the convenience of the physicians who did not want to have to come to the unit to care for the patient. Convenience of the housestaff is more important than continuity in nurse-patient relationships. So, neither nurses nor physicians had patient continuity as a goal. Rather, the norm was that decisions get made for the emotional peace and ease with the staff.

Communication and Language as a Means of Forming Reality

Pondy and Mitroff (1979) have stated that language controls our perceptions [p.33]; it filters out of conscious experience those events for which terms do not exist in language. Language defines meaning of our experience by categorizing streams of events. It provides a channel of social influence and influences the ease of

communication. One is only able to exchange ideas, information or meaning as language permits. It is with this understanding of language's power that the following observations become helpful in understanding "reality" for the nurse on Baker 5.

Language as a limiting factor. Medical pathology terms became the limiting factor in predicting nursing behavior. Because patients had a Myocardial Infarction or chest pain, the nurses automatically patterned their care from the pathology perspective (concern about heart rhythm, vital signs, enzyme values; information the physician wanted to judge physical status of the patient and to prescribe their medical orders). There could have been many other perspectives considered (i.e. the patient's response to the heart attack; coping patterns, methods to help him adapt, crisis intervention etc.) but the domination of medical language on this unit precluded or blocked other, more autonmous and whole person-centered ways to evaluate, plan and be with the patient.

One explanation for several opportunities for independent nursing intervention that were missed could be because the patient's need was not expressed in medical terms and consequently there was no predictable nursing interventions. (i.e. patient was not sleeping at night since her husband died [unresolved grieving]; patient facing a possible amputation because of embolus in leg [potential

loss], obese women who obviously needed counseling on her dietary habits and her fears about dying [nutritional abnormality]). All these required autonomous nursing interventions but they were missed because nurses did not have clear labels or language to address the patients' needs or nursing diagnosis. It might also be that the nurses were responding to the clues in their environment that suggested that professional nursing behavior requires attention to physiological symptoms rather than open support for attending to feelings.

The concept of nursing diagnosis as used in the brackets [] above came to be used about thirty years ago. It was the term given to the process and outcome that a nurse goes through to collect information about a patient in order to plan his care.

> "The idea of diagnosis broke the link between information collection and care planning. Clinical judgment was inserted as a recognized responsibity.
>
> Stopping to make a judgment or diagnosis, before determing the client's need for care revealed an important fact. Some of the information nurses were collecting signified health problems not described by the language of medicine, that is disease names. New terms had to be created. The new terms described the judgments upon which nursing care was being based" (Gordon 1982, p. 1).

It is this notion of language for describing nursing judgment that was so desparately needed by the Baker 5 staff to talk about the special independent contributions that the staff could and did make for patients.

Communication competence. Kasch (1983) viewed

communication as the primary resource for nurses [p.36]. She suggested that the essence of the therapeutic relationship between patient and nurse was empathy. A competent nurse would use language and discourse primarily in caring for patients. The Baker 5 nurses and supervisors demonstrated varying degrees of both social cognitive competence and strategic message competence to help each other and the patients to understand the issue at hand.

The teaching nurses frequently turned to similes or metaphors to help the patients understand or visualize internal phenomenon. One used the example of river and riverlets to describe coronary arteries and capillaries and the metaphor of a pump for the heart. She also used the image of scar tissue to describe the heart after an MI. Each of these images seemed to help the patients understand the phenomenon being discussed.

The supervisor gave an explanation to an administrator about the limits of the trust relationship with nursing peers. The example of "trust me" to the administrator from the nurse manager, while I (the nurse manager) spend $2000 on monitors, I'll tell you why when I have time! Immediately the administrator understood the limits of trust and professional responsibity nurse have to each other and their patients. The Vice President for Nursing used another strategic message with ICU nurses to help them understand today's fiscal environment; " an ICU where all the monitors

sounded the same, but every physiological system had changed". Quickly the nurses grasped the salient features of the fiscal environment.

On the other hand, the prior descriptions of nurses lacking the confidence or competence to communicate openly with pateints or staff in stressfull, emotionally charged situations, suggests that the area of communication competence may be an area for further development for the Baker 5 staff.

Modes of Communication Between Staff Members

The researcher took special note of the many routines and rituals that had been established on this unit for communication among the members. The content and form of these ritualistic behaviors served to clarify what each member thought the other members wanted from her.

Report between shifts. All the details from the Kardex were usually addressed for each patient including all the NORMAL values for vital signs and laboratory tests on blood and diagnostic tests etc. Each person listened intently writing each piece of information down on a report form that had places labelled for the various studies. Much time was spent on information about patients that is normal. Eventhough the nursing assessment and nursing care plan are placed next to the Kardex, they are never referred to when giving report or when the nurse listens to the tape recording about her patients or, as she is reviewing the

Kardex that contains the same information that is being verbally reported on the tape. It is as if the Kardex becomes the ultimate guide and ruler for what must be done for the patient. The Kardex equals nursing care.

The one exception to this reliance on the Kardex during report was a brief discussion about the patient's general demeanor. The nurses tried to prepare each other for what to expect when meeting the patient. If the patient had a particularly bad day or was depressed for some reason, or there might be a potential problem with a family member, the nurses tried to prepare each other before they walked in on an unexpected problem. This expectation was underscored by the questionnaire (Appendix D #2).

Documentation on the patient's progress notes. There was usually a report of the vital signs; the patient's cardiac rhythm, whether pain medication was given and sometimes the effect; a statement about patients' activity for the day and his state of orientation if other than normal. Once in a while, a note was included about the patient's appetite if nutritional status was of concern. If the patient had gone through some kind of physiological crisis, such as hypotention; cardiac arrest; or significant cardiac arrhythmia there would be careful documentation of events. Seldom found were notes about patients' response to the illness; coping patterns or adaptation methods that were successful.

There were notes Scotch taped to the front of the chart. This method was used to ask a question about a consult or to remind MD that one of his orders would run out i.e. respiratory therapy; analgesics. These notes were tossed out after they had served their function. This made it so the nurse did not have to seek out the MD when he came to the nursing unit. The expectation was that nursing was responsible for reminding the physician of his patient's medical orders.

Telephone calls to physician. Frequently nurses called the physician to report abnormal lab values and secure orders for intervention i.e. Potassium; clotting time; blood sugar levels. It was the expectation that the nurse get he results and call the physician. An alternative might be that the physician remember that certain patients require follow up based on certain hospital policies or because lab values require intervention. There were some calls from nurses to physician to report sudden changes in the physiological status (intractable chest pain; changes in the EKG; similar reasons provided the impetus for extensive notes in progress note). These calls were substantially different in content because they represented unexpected changes in the patients' condition.

These communication behaviors served to underline the dependent nursing function that is focused on carrying out the physician's orders. There was also the added dimension

of the nurses serving as the "nagging wife", reminding the physician of orders or laboratory values that he had ordered himself.

Staff meetings with unit supervisor, staff and CNMs. The unit supervisor set the agenda. She scheduled meeting times six months in advance and held the same type of meeting three times in a day. The expectation was that the all staff members would attend and come in from home if it was their day off. The items discussed included such things as plans for national nurse week; budget overage for pharmacy supplies (both items had action taken by supervisor and CNMs before the meeting); discussion of audit results; (referred to CNM's and audit committee for resolution). The norm was that the meeting was used for giving information; not for problem solving with staff. The problem solving took place in another meeting with the unit supervisor and the CNMs where no other staff are present.

Staff members were asked to report on various meetings thay had attended as representatives of the nursing unit i.e. Nursing Practice Committee, Medical Nursing Audit; New Documentation group; Medical Nursing Representative group. The expectation was that staff be active members in these groups and bring back the important data. It was at these meetings that the nurses had an opportunity to be accountable for their part in influencing the nursing services at Valley Medical Center. More such discussions

might increase the nurse's value for defining one's practice.

Written Material

Review folder and bulletin boards. The documents sent to the nursing unit concerning policy changes, directives; memos, etc, were placed in a review folder that the staff were EXPECTED to read and initial monthly. The new supervisor added the dimens'ion of the bulletin board and chalk board as a means to call attention to notices about immediate changes that staff must know, because they would be happening so soon. It was expected that staff would read the notices and be aware of changes. They were not to expect to be told everything or anything verbally.

Baker 5 policy book. This book contained the written standards of unit routines for telemetry patient care. It addressed tasks specific to maintaining the telemetry monitoring program i.e. replacement of electrodes, checking the code cart, reporting of blood work, how rhythms are to be charted every shift, and directions for placing rhythm stripes in a notebook and on a bulletin board. These standards were signed by the Unit Supervisor.

This book also contained the standards for staff nurse orientation. These standards required demonstrated competencies i.e. identyfying signs and symptoms of an M.I., identifying pacemaker capturing etc. All the policy-mandated competencies involved technical and assessment

skills required for observation of the physiological affects of the cardiovascular system. The message in both these policy statements was: be sure to do these tasks for all patients with telemetry. This standard was signed by the Unit Supervisor and the Vice President for Nursing.

This message was verified by the responses to the questionnaire (Appendix D #12). The responses stressed the importance of the nurse knowing the routines and assessment skills in order that the new nurse be flexible in handling any emergency. These skills were identified as necesary for a new nurse to slip into the way things were on Baker 5.

Nursing Process

Nursing as a profession has long recognized, but not put fully into practice, the nursing process as the appropriate method of problem identification and problem solving.

> "Although derived from the supposedly objective scientific method, nursing process is not applied in an objective, value-free way. Human values influence both problem identification and problem solving.
>
> The components of nursing process discussed in textbooks vary greatly but generally include assessment, diagnosis, outcome projection, planning, intervention, and outcome evaluation. Having the key components spelled out encourages deliberation, organization, and thought as opposed to haphazard care planning. This is important when human beings are the recipients of care.
>
> The six components named above only specify the activities to be done. How these activities are done requires a conceptual framework. A conceptual framework is a set of concepts that guide general decisions about what to assess and diagnose, how to intervene, and what to evaluate." (Gordon 1982, p. 21).

The Valley Medical Center nursing policies and forms

were unclear about how they expected the nurse to think or focus her attention and formulate her plan of care. The section that is to be used by nurses to label the concept they are addressing as the area that requires nursing intervention has three different titles; "patient problem" (nursing evaluation form) "Nursing problem statement" (nursing care plan that is a permanent record), "Nursing Diagnosis" (Staff nurse job description and Kardex). The issue is what level of integration and clustering of data is expected?

The Valley Medical Center nursing policy states:

> "Nursing Problem is the description of the patient's actual or potential health problems as derived from the nursing assessment. . . . The nursing assessment is used for two primary reasons: (1). To present an opportunity for the patient to meet and become familiar with the nurse who will be assisting the patient with activities of daily living (hygiene, rest, elimination, nutrition) and related therapeutic activities during hospitalization. (2) to allow the nurse to collect data in a systematic and organized fashion which will be used in planning nursing care to meet the individual's needs, e.g. normal sleep and elimination patterns, food prefrences/dislikes, visual or auditory impairments, difficulty with ambulation, etc., as well as specific signs and symptoms related to the condition for which the patient was admitted to the hospital".

Each of the suggested questions in the guidlines for the assessment form emphasizes identifying in the various physiological systems, limiting activities of daily living so that nurse can plan an intervention. The message seems to be saying that nursing needs to know the patients limits in physiology (not strengths) to create a plan to help patient manage "activities of daily living".

In contrast to that message, the staff nurse job description states that the nurse will

> "Make nursing diagnosis after assessing patients' needs. Implement nursing care plan utilizing information from admission interview regarding patient's clinical history and family background. Execute physician's orders within accepted Medical Center policies, referring questionable cases or problems to physician or appropriate nursing personnel. Provide information in answer to inquiries from patients visitors and family within the limits of professional ethics and Medical Center policies. As required, provide health teaching of patients and relatives according to physician's orders and/or recognized need for teaching. . . . [will] administer professional nursing care such as: giving baths and enemas; taking and charting temperatures, pulse, respiration and vital signs; administering medications and working with various types of medical equipment; setting up treatment trays and preparing instruments; assisting with specialized therapy using complicated equipment; recording observations, symptoms unusual reactions and conditions of patients; and performing other duties related to patient comfort care, and treatment. (Job Rating Specifications, 5/18/78).

The message here seems to be suggesting that nurses will examine the clinical and family situation (this information will provide direction for nursing tasks based on patient problems). She will teach; and will provide technical interventions and observations that will monitor or support the "clinical problem" (pathology) and patient comfort. Some how the patient's response to the medical crisis has been ignored along with an expectation that nurses will do more than observe, teach, and follow the physicians orders.

The Department of Medical Nursing Statement of Philosophy (1/24/85) states that: " We believe that through

a partnership with people, we assist our patients to attain their optimal level of wellness. . . We believe in the ANA Social Policy Statement which defines Nursing as 'The diagnosis and treatment of human responses to actual or potential health problems' ". The Medical Nursing Statement of Philosophy, a more current document, seems to be trying to enlarge the vision of nursing intervention to include human responses to health problems and has a notion of wellness. . .not defined for the reader; but reaches beyond the clinical pathology of the patient and may be looking at the strengths of the patient.

The point of this documentatiion analysis was to heed the advise of Barbara Stevens (1979) who suggests that the structures that are built to manage nursing care can either facilitate or inhibit the practice of nursing. If the messages are not consistent, the view of nursing is unclear and undirected. And in this case, through, nursing policies for nursing competence and nursing assessments, job description and philosophy statements, the written word did not support a consistent, person centered, autonomous view of professional nursing.

Bureaucracy as Culture: Limitations to Professional Nursing

Bureaucracy, the management system that depends on close supervision, detailed rules, and a many level hierarchy, was the organizational form of Valley Medical Center. Bureaucracy exerted an influence on the creation of nursing

for the staff on Baker 5. The following descriptions are but a few examples of how the bureauacratic form of organizing affect patient care.

Medication system as a major element of nursing time. Nurses spent time sorting medication tickets, checking medication tickets with the Kardex, checking medication orders with the MD order, ordering medications, crediting medications to patients' accounts, counting narcotics and possibly counting all stock medications and stocking her medication cart before she begins her rounds. The nurse also could be found "borrowing" medications from other patients' medication carts or other nursing units because she believed the medications ordered for her patient would not be up on time from the pharmacy.

Occasionally, the nurses even found time to wash the medication cart. All these systems are required before the nurse actually began to pour her meds for her patients. Then she must sort through crowded draws that contain up to three days supply of many different medications for a single patient. She must also find time to mix and hang the occasional IV that a patient might have. Once this process had been accomplished, she must find her patients' charts and document that the medications were given. This system on this medical unit required a great deal of nursing time, perhaps the greatest nursing time of any nursing function. The message is "Nursing and pharmacy have colluded to use

valuable nursing resources to accomplish the task of giving medications". Nursing could bring this time issue into awareness and could work collaboratively with the pharmacy to develop a process that would free nursing time to serve the patients.

Laboratory system devoured requistions and the unit's time. There was a complicated system of many specific requisition slips that had to be filled out according to the MDS' orders, sent to the laboratory and documented on the blood board that they were sent. The unit kept the carbon for reference. The night charge nurse had to review all patients' charts and Kardexes to be sure that all requistions were sent. The nurse called the lab tech if he did not show up to draw the blood on time. At this time the nurse must make out a new requisition because the original was lost. They must then call the lab for results if they are important, and then call MD if results require a medical intervention. Again the message is: "Nursing and laboratory have colluded to use valuble nursing time to maintain the laboratory system". The implication is that nursing needs to increase its influence on other systems so nursing time can be valuably used.

Messages from nursing management that support bureaucracy. The Medical Nursing Directors's rounds for Joint Commission for Accrediting Hospitals' (JCAH) readiness entailed looking at policy manuals and checking with staff

to be sure they knew where to find certain policies. It was important to the accrediting body that the rules were current and accessable to all the staff. The nursing director also expressed budget concerns (the pharmacy overage will be addressed and be rectified). She sent notices about discharge order of patients' charts. There were memos concerning the appointment of nurses and physicians in order to establish who was responsible for accomplishing which tasks. There were similar notices from the Vice President of Nursing. The message was "Nursing management expects the nursing staff to correctly use the many systems and policies within the hospital bureaucracy and feels a responsibility in informing the staff of changes in the system".

Time scheduling as powerlessness. Time scheduling was a means of depersonalization and loss of control for the nursing staff. The schedule came up from the nursing office hopefully two weeks in advance of the effective date. The nurses have every other weekend off but do not have a regularly scheduled day off during the week. Days off are subject to the unit's need for staffing. The nurses could make a special request for time off by filling out a special form many weeks in advance. One nurse said she was working for the day she had control over her work schedule so that she could feel control over her life. The dilemma of priority patient care needs versus the control over working

time by the nursing staff continues to challenge the most creative nurse managers.

Reimbursement rules and regulations. The constantly changing fiscal environment and the changeover to reimbursement by DRGs was causing concern for the practice of nursing. This method of payment is to presribe in advance what the hospital will recieve per diagnosis no matter what the cost incurred for the health care of the patient. The supervisor emphasized the impact of DRGs at all the employment interviews and at staff meetings. Her sense was that there must be changes in practice when the hospital starts being reimbursed under the Diagnostic Related Group system. Unit Supervisor felt "that the resouces are getting shorter and they are not going to be giving us anything, only taking away . . . "

In contrast, the Vice President for nursing saw DRGs as an opportunity for nursing; "Nursing care must be unbundled from room and board so that nursing will be seen as a "revenue producer". She also suggested that nurses will have to look at the most effective ways to carry out their tasks and still be effective to prevent complications. i.e. group teaching methods; protocols for maintaining skin integrity, and standard care plans. Her sense was that nurses will be accountable for preventing complications and that nursing will finally be seen as an important influence in the success of the hospital's future.

Summary of the traditional culture. The traditional culture of nursing was dominated by the language and values of medicine and bureaucracy. The medical perspective made subliminal inroads to the way the nurses viewed and cared for their patients. The assessment forms, the teaching curriculums, the language and ritual of shift report and patient progress notes all reinforced the medical pathology of the patient. The nurse used the majority of their time observing this pathology and following the physicians orders to cure the patient.

The bureaucratic form of organization served to exhaust the nursing resources in time consuming systems and routines. The emphasis on rules and task assignments by way of policies, memos and job descriptions, focused nursing care in such a way that there was little room to be creative and use autonomous nursing judgment. Fortunately, these influences were only part of the vision of nursing. While the staff was functioning under these forces there was a dialectical energy evolving a new vision that would encourage more autonomous nursing practice at Valley Medical Center.

Emerging New Culture

Leninger (1970) described a new view of nursing that was emerging across the nation. It characterized the nurses as

self-directed, articulate and knowledgeably able to communicate democratic values; and deal directly with issues of authority. This view of nursing was not accepting the views of the oppressor, but rather, nurses were looking to their own inner strengths to establish their own values and beliefs about their special contributions to patient care [p. 29]. There were several examples of this new vision observed during the ten week observation period. They are presented to document the changing values that were evolving during the research.

Patient advocate. At times nurses had to be aggressive to secure medical attention for patients. There was an insulin order that waited for four hours to be covered by a physician. The nurse had to call several times and was about to go to the interns superior when he finally wrote the required orders. Another instance involved a patient having changes on her EKG and an intern who was not responding to the nurse's repeated requests for action. The nurse took a copy of the EKG and went to the next unit to secure the physian's cooperation in transferring the patient to the Coronary Care Unit. There were three patients transferred to Baker 5 for four hours without orders for medical care. The nurses had to call the nursing supervisor to secure some action for the patients.

Each time the nurse intervened based on her clinical judgment, she ran the risk of being judged and the risk of

the physician's negative reaction to her assertive behavior. Nevertheless, the behavior demonstrated that the patient was more important than the risks involved to secure the medical attention required. Patient advocacy was important.

The questionnaire demonstrated the nurses' belief that it was nursing's expectation that they be vigorous in the role as patient advocate, particularly in the area of medications and inapproprite medication orders (Appendix D #6 + #7).

Support for continuing education and staff development. It was an expectation on the staff nurse evalution form that staff participate in professional development. There was planned time on assignments to attend inservices. At staff meetings there was discussion of reimbursement monies for workshops. Money and time were available to support staff development and it was expected.

Notices for numerous programs available within the institution hung on the bulletin board. These programs reflected values in improving nursing care. Nursing Grand Rounds provided an opportunity for nurses to examine with their nurse collegues the nursing care of a diverse set of patient issues. Nursing Ethics Rounds was a forum for discussing the special ethical delemmas nurse face on a day to day basis. There were special programs on the education station. During National Nurse week there was a special program on the image of nursing by Sigma Theta Tau's

entitled "Richness and Diversity of Nursing". The department of nursing supported with money time and resources professional development for nursing care improvement. Clearly, nursing management expected and supported the professional and educational growth of the nursing staff.

Autonomy. Even though the nurses were dominated by the need to carry out the physician's orders, they demonstrated flexibilty and intiative in some nursing measures. For example, the nurses freely adjusted medications to a schedule that was more manageable by either patient or staff. They also initiated many variations on ways to give medications that would be easier for patients: mixing them in pudding; potassium in fruit juice; pills in gelatin capsules; a couple pills every twenty minutes to help digestion. The nurses used their ingenuity and expertise to make the interventions more palatable for the patient.

They showed great flexibility about family visiting and staying overnight. Frequently they assessed that it would be comforting and sometimes safer if a family member stayed overnight with the patient. Usually visiting hours ended at 8 PM but this was not the case when the staff recognized the needs of the patient were different than the policy.

The questionnaire responses supported the view that nurses felt comfortable in scheduling patient activities according to the patients' needs (Appendix D #6 +#7). They

even suggested they should have more input into establishing the activity levels for their patients. The responses indicated that the nurses recognized some health care needs for their patients were not being met by the primary physician, and felt they should be able to seek out the appropriate consults for them.

The major barrier for autonomous nursing decisions was the concept of legal coverage and hospital policy (Appendix D #7A). The nurses seemed to be saying that if they had a physician's order or a hospital policy to cover what they wanted to do for the patient, they would feel comfortable in doing it. The nurses lacked the insight to see the role they played in developing their professional autonomous practice. Furthermore, the inference from the responses to the questionnaire was that the physician's inexperience or reluctance to change was a major barrier in their autonomous practice.

Peer review. There was a beginning recognition that CNMs are accountable for nursing practice as well as nursing policy. The discussion in the CNM meeting about the nursing process audit, suggested that the present system was only "a paper compliance" with the policy of nursing process documentation. The audit forms did not look at quality nor content of the nurse's thought process that led to the care plan and documentation. They were anxious to be part of a nursing audit that looked at the process in greater depth.

One CNM occasionally took time to actually examine and question the nursing practice of her staff. She was heard to ask, "What does the nurse plan to do about a patient's trach? Does the nurse want to stay with patient even though the districts should be changing, but the patient may benefit by keeping the same care givers? Could another nurse write a care plan about patient's depression? Could the nurse try to write a progress note that addressed that plan?" Initially when she took this approach, the staff told her they were not used to that kind of supervision (the questionning to urge individual thinking), but eventually accepted it. This CNM also acknowledged that she was responsible for handling clinical nursing deficiencies that she knew existed in some staff. Gradually the norm of evaluating nursing care is beginning to be discussed, at least on this CNM's shift.

Skin integrity protocol as a symbol of autonomous nursing intervention. The nursing staff on the long term care unit at Valley Medical Center had examined its nursing practice. The nursing audit results suggested that the nurses needed to develop a systematic program for maintaining skin integrity for their patients. These nurses initiated uniform assessment criteria that would categorize the skin's status. Once the skin integrity had been documented there was a series of nursing interventions that were to improve and maintain healthy skin and prevent

breakdown.

These protocols were endorsed by the nursing department and were to be used hospital wide. They became a topic at the staff meeting on Baker 5. Furthermore, there was to be a nursing audit thoroughout the hospital to evaluate how well the new protocols were working. This was an example of the nurses recognizing a concern within the domain of nursing. They took the initiative to develop the language and criteria for nursing intervention. Most importantly, they were able to influence the nursing practice hospital wide. The skin integrity protocol was clearly a sign of self-directed, autonomous nursing practice that was serving as a model for the entire hospital.

The special domain of nursing symbolized by the new documentation package. Perhaps the most powerful force developing within Valley Medical Center for self-directed autonomous nursing practice was the new nursing documentation protocols for all of nursing. These new protocols have the potential for changing the way nurses think by focusing their attention on the patients' functional health patterns rather than the patients' pathology. Many sections of the policies, forms and implementation plan signify a broadening of the previous established view of nursing.

The objectives for the new package include a desire for the division of nursing to:" 1. Foster clinical

investigation and research and 2. Define the dimensions of nursing and reestablish the unique role of the nurse as a health care provider." From the beginning the nurse understands that there is a unique and special role for her at Valley Madical Center.

The nurse is told in the purpose of the health data base that "The focus of the data base is for planning nursing care and should not duplicate data collected by other health care professionals. . . ." The Data Base guide is organized under functional health patterns (not physiologic systems). . .to be used as a screening tool to determine the focus of nursing care during hospitalization".

The choice of "functional health patterns" as the framework for nursing assessment is key. This framework was developed by Marjory Gordon (1982). She was searching for areas of agreement among the many abstract models of nursing theory that were prevalent in the 60's and 70's. She found eleven common ares of information about the patient that are needed to implement any model of nursing. They are:

1. Health perception-health management pattern; describes the client's pattern of health and well being and how it is managed.
2. Nutritional-metabolic pattern; describes pattern of food and fluid consumption reltive to metabolic need and pattern indicators of local nutrient supply.
3. Elimination pattern; describes patterns of excretory function (bowel, bladder, and skin).
4. Activity-rest pattern; describes pattern of exercise,

activity, leisure, and recreation.

5. Cognitive-perceptual pattern; describes sensory-perceptual and cognitive patterns.

6. Sleep-rest patterns; describes patterns of sleep, rest and relaxation.

7. Self-perception-self-concept pattern; describes self concept and perceptions of self (e.g. body comfort, body image, feeling state).

8. Role-relationship pattern; describes self concept of role engagements and relationships.

9. Sexuality-reproductive pattern; describes client's patterns of satisfaction and dissatisfaction with sexuality pattern; describes reproductive patterns.

10. Coping-stress-tolerance pattern; Describes general coping pattern and effectiveness of the pattern in terms of stress tolerance.

11. Value-belief pattern; describes patterns of values, beliefs (including spiritual), or goals that guide choices or decisions (Gordon, 1982, p.81).

The emphasis was on what information to gather. "The result would be that (1) the domain of responsibility and accountability would be clear, (2) the focus of clinical studies would be identified, and (3) the focus for development of expertise in assessment and diagnosis would be clearly delineated for teachers, students, and practitioners" (p.81).

The introduction of functional health patterns on the new assessment form was the beginning of a new language and perspective for the nurses at Valley Medical Center. They were beginning to breakaway from the medical domination. In fact, the feedback from one physician was "there is nothing

on the data base that will help me".

The new message was nursing care will focus on patients' response and upon an empathetic relationship where the nurse is able to understand the perspective of the patient and his family. "Data recorded under functional patterns I-XI should be subjective data provided by the patient/ family/ significant other responses. This is to be used as a screening tool to determine the focus of nursing care during hospitalization."

An expectation for the nurses to make a judgment about each functional health pattern and plan her care accordingly was established. "The RN must interpret the data collected in each section and make one of three judgments: 1. There is no problem; 2. There is a problem which indicates; a. Health promotion activity required, b. Actual /Potential Nursing diagnosis, c. Actual/Potential Clinical Problem. 3. There is a need for further information before judgment can be made. The nurse was expected to cluster all the clues she had gathered in her data collection and make judgments about her focus of care.

The development and implementation of the new package suggested that the broadest possible input from staff, nursing literature and sister hospitals was used to come up with the new forms and policies. The staff input led the planning committee to recommend the most efficient forms that would ease the repetition that was present. There was

even discussion about developing new standards for patient report that would include functional health patterns. The resource people on every nursing unit were being developed as the package was being piloted and the rough spots worked out. A new norm of turning to nursing peers for guidence, direction and support was in the making.

Summary of the new culture. As the nurses on Baker 5 were busy caring for their patients, under the domination of the language and cultures of medicine and an administrative bureaucracy, a dialectical energy was pushing the nursing department away from its oppressive domination. The forces of this energy were evident in the demonstrations that nurses must be their patient's advocate. The emphasis on professional development in areas of nursing ethics and clinical nursing grand rounds was a beginning for nurses to identify domains that were unique for nursing. Finally, the documentation package provided the method and process for nurses to begin to use a new exclusive framework for assessing their patients and planning their care. The new culture was beginning to recognize and use the power within nursing to establish new values and directions.

C H A P T E R V

SUMMARY AND IMPLICATIONS FOR NURSING

Summary

The purpose of this study was to explore the meaning of nursing today on a nursing unit at New England's Valley Medical Center Hospital. Specifically there were two purposes of this study: (1) to discover the process by which the definition of nursing becomes known to the staff members on Baker 5 and, (2) to describe the unit's definition of nursing and to document how it is practiced. The motivation for this research was a search for a way for the nurse manager to understand how nursing comes to be known on a nursing unit. Once this is known, the manager would be in a stronger position to support a collaborative process for the development of a "new" vision of professional nursing.

Findings

The definition of nursing for Baker 5 was a complex mixture of the "old and new" cultures discussed in nursing literature today. The unit was characterized as dominated by the world of medicine and bureaucracy with a beginning recognition by the nurses that things could be different for themselves and their patients. The highlights of this view of nursing are listed below.

Bureaucracy. The time demands of the auxillary hospital systems also served to determine the definition of nursing

by determining much of the nurses activities. The unit routine, or daily flow of events was determined by the bureaucracy of the hospital. The bureaucratic form of organization requires a division of labor and dependence on rules, regulations, and close methods of control for survival. Most notable was the routine for patient assignment to the unit and to staff members, the routines for giving medications, the routine for nursing documentation, and the routines for securing specimins and the follow-up laboratory results. It is important to note that nursing did participate in the creation of these policies, but the values of control and meeting the needs of the hospital systems seemed to be more powerful than the nursings' need to be autonomous, whole person centered professionals.

Models for care. The current nursing assessment forms focus the nurses' attention toward the patients' pathology rather than on functional health patterns that could be used to help the patient adapt to his illness. Nursing management was addressing this phenomenon with a hospital wide effort to develop a new documentation package.

The Kardex became the "ruler" for the daily activities for each nurse. The physician's orders and the laboratory tests and results consumed most of the nursing resources on Baker 5. The power of the Kardex was most notable during shift report. The ritual required that the Kardex for each

patient be discussed in great detail. Because the content of the Kardex centers on physician's orders, it forced the report on each patient to focus on physician's orders and laboratory work rather than on nursing diagnosis and concerns of the professional nurse.

Language. The medical language used in day to day discourse between nurses and nurses and physicians appeared to have a subliminal influence in shaping the actors' perspective on what they were to be doing for patients. The medical culture's emphasis on diagnosis, physiological status, and cure, overshadowed the special contributions nursing could have been delivering to patients. The nurses seemed to lack the words and language to describe their unique relationship and interventions with patients. Communication competence was an area for development.

Oppression and collusion. Many of the values of bureauacracy and medicine appeared to be the values adopted by the nursing staff. The emphasis for the nursing staff was on curing the patients' pathology and doing their part to make the myriad of systems in the complex hospital environment run. The nurses had several opportunities to begin to assert their potential contributions, but lacked a vision for their potential and failed to act. Examples of these potential contributions were concerns about home care, patient teaching, different measures of quality nursing care, and different standards for orientation and shift to

shift report.

New culture. Even as the nurses were working in the culture of medicine, a dialectical energy was beginning to push for a new way for nurses to see and think about their patients. The nurses were evolving a new meaning for advocacy, reafirmming the value in professional development, and developing a new language and communication package that would encourage the nurses to look at and care for the whole patient.

Model for discovery. This study has served as a beginning model for looking at the phenomenon of nursing from an interpretive approach. The sociological and organizational behavior literature provided the guide posts for a different perspective on how reality becomes known to the actor. This study put those assumptions into action and tried to see from the actors' perspective the social process that created nursing on a nursing unit.

Limitations

The strength of this study might also be considered its limitation. An ethnography comes from the subjective understanding of the actors involved. This must also include the "subjective" view of the researcher. The researcher's previous experience in nursing management and her exposure to the sociological and nursing literature must have had an influence on the researcher's "reality". The framework chosen to organize the observations and evidence came from

the reseacher's interpretation of the action on Baker 5. Even though the case for the definition of nursing was based on observable evidence, the researcher must acknowledge that her biases and assumptions must have played a part in selecting the evidence gathered and this definition.

With this limitation acknowledged, the reader is reminded that the interpretive approach was chosen on the assumption that in many ways "nursing" is subjective in nature. The researcher was placed in the position of finding out what was going on there on Baker 5. It was recognized in the literature review that enactment is rather random and arbitrary. Because sensemaking is an invention from the "facts", it is characterized by reasonableness rather than accuracy. This report is one way of interpreting the facts. The reader is left with the challenge of deciding the reasonableness.

Implications for Nursing

The oppression described in this study (e.g. owning the values of the oppressor) is similar to that documented by Ashley (1976) in the nursing profession. Yet, if one looks at the oppression theories articulated by Jackson (1976) and Friere (1978), there is hope. They speak of a stage when the oppressed begin to look to themselves for inner strength, to develop pride, self-control, and a unique identity. Nursing has begun to recognize the myths and ideologies that have served to dominate the world of nursing. For example, the

nurses on this unit were dominated by the medical communication systems that were used to define and shape the care they gave. The written and verbal discourse between nurses and between nurse and physician was characterized by medical terminology. This language defined their practice. The nurses were stumbling for the terms to describe what they were going to do for the patient that was unique. They needed a new way to see the patient and his health care. They were beginning to develop their own language, and to articulate their own values.

Nursing has begun to search for and articulate its own values and domain for assisting patients with their health care. The work of Marjory Gordon (1982), who has deliniated eleven functional health patterns and Patricia Benner (1984), who has described seven domains of nursing, are possible models. These, combined with the beginning work in theory development by numerous nurse theorists give hope for a language and a descrete set of concepts (e.g.functional health patterns) that define the world of nursing. The nurses at Valley Medical Center were beginning to use this approach to define their world. The hospital wide energy and resources that went into the new documentation package demonstrate the broad base of support for this change. They had moved beyond accepting medical domination and were actively seeking a new way to talk about what they do for patients. As this "new" way of talking becomes known, a

vision for nursing practice becomes clear and meaningful for each nurse.

This research shows the powerful influence of models in determining what is to be done for the patient. The Kardex actually became the definition of care. It became the framework for organizing care and for seeing the patient. The tasks on the Kardex became the areas that nursing decided to evaluate to address quality of nursing care. This suggests that as the profession develops new models (assessment forms; evaluation forms; care plans; nursing standards), care must be taken to allow for the uniqueness of the patient and the context of the care situation to be addressed. Standards of care can provide a model for safe care but not necessarily the best care. The bureaucratic values of conformity, may easily constrict the options open for an expert nurse (Benner, 1984).

Just as nursing is practiced in the context of the patients' environment and personal situation, so must the evaluation of nursing care. Linear standards such as " patient will inject himself with insulin correctly," do not acknowledge the complexity of the context nor the various levels of expertise that nurses bring to the situation. An interpretive approach that includes the context for patient care recognizes that nursing is hollistic and not merely the sum of each standard or task. For example they might create a nursing audit that reviews the entire teaching done for

the patient and his family while the patient was on Baker 5. This would necessarily include an indepth exploration of the many facets that went into the patient's learning and the nurse's teaching but it would offer a more comprehensive view of what was accomplished. These evaluations could then be synthesized to add to future teaching programs.

Implications for Nursing Management

The nurse manager is immediately struck by the power of hospital systems to determine how valuable nursing time will be spent, in fact, defining nursing practice. The medication and laboratory systems on this unit drained the nursing resources because of their demands on nursing time. This finding encourages the nursing manager to examine how time is spent and to ask the question, "is this the best use of our valuable nursing resources? Does this activity support our vision for nursing?" If not what is the nurse manager to do?

The nurse manager must develop in her staff and herself the ability to manage creatively. It will be a delicate balance between the dialectic of organization's expectations of conformity and the creative abilities of nursing. The function of this creativity is to discover new ways of seeing, new behaviors and, possibilities. Daniel Pesut (1985) comments,

> "that creativity is the necessary sequal to being. Whereas moral courage is the righting of wrongs, creative courage is the discovery of new forms, symbols, and patterns on which society can be built.

> . every profession can and does require some creative courage. The need for creative courage is in direct proportion to the degree of change the profession is undergoing" (p.6).

Implications for Establishing Professional Nursing Practice

One way practicing nurses will know if their day to day activities embody their vision of nursing is to make a comparison between their activities and their vision. Inherent in this comparison will be a clear description of what nursing is for them. This discourse must come first so that they know what they are seeking to become. Again, the primary importance of a clear vision becomes evident. This vision will provide the basis for all future decisions for that nursing service.

It would be possible for them to move even closer to this new vision, if they were to complete their conceptual framework by identifying a model or theory of nursing that is most consistent with their view of nursing. The model would provide the focus for all nursing interventions. The considerable discussions that would be necessary for this collaboration would provide a valuable avenue for clarifying assumptions about patients, health, nurse-patient interactions, and the concept of nursing goal. Inherent in this articulation of nursing theory and clarification of assumptions would be the expectation that the nurse managers would have the skills to collaborate, solicit and operationalize this new vision. The process as well as the

outcome would provide the firm foundation for the unique contribution of nursing.

Barbara Stevens (1979) wrote of the importance of consistency in all structures that are used by nursing. For example, the routine and language for shift report must support the expectations for nursing care planning and nurse to nurse discourse about the new vision of nursing (e.g. functional health patterns or another chosen language or framework selected by nursing).

Communication competence is a necessity for both nurses and nurse managers. Managers must have the skill to organize communication systems that support the language of the domain of nursing. They must also be sure that the routines on the nursing units use the same consistent language for all discourse so that it becomes a way of "seeing" and "being". The use of the nursing diagnosis language and the eleven functional health patterns would make a significant contribution. At the same time, nurse managers must recognize how standards and language can be binding and limited. There must be mechanisms for the creativity that will support growth and change as nursing practice must change.

As the new vision is being developed throughout the nursing department, methods for measuring and evaluating performance against the new vision become important. The nurse manager might use a questionnaire similar to the one

used in this research to discover the expectations of nurses in their day to day practice. An analysis of unit and department policies and nursing care documentation would measure progress toward the new vision. She might also analyze a sample of the nurse to nurse discource during shift report. These measures would highlight the nursing department's areas of strength and areas yet to be developed.

Communication competence will be demanded of the nurse manger when she addresses the oppressive influences of the bureaucracy and medicine. Here the nurse manager is advised to develop what Kasch (1983) has referred to as social and strategic message competence. She must be able to escape the confines of personal perspective and to assume or construct the viewpoint of the other person. Once she understands the oppressors' world she must use her communication skills to form messages from the oppressor's perspective that will cause the opppressor to see how much he is losing by the oppressive situation.

Another important concern for managing the impact of oppression is the image of nurses as "victims". As Leah Curtin (1985) points out, the image of victim undermines credibility in an incidious and seductive fashion. " Unless one is collecting money for war refugees, the last thing one wants is to elicit the consumer's pity. Rescuers seldom see objects of compassion as influential. Put simply, the

victim role does not inspire confidence in competence" (p.8). The nurse manager must find ways to build and maintain a positive identity. She must channel the staff's creative energy toward their vision.

One way to use the creative energy of the nursing staff would be for the nurse manager to support the development of a peer review system and reward systems that would encourage nurses to improve their clinical skills. There is a significant difference in the kind and quality of care provided between a novice practitioner and a nurse expert (Benner, 1984). Expertise comes with years of experience and growth as was seen in this study and as Brenner's work illustrates. There must be ways for nursing excellence to be recognized and encouraged to flourish. Rewards in the system must acknowledge excellence and ensure mechanism for this excellence to be used and developed in others. The norm must be for beginning nurses to actively seek the advice of experts and the experts must expect to actively search out interactions with the beginners in ways that will improve and guide their clinical expertise.

The consequences of a new langauge for the practice of nursing will place considerable challenge on the nurse manager who will be responsible for helping the "old" staff become proficient in the new form of discourse. It may be that the experience gained by professionals currently working in bilingual programs would be useful. This task

will be particularly formidable because the language is still being developed and the skills for nursing diagnosis require a new way to see the patient and to formulate nursing interventions.

Implications for Nursing Education

As nursing educators are preparing the nurses of the future, the importance of a clearly articulated vision of nursing becomes imperative if the novice nurses are not to be swollowed up in the medical culture and language. This vision must become a part of them, it must transform them. It must be so strong that it can resist the power of bureauacracy to dominate their day to day life. This vision must address the domain of professional nursing in the langauge of nursing. It must help the student clarify in her own mind what the concept called "health" really means. She must be able to articultate what it is that nurses do with patients to reach that goal.

A strategy for helping the students to prepare for these dominating forces would be course work in womens issues and oppression. Once the student was exposed to this theoretical perspective, it may help her to critically view her practicing environment. The faculty may even strengthen their methods of developing critical thinking and ideology identification. This skill would be useful for identifying patterns in patients' behavior as well as the behavior of the system with in which they practice. The key to

liberation from oppression is the identification of the assumptions that underly the behavior of the oppressor and the oppressed. But the behavior must be recognized first.

If nursing is to continue with this change in identity, the future generations of nurses must be able to draw upon all their creative energies to meet the barriers that are placed in their path. These energies could be nurtured in the written assignments that students are asked to do. At times, the faculty may request students to use their most ingenious or unusual problem solving stradegies to overcome their patients' problem or a practice problem they encounter. They would be encouraged to get in touch with their creative side, where rules can be broken, risks taken, speculation reigns, where being wrong is all right, where whimsey and intuition are important. Practice in developing these strengths and recognition that they are valuable, will form a great potential for reframing the future of nursing.

Finally, graduate level nursing education must encourage nurses to look beyond their field for clues for shaping and managing nursing's future. The fields of linguistics and communication studies may offer considerable help in developing the new langauge for nursing. Organizational studies offer new ways of looking at groups and organizing. Education schools may provide direction for adult education that will be needed for both patients and nurses. As graduate students form linkages with these new fields, they

will bring valuble insight to nursing.

Further Research

The researcher recognizes the values of ethnography as a method for studying a culture and discovery of the common sense rules that socially create reality. Yet, one wonders if a few salient features of this study would serve to condense the time and resources necessary to detect the key features of a nursing definition. For example, one might do analysis of the shift reports or the answers to the questionnaire to discover those areas that nurses expect one another to address. The language and subject matter may provide sufficient clues for a fairly clear view of the units defintion of nursing and their values. Another strategy might be an analysis of nursing time use. The activities that dominate nursing activity may predict what the nurses see as their vision. These methods would greatly reduce the resources required for a nursing staff to undergo the tasks of self-reflection. If the technique could be condensed it may provide a valuable tool for nursing to keep itself on track towards its new vision.

Furthermore, it would be interesting to note if a change in the salient features, actually precipatated a change in the unit's definition of nursing. Does a change in the unit routine or a new language influence how nurses see their patients? Do new standards of shift report help the nurses change their view of nursing? All of these questions

indicate the value of ethhnography for providing the content and context for further research of this phenomenon called nursing.

Conclusion

This study has introduced a new method for understanding the phenomenon called "nursing". The dynamic social energies found on the nursing unit have an incidious way of framing the definition of nursing for the actors. Only by discovering these hidden influences will the nurses and nurse managers come to understand what they are doing and why.

Once the assumptions are discovered, nursing is in concrete position to evaluate if this is what they see as the role for themselves. The assumptions can be changed. These potential changes could be the beginning of the truly professional nursing practice that nursing has been searching for.

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APPENDIX

APPENDIX A

A DESCRIPTIVE STUDY CONCERNING THE SOCIAL CONSTRUCTION OF THE DEFINITION OF PROFESSIONAL NURSING

Information for Nursing Unit

I am a nurse and graduate student at the University of Massachusetts. I am here to explain to you a research project that I would like to carry out on this nursing unit.

My work with nurses in the past has demonstrated to me that there are many ways that people look at and define professional nursing. I have a hunch that if we had a more universal definition of professional nursing that could actually be put into action when we work with patients, we would be able to use the potential we have within us, and the patients would receive better care as a result.

This research project is designed to help discover how a nursing unit has come to have a its unique view of nursing. In order to find this out, I will study the way we use language and rituals to create a "unit definition" of nursing. I might be doing several things to find this out. For example; listening to reports, looking at care plans, asessment forms, nursing notes, policy and memos from nursing management, and chatting with each of you to hear your thoughts on nursing.

As the project proceeds, I will come to a point when it

will be necessary to check out some parts of the definition I have put together. To do this I may need your individual participation with a special questionnaire that I will design. At this time participation will be voluntary and there will be an informed consent for each of you who decides to participate in this verification work.

The information that I gain from this project will be anonymous and will be written up in a way that no individual may be identified. The exception to this rule would be a case where patient safety was at stake. Nursing management will then become informed of the patient safety issue.

In order to maintain the richness of your culture and to maintain anonymity, the descriptive narrative will use pseudonyms and other techniques to disguise unit members. The final dissertation will be a public record at the University, and there may be a journal article describing the project.

There will be no personal risks or benefits to you. The information gained may be of benefit to the nursing profession by contributing to the enactment of a definition that realizes the potential of nurses today.

Are there any questions?

As we go along, please feel free to ask any questions that may occur to you.

Thank you,
Eve Keenan

APPENDIX B

A DESCRIPTIVE STUDY CONCERNING THE SOCIAL CONSTRUCTION OF THE DEFINITION OF PROFESSIONAL NURSING

Dissertation research conducted by:

Eve Keenan
244 Overbrook Road
Longmeadow, Massachusetts, 01106
(413) 567-5600

CONSENT FORM

This research instrument is part of on an ongoing study. The research is attempting to document the social construction of the definition of professional nursing. In order to verify beginning themes that are emerging from the results of the study to date this instrument was devised. It would be helpful to have you participate.

If you choose to participate, you will be asked to complete the attached questionaire. It is important that you give the first answer that comes into your head. There are no right or wrong answers to these questions. It should not take more than 30 minutes to complete the answers.

Any questions that you have concerning the form will be answered at any time. You can choose whether or not to participate and are free to stop participating at any time. Whatever you decide, there are no adverse effects for your employment at the hospital.

There will be no risk to you if you decide to participate. There will be no direct benefit. Your participation may contribute to understanding the social construction of nursing.

If you participate, all the information that you provide will be kept anonymous. All information that is obtained will be recorded on forms that contain only a code number. The information will be reported in an aggregate form.

Please sign this informed consent below.

Signature_____

Print name _____

Date_____Researcher_____

APPENDIX C

THE MEANING OF PROFESSIONAL NURSING

Please complete the sentences with the first thoughts that come to your mind. There are no right or wrong answers.

1. In order to gain the approval of the next nurse taking care of my patient after me I must be sure to have done at least the following kinds of things for my patient in addition to the treatments and medications the physician ordered:

_____

_____

_____

2. The next nurse to care for my patient will probably want to know at least the following things about my patient, in addition to the physical status:

_____

_____

_____

3. When the physician comes to talk to me about my patients, she/he usually asks me the following kinds of things:

_____

_____

_____

4. When I seek out a physician to talk about my patient, I usually talk about the following kinds of things:

_____

_____

_____

5. I know that in order to receive an "excellent" evaluation from my clinical nurse manager I must consistently do the following things:

_____

_____

_____

6. I feel that nursing supports me in making the following kinds of decisions about my patient's nursing care:

_____

_____

_____

7. I think as a professional nurse with some autonomous role expectations, I should be making the following kinds of decisions about my patients nursing care, but I do not feel assured of support in making them at the present time:

_____

_____

_____

7 A. The major barrier for making these decisions is:

_____

_____

8. When I talk to my supervisor, I usually look to her for the followings kinds of information:

_____

_____

_____

9. When my unit supervisor seeks me out for conversation, she usually has the following kinds of topics she wants to cover:

_____

_____

10. I know that the top nursing administration is most concerned about the following areas of my nursing care:

_____

_____

_____

11. The following are the kinds of things that I always do for my patients because I think these are the activities that are special to nursing, and no one else is accountable to do them:

_____

_____

_____

12. When a new nurse comes to this floor she will most quickley slip into the way things are around here in nursing if she learns the following things:

_____

_____

_____

13A. The telemetry on our unit makes us different and we must consider the following for our patients:

_____

_____

_____

14. What are the unique characteristics of this nursing unit that affect the delivery of nursing care?

_____

_____

_____

APPENDIX D

THE MEANING OF PROFESSIONAL NURSING

Summary of Responses to Questionnaire

Please complete the sentences with the first thoughts that come to your mind. There are no right or wrong answers. [* Indicates the number of similar responses.]

1. In order to gain the approval of the next nurse taking care of my patient after me I must be sure to have done at least the following kinds of things for my patient in addition to the treatments and medications the physician ordered:

BATH GIVEN****, BED CLEAN***, LAB RESULTS RECEIVED AND REPORTED***, ROOM NEAT AND CLEAN**, CHART IS CHECKED, SUPPLIES ARE READY FOR NEXT SHIFT*****, ASSESSMENT DONE*

2. The next nurse to care for my patient will probably want to know at least the following things about my patient, in addition to the physical status:

EMOTIONAL RESPONSES OF PATIENT******, LIKES AND DISLIKES OF PATIENT, APPROACH TO PATIENT CARE THAT WILL WORK EFFECTIVELY WITH THIS PATIENT, POTENTIAL PROBLEMS WITH THE FAMILY****, MENTATION OF PATIENT, TEACHING DONE, CONSULTS NEEDED, WHEN RECIEVED LAST PAIN MED. BLOOD WORK DONE, TELEMETRY RHYTHM, SPECIAL TESTS*****; DISCHARGE PLANNING, STATUS OF DX

3. When the physician comes to talk to me about my patients, she/he usually asks me the following kinds of things:

MEDICATIONS****, PHYSICAL STATUS***, CHEST PAIN. MONITOR READINGS; VITAL SIGNS, I+O, CHEST PAIN, FEW DOCTORS ASK ABOUT EMOTIONAL STATUS, PHYSICAL DATA, BLOOD WORK, WEIGHTS,, ACTIVITY, MOST QUESTIONS FROM OLDER MDS, VERY FEW FROM YOUNG ONES, SOME HOUSESTAFF, LUNG STATUS, MENTAL COMPLIANCE WITH HEALTH STATUS, VERY FEW PHYSICIANS COME TO TALK TO ME ABOUT MY PATIENTS, IF DO ASK VITAL SIGNS AND WRITE THEM IN THEIR PROGRESS NOTE, REQUEST ADMINISTRATION OF A MEDICATION

4. When I seek out a physician to talk about my patient, I usually talk about the following kinds of things:

PHYSICAL STATUS****, MEDICATIONS*****, MENTAL STATUS AS IT EFFECTS HEALTH STATUS/ SAFETY, ARRHYTHMIAS, WHY THE PATIENT IS HAVING CHEST PAIN, MAKE SUGGESTIONS ABOUT MEDICAL ISSUES, EMOTIONAL PROBLEMS OF PATIENT INCLUDING ANXIETY OR

CONFUSION, PATIENT NEEDS, DRUG PROBLEMS PATIENT REQUESTS, ORDERING LAB WORK OR REPORTING IT****, REQUESTING CONSULTS**, CHANGE IN STATUS, CHEST PAIN UNRELIEVED BY NITROGLYCERIN, CHANGES, GO BETWEEN FOR FAMILY, HOME CARE PLANS, WHAT IS PLAN OF CARE FOR THIS PATIENT

5. I know that in order to receive an "excellent" evaluation from my clinical nurse manager I must consistently do the following things:

USE RESOURCES, TO ANSWER QUESTIONS, TO BE AUTONOMOUS, ASSESSMENTS*******, CARE PLANS (ON PAPER) , FOLLOW THROUGH WITH PROGRESS NOTES, WORK TO THE BEST OF MY ABILITY, BE INITIATIVE, VOLUNTEER, BE A MEMBER OF A COMMITTEE, PERFORM ACCORDING TO VMC POLICY, DEMONSTRATE I AM KNOWLEGEABLE ABOUT MY PATIENT'S CONDITION, RENDER CARE IN A PROFESSIONAL MANNER, BE COMPASSIONATE AND CARING, TO BE HELPFUL AND SUPPORTIVE OF STAFF, COMMUNICATE WHAT I HAVE ACCOMPLISHED AND WHAT NEEDS TO BE DONE,**** PROVIDE QUALITY CARE, MONITOR MY ASSERTIVENESS

6. I feel that nursing supports me in making the following kinds of decisions about my patient's nursing care:

WHEN TO GIVE MY NURSING CARE AND WHEN IT IS MORE IMPORTANT TO LET MY PATIENT REST; STOPING FREQUENT VITAL SIGNS WHEN STABLE, QUESTION ORDERS ABOUT MEDS, DETERMINING HOME CARE, CALLING SOCIAL WORKER, FOLLOWING WRITTEN ORDERS; FOLLOWING ACCEPTED PROCEDURES ACCORDING TO VMC POLICY; (DON'T KNOW IF NURSING WOULD SUPPORT ME UNLESS I COULD SHOW WHY I MADE THAT DECISION. REFUSAL TO CARRY OUT INAPPROPRIATE ORDERS--WRONG DOSAGE**, ROUTINE OF CARE INSTITUTED IN A CARE PLAN TO GIVE SAFE AND RENDER POSITIVE RESULTS IN PATIENTS HEALTH STATUS. BY THE POLICIES WE FOLLOW REGARDING CARE, IDENTIFYING PATIENTS NEEDS AND SEEKING TO PROVIDE FOR THEM, SUPPORTIVE OF INNOVATIVE IDEAS IN SOLVING NURSING PROBLEMS, NURSING CARE DECISIONS; TREATMENT FOR IMMOBILITY, FOR EMOTIONAL RESPONSE, BOWEL REGIME. THREE ANSWERS WERE BLANK

7. I think as a professional nurse with some autonomous role expectations, I should be making the following kinds of decisions about my patients nursing care, but I do not feel assured of support in making them at the present time:

CHANGE IN FREQUENCY OF VITAL SIGNS OR ACTIVITY LEVEL****, WHEN I+O IS NOT APPROPRIATE, HOME CARE FOLLOW UP; HARD TO ANSWER--PATIENT MAY BENEFIT FROM A CONSULT FROM ANOTHER PHYSICIAN--IF PATIENT ATTENDING CARDIAC CLASSES HE SHOULD BE ALLOWED TO STAY AND NOT BE TRANSFERRED TO ANOTHER FLOOR. DEMANDING TRANSFER OF PATIENT WITH EPISODES OF FREQUENT CHEST PAIN TO CCU--REFUSAL OF MD TO MAKE NECESARY CHANGES IN MEDICATION, GOING MONITORED OR UNMONITORED TO

TESTS. SKIN CARE, NURSING HERE IS SUPPORTIVE--ITS A LACK OF TIME TO FORM AND PUT INTO EFFECT NURSING JUGEMENTS/TREATMENTS*, NONE, REFERRAL TO CLINICAL SPECIALIST AND SOCIAL WORKER

7 A. The major barrier for making these decisions is:

LEGALLY NOT COVERED WITHOUT MD ORDER IN CHART, RED TAPE; VERY LITTLE STAFF INPUT INTO STAFFING PATTERNS; HESITENCY OF INTERNS TO TRANSFER PATIENT? LACK OF EXPERIENCE--MDS UNABLE TO ACCEPT ADVISE FROM A NURSE; MDS DO NOT WANT CHANGE TO NEW IDEAS, TAKES TIME. NEED MD ORDERS, CARDIAC REHAB ACTS INDEPENDENTLY, RARELY CONSULTING THE NURSE, LEGAL COVERAGE; TIME STAFFING

8. When I talk to my supervisor, I usually look to her for the followings kinds of information:

USED AS RESOURCE PERSON/ AND/ OR FOR A SECOND OPINION WHEN I ENCOUNTER AN USUAL OR DIFFICULT SITUATION. ALSO, FOR SUPPORT IN DIFFICULT SITUATIONS. EDUCATIONAL TRAINING. NEW POLICIES, UNIT POLICIES**, SUPPORT/ AND OR CORRECTION. QUESTIONS REGARDING HOSPITAL POLICY, PROBLEMS NOT ABLE TO BE SOLVED BE SELF OR MY PEERS;, VERIFICATION OF SPECIFIC NURSING PROCEDURES**, ADVICE FOR CARING FOR DIFFICULT PATIENT OR FAMILY; TO PLAN AND PREPARE FOR NEW IDEAS*, CHANGES**, POLICIES**, GOALS AND WHAT'S HAPPENING*. STAFF DIFFICULTIES; EXPRESSING FEELINGS ABOUT MEDICAL CARE, LEAVE VACATION SICK TIME

9. When my unit supervisor seeks me out for conversation, she usually has the following kinds of topics she wants to cover:

INFORMATIONAL TOPICS--TO INFORM ME OF UPCOMING MEETINGS, TO SECURE FROM ME THE STATUS OF THE UNIT WHEN I'M IN THE CHARGE NURSE ROLE. INFORM ME OF NEW DEVELOPMENT IN FLOOR POLICY****; TO SAY HI,. WHAT KIND OF A DAY AM I HAVING*, WHERE SHE CAN BE REACHED BECAUSE SHE IS GOING TO BE OFF THE UNIT. PERSONAL PROBLEMS REGARDING WORK RELATED SUBJECTS; STAFFING PROBLEMS, FAMILY COMPLAINTS. MY EXPERIENCE WITH A CERTAIN SITUATION OR PATIENT. BUDGET, GENERAL INFORMATION

10. I know that the top nursing administration is most concerned about the following areas of my nursing care:

USING THE NURSING PROCESS**; PERFORMING ASSESSMENT OF A PATIENT/ INITIATING A NURSING CARE PLAN TO AID OTHER NURSES IN CARING FOR A PATIENT IN CONSISTENT/ COMPETENT MANNER. PATIENT COMFORT*. MEETING PATIENTS NEEDS, SETTING PRIORITIES ABOUT THEIR "WANTS" WITHIN OUR FRAMEWORK OF TIME. DOCUMENTATION**, USE OF PROPER FORMS, ATTENDING INSERVICE

MEETINGS. PROCEDURES AND STANDARDS OF NURSING CARE FOLLOWED ACCORDING TO HOSPITAL POLICY** PATIENT AND FAMILY SATISFACTION, COST EFFECTIVE CARE*, BUDGET BALANCING, ADEQUATE TIME MANAGEMENT, DISCHARGE PLANNING. I AM NOT REALLY SURE, I ONLY SEE HER WHEN THERE SEEMS TO BE AN ISSUE INVOLVONG THE WHOLE HOSPITAL (UNION). LEGAL IMPLICATIONS, GOOD NURSING CARE

11. The following are the kinds of things that I always do for my patients because I think these are the activities that are special to nursing, and no one else is accountable to do them:

PATIENT COMFORT MEASURES****/ WELL BEING; HELPING PATIENT FEEL COMFORTABLE IN UNFAMILAR AND THREATENING SITUATION. THIS IS DONE THROUGH CREATING A PLEASANT SUPPORTIVE ENVIRONMENT. ASSISTING PATIENT WITH ADL (AS NEEDED) IS SPECIFIC TO NURSING; WE GIVE MOST OF THE EMOTIONAL SUPPORT AND INFORMATION TO THEM, THOUGH NOT ALL. AMBULATE, IF LONELY SPEND SOME TIME WITH THEM. LISTEN*, TLC, MEDIATE BETWEEN PATIENT AND MD (INTERPRETER)*. PATIENT ADVOCATE ANSWER AND ENCOURAGE QUESTIONS, GIVE ASSURANCE**, TAKE A FEW MINUTES TO TALK WITH A PATIENT TO DRAW OUT HIS CONCERNS*, AWARENESS OF THEIR INDIVIDUAL NEEDS, OTHER THAN THOSE SPECIFIC TO HEALTH STATUS, ACQUIRE PATIENTS CONFIDENCE IN ME TO RENDER HIS SAFE CARE. TEACHING***, LOOKOUT FOR THEIR CARE AND NEED FOR CHANGES, SAFETY. DISCUSS ACTIVITY CHANGES, SUPPORT SYSTEM, WAYS TO MAKE ALTERATIONS IN SMOKING AND HEALTH HABITS, AVAILABLE COMMUNITY SUPPORTS, CLEAN UP THE ROOM A BIT TO MAKE IT LOOK MORE PLEASANT

12. When a new nurse comes to this floor she will most quickly slip into the way things are around here in nursing if she learns the following things:

NURSES TEND TO BECOME ISOLATED FROM EACH OTHER (IN REGARD TO PATIENT ASSIGNMENTS) DUE TO SEPARATION OF FLOOR INTO FOUR TEAMS AND TWO SIDES. PATIENT COMES FIRST, SHOW ROUTINE*** AND TRY TO GO WITH THE FLOW, MONITOR IMPORTANT PART OF LIFE HERE, SPEAK UP BE ASSERTIVE. DON'T BE AFRAID TO ASK QUESTIONS , LEARN TO WORK TOGETHER AND ASSIST EACH OTHER., SET PRIORITES AND PERFORM TO THE BEST OF HER ABILITY. KNOW THAT OTHER STAFF MEMBERS ARE AVAILABLE TO ADVISE IF NEEDED. I ALWAYS TELL EACH NEW MEMBER TO TREAT THAT PERSON AS IF THEY WERE YOUR MOTHER OR FATHER. ALWAYS REMEMBER THEY ARE PEOPLE AND CARE FOR THEM AS SUCH. QUICK PHYSICAL ASSESSMENT SKILLS*, WILLINGNESS TO GAIN NEW KNOWLEDGE, FLEXIBILITY TO CHANGES OCCURING FREQUENTLY*. WHAT THE EXPECTED QUALITY OF CARE IS HERE , BE WILLING TO ASSIST OTHERS AS NEEDED, ACT PROFESSIONALLY AND RESPONSIBLY

13. The telemetry on our unit makes us different and we must consider the following for our patients:

MANY POST MI PATIENTS (MUST CONSIDER EMOTIONAL COMPONENT OF THIS DX)******. TEACHING NEEDS OF PATIENT WITH CARDIAC PROBLEMS, POTENTIAL FOR RAPID UNEXPECTED CHANGE IN STATUS OF PATIENT. THEIR FEARS ABOUT HEART PROBLEMS, THEIR FAMILIES' FEARS*, MINDFUL ALWAYS OF POSSIBLE ARRHYTHMIAS*, TEACHING NEEDS*, CARE OF SELF. INCREASED AWARENESS, THE LEVEL OF ACUITY ON UNIT IS HIGHER, TEND TO HAVE MORE MEDICAL EMERGENCIES AND CODES*; THE MONITORS NEED FREQUENT ATTENTION*, HALF THE PATIENTS ARE NOT MONITORED AND SOMETIMES REQUIRE MORE PHYSICAL CARE THAN STABLE M I. IMMEDIATE ATTENTION TO CHEST PAIN. UNDERSTANDING OF EQUIPMENT. SHORT PATIENT STAY--MANY TRANSFER TO OTHER FLOORS, DISUPTION IN SLEEP CHECKING LEADS AND BATTERIES, TRANSPORTATION WITH THE PORTABLE MONITOR. GOOD QUICK NURSING DECISIONS, PATIENT ADVOCATE

14. What are the unique characteristics of this nursing unit that affect the delivery of nursing care?

MUST PICK UP CHANGES IN PATIENT'S CONDITION, NOTING CHANGES IN RHYTHM. MORE RESPONSIBILTY DUE TO EXPECTATION OF TELEMETRY ALONG WITH TEAM LEADER ROLE AND PATIENT ASSIGNMENT. WE SEEM TO BE ABLE TO CARE FOR OUR PATIENTS PHYSICALLY AND MENTALLY. REALLY LOVING CARE THAT THEY SENSE AND FEEL. BECAUSE OF MONITORS HAVE ALL TYPES OF PATIENT RATHER THEN A GENERAL MEDICAL OR SURGICAL UNIT, RAPID TURN OVER OF PATIENTS--NOT ALLOW FOLLOW-UP FROM ADMISSION TO DISCHARGE. TELEMETRY WITH KNOWLEDGEABLE TRAINED NURSES TO RECOGNIZE AND TREAT ARRYTHMIAS AS REQUIRED. CARDIAC TEACHING VIA CLASSES AND INDIVIDUAL TEACHING BY NURSING STAFF CARDIAC REHAB TEAM.

THE CHANGES THAT ALL THE NURSES HAD TO GO THROUGH WHEN THE STAFF IS PREPARED AND GIVEN THE INFORMATION, EQUIPMENT, THEY NEED TO DELIVER CARE, IT WAS EASY AND COMFORTABLE FOR STAFF. WHEN THE STAFF IS NOT PREPARED AND ADDED PATIENTS OR EQUIPMENT OR TYPES OF NURSING CHANGES, THEN DELIVERY OF CARE IS UNCOMFORTABLE AND I FEEL PRESSURE.

CRISIS TYPE ATMOSPHERE, HIGHER RATIO OF RNS*, INCREASE EMPHASIS ON TEACHING. THERE ARE MANY TRANSFER TO AND FROM THIS UNIT WHICH TAKES AWAY FROM PATIENT CARE*. THE ACUITY LEVEL IS HIGHER THAN ANY OTHER MEDICAL FLOOR. NURSES MUST BE ABLE TO THINK QUICKLY AND BE FLEXIBLE.* LESS PHYSICALLY HEAVY PATIENTS THAT REQUIRE MORE ON OTHER AREAS LIKE TEACHING,