SURVIVING CLINICAL NURSING:

A PHENOMENOLOGICAL TEXT ABOUT THE LIFEWORLD OF THE CLINICAL NURSE SPECIALIST.

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Candidate's Certificate

I certify that this thesis entitled 'Surviving Clinical Nursing: A Phenomenological Text about the Lifeworld of the Clinical Nurse Specialist', and submitted for the degree Doctor of Philosophy, is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed: [redacted] .....

Date: 1 Dec. 1995 .....

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ABSTRACT

This study, based on hermeneutic phenomenological principles, sets out to uncover the ontology embedded in advanced clinical nursing by exploring the experiences and attitudes of nine clinical nurse specialists (CNSs) engaged in bedside nursing in a large teaching hospital in Sydney.

The study stemmed from a personal disillusionment with being an experienced nurse, and in view of the inception of a clinical career structure and various other developments within the discipline, it was decided to return to the bedside to discover if today's advanced nurses face a different and 'improved' reality. Through a process of participant observation, the nurses' world was entered and their actions and interactions observed while they were accompanied on their rounds in general surgical wards. This was supplemented by a series of interviews, akin to 'conversations', in which the phenomenon of their immediate experience was more fully explored.

Part of this involved the CNSs' journalled thoughts regarding events, situations and behaviours in their workworld; even poems about it, and conceptualisations in the form of maps which included tracing their footsteps. In addition, 26 patients were interviewed as to their perceptions of the 'being-in-the-world' of these nurses.

The fieldwork took place over a 10 week period, undertaken in three blocks (2 weeks; 4 weeks and 4 weeks), spanning one year. During this time, field notes were compiled and a total of 61 tape-recorded interviews conducted (49 with the CNSs; 12 with patients - the tape recorder was waived in the remaining patient interviews). Adopting a research methodology informed by phenomenology, the material gathered from the field (depicting the 'ordinary, everyday' existence of advanced practice nurses), has been reconstructed to produce a phenomenological text. This text is constructed around the concept of 'the meaning' of their being, doing and knowing in the world, and in terms of their relationships with 'Others', namely, medical officers, other nurses and patients. This text has captured 'immediate' experience in an attempt to describe, elucidate and validate the domain of practice belonging to these advanced nurses. It has attempted to clarify the phenomenon of 'CNSing'. The 'data' furnished by the patients has also been compiled into a phenomenological text and highlights the perception by patients of differing types of nurses,

that is of 'experienced', 'better', and/or 'special' nurses as opposed to 'lesser' ones.

The phenomenological text on the meaning of being a CNS highlights the richness, complexity, mundanity (ordinariness) and changeability (extraordinariness) of the CNSs' world. It uncovers their expertise and demonstrates how they do indeed make a difference to patient care outcomes. It places their existence in context and illuminates the forces that are working for and against them, within that world. It shows that their lives are far more complicated than a list of tasks or competencies, and that aspects within that world influence directly their ability to fulfil such prescriptions of practice. Also, the text unveils the 'more than that' of their practice, the care they give that cannot be costed out.

From the research it became clear that there are two types of CNS; these will be referred to as phn-A and phn-B. While, for a number of reasons, phn-B CNSs are, on the surface, satisfied with the reality of their everyday existence as nurses, the phn-A CNSs are not. And, from the text it becomes apparent that despite progress in the discipline in other areas, the experience of the phn-A CNS in the 'real world', to a large extent mirrors that of this researcher ten years ago. It could also be said, that to varying degrees, both types are *'surviving clinical nursing'*.

The study points to the potential for nursing to lose its highly skilled CNSs, (especially phn-A) unless the constraints inherent within their workworld are overcome. This phenomenological text is testimony to the lived experience of these CNSs thus preserving their practice for other CNSs, nurse administrators, policy-makers and future generations of nurses, to behold.

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KEY TO TRANSCRIPTS

CNS	Clinical Nurse Specialist
NUM	Nurse Unit Manager
CNC	Clinical Nurse Consultant
RN	Registered Nurse
EN	Enrolled Nurse
MO	Medical Officer (HMO - Honorary MO)
NA	Nursing Administration
ADN	Assistant Director of Nursing
Names	All names used to refer to study participants are pseudonym
[square brackets]	Researcher's comments added to provide clarity or explanation
. . .	Material edited out
bold	Words or phrases emphasised in the original material
(parenthesis)	CNS affect

All non essential speech, e.g. 'I mean'; 'you know' etc. has been edited out of the original material.

Additional information regarding the phenomenological text is provided on page 188.

CHAPTER ONE

BACKGROUND TO THE STUDY

Introduction

Adopting a hermeneutic phenomenological approach to inquiry, this study sought to reveal the 'knowledge' and 'truth' embedded in the meanings and understandings of the life experience of Clinical Nurse Specialists (CNSs). CNSs are registered nurses who nurse at the bedside and who have been doing so in one specialty area for such a length of time that their experience warrants the title, nurse specialist.

According to the job description of one major teaching hospital, the aim of a CNS is:

> To provide the highest standard of total patient care by utilising clinical, educational and organisational skills developed in a specialty field in nursing practice.

In order to achieve this aim, a CNS is advised that her[1] role and function consist of the following:

1. To deliver the highest possible standard of nursing care.
2. To be a resource person to other nursing staff, and a source of expert knowledge within the acknowledged specialty.
3. May be required to relieve Nursing Unit Manager as necessary.
4. Participate in orientation of new staff.
5. Understand and comply with hospital policies, protocols and procedures.
6. Participate in preparation and review of ward policies.
7. Participate in in-service programs for staff to maintain levels of clinical skills appropriate to ward/ department.
8. Identify, access and utilise the appropriate resources to develop educational programs for staff.
9. Support educational programs which enable staff to develop skills for patient/relation education.

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[1] Throughout this thesis the CNS is referred to as 'her'. This is not in any sense, symbolic, except that it reflects life on the ward; the majority of CNSs are women. The male CNS, of which there are several in practice, is incorporated therefore under the feminine descriptor. Furthermore, it should be stated that because the majority of medical staff, especially those in senior positions, are male, 'he' has been used when describing doctors. The use of a discrete descriptor avoids the use of the cumbersome s/he; his or her etc., and assists the discourse to flow more smoothly. This was especially significant in regard to the phenomenological text presented in chapters 7,8,9.

10. Participate in quality assurance activities.
11. Maintain and improve own knowledge and expertise.
12. Be aware of and contribute to relevant research programs/activities.

(Extract from the 'Job Description' of a Clinical Nurse Specialist - Feb. 1991 - Major Teaching Hospital Sydney)

The question is: Does this list of tasks represent and determine the essence of the job? Does it in some oblique way reveal what it is to be a CNS? Can this list reveal what the real world of long-term clinical nursing is about? Can it be assumed that a list of rather vague duties is a reliable summation of a competent nurse's experience? Could it be said that a non-nurse, in 25 words or less, would be able to accurately describe the role of the CNS from reading the above? (Kermode, 1993). Or is the case perhaps, that the job of the CNS is more acutely reflected by the slogan, promoted by the NSW Health Department, that simply states: *'Nurses. We can't live without them'.*

Which of the two is closer to reality? Can the general public live without nurses? What *is* it about the job of the bedside nurse they are unable to live without? More to the point what *is* the job of a bedside nurse? This study posits that a CNS will tell you the statement *'Nurses. We can't live without them'* comes closer to her day-to-day existence than does the index of her functions. Yet what about the CNS? Has anyone asked her? Where is her voice?

This thesis maps the journey of an in-depth study that seeks to understand and make visible what it means to be an experienced nurse at the bedside. Specifically, it looks at that category of nurse designated Clinical Nurse Specialist (CNS), an advanced practice nurse who has fulfilled certain criteria in order to be able to claim expertise in a given area and thus receive the title of CNS. Under the Australian model, until 1986, the career path for nurses working at the bedside had traditionally been into education or administration. In effect, there was no recognition or valuing of the nurse who had become an expert in direct patient care. The lack of opportunity for promotion in the immediate clinical environs led to a steady and significant turnover of nursing's most experienced staff. In an effort to remedy this situation and retain advanced practice nurses at the bedside, a new clinical career structure was introduced into New South Wales during 1986/87. From out of this framework, the Clinical Nurse Specialist role emerged.

Since then, suggestions regarding the nature of the role have been debated, and lists of CNS functions/competencies drafted, yet little has been done in the way of actually going to the source and uncovering the CNS's perspective of the world of nursing as presented to her through her experience of it. Aspects such as: how life is for her in the real world; her understanding of her practice; what she believes her role is, what her role involves, have not been explored. What, in fact, the creation of this position has meant for these nurses and for nursing practice? If they perceive that they do make a difference to patient care as CNSs. And, if so, how is this manifested? The essential question is - what is it to be a CNS and what distinguishes them from other nurses?

The intention of this study was to gain insight into the human experience of specialty bedside nursing and the meaning these nurses ascribe to their world: to ascertain their immediate experience of a reality, the dynamics of which affects them from day-to-day. In so doing, this thesis is devoted to illuminating the contribution of these nurses to patient care.

The Study's Evolution

In order to address the background to the study, it was necessary to revisit the researcher's personal experience as a former advanced practice bedside nurse. Her encounter with the bedside raised an awareness of certain issues considered worthy of exploration. As will become clearer, the study is in part, an attempt to make meaning out of a personal struggle with nursing, and as such, the researcher's own voice is inexorably bound-up in it.

As Merleau-Ponty (trans.1962:viii) points out, 'all my knowledge of the world. . . is gained from my own particular point of view, or from some experience of the world'. Consequently, the first section of this chapter deals with recollecting and redescribing the essence of life at the bedside as it was for the researcher, and as her 'story', it presents as an introduction to the study itself (and is written in the style of the first person). The ensuing sections of the chapter turn to address the purpose of the study and go on to discuss issues concerning the culture[2] of nursing - specifically those aspects having a direct influence on the progression of the study. The final section of this

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2 Street, (1992b:1) describes culture as 'not only a concept that describes the language and way of life of a particular group, but also a concept which describes particular groups in relation to others'. A nursing culture includes the practices, beliefs, knowledge, language and resources specific to nursing.

chapter reviews the significance of this research in terms of its contribution to the discipline and practice of nursing.

Personal and Professional History - (My Story: 1976 -1986)

Nursing came to me relatively late by comparison to my fellow trainees. I was already in my early twenties by the time I began a three-year course to prepare me to care for people who, nowadays, are labelled intellectually disabled, but at that time were called 'mentally deficient'. As I was to learn, the pervading ideology of the era was that 'mentally retarded' individuals be estranged from the mainstream of society - incarcerated - yet within as 'normalised' an environment as possible. For example, on a superficial level, instead of 'patients', we were to call them 'residents', and instead of institution we were encouraged to call it 'home' or the 'cottage' or 'village' or similar euphemisms. Nursing and I took to each other, even though I was bound to the apprenticeship system which meant I was not supernumerary but functioned as a worker while trying to learn on the job skills. This meant that shiftwork and studying in my time-off period became routine. Because of the myth that women were not analytical, a college education was deemed unnecessary. Nursing was considered a practice discipline, our work perceived as nurturance and caring, and so to a large extent, theory was neglected (Muff, 1982; Roberts, 1983; Short, Sharman and Street, 1993).

I was the 'malleable' trainee nurse who entered the preliminary training school to learn aspects of nursing that included bed-making, sponging of patients, temperature charting and so on, and was then let loose in the ward to learn most of the other essential skills from more senior nurses. McMurray (1990, cited Siegloff and Walker, 1992:230) describes this system of training as 'enculturation', comprising a type of 'osmotic process' that takes place throughout the years of on-the-job training and in which the impressionable trainee becomes inculcated into the essence of the social reality of nursing.

During this process of 'enculturation', there was no doubt I had to come to terms with many peculiarities in the behaviour of some of the residents, and at times, to deal with some extraordinary sights and sounds that were quite disturbing. Initially, it was the camaraderie amongst the staff that cushioned the effects of this introduction to nursing, but later it was the residents themselves that sustained me. I became accustomed to their institutionalised ways of

being and discovered many of them to be personable individuals.

In particular, I recall the children. There were two who stood out most especially - both classified Down syndrome - Abigail was three years of age, and David, eighteen months. Abi would go home to her family quite regularly and each time she returned; there would be tears and protestation as to why she had to live in an institution when her siblings lived at home. Thus every Sunday when 'rostered on' in Abi's world, I would have to try and make her understand the reality of her sadness. Nevertheless, my life experiences being what they were, and my own recollections of life at three non-existent, I doubt I was much comfort to Abi. As was my practice at that time, I sought guidance from the recommended text, which simply stated:

> Only a few years ago mothers who gave birth to obviously retarded children such as "Mongols" were advised to give up their child immediately to save heartbreak at a later date, but nowadays parents are often encouraged to keep their child until at least three years of age. . . (Ashton, 1977:97).

Back then, while I felt compassion for the children, I accepted their situation. Abi's concrete existence in the world had already been prescribed for her by others. In a Heideggerian (1962) sense, Abi and I had momentarily been 'thrown' together in a social environment - and while Heidegger's *Dasein* (human *way of being*) can make sense of itself out of the world into which it is thrown, Abi, I believe, had been thrown into two worlds, and could make sense of neither. David, on the other hand, like many of the residents, had been abandoned by his family. Consequently, he rarely cried on Sunday evenings. Perhaps he would have had he been privy to the knowledge that his existence, his average everydayness, would see him effectively cocooned from the 'community' for much of his life. Worse still, he would be dependent for his entire emotional and physical needs on rotating shift workers, most of whom had just finished school. To be sure, Abi and David's being-in-the-world presented them with fewer possibilities to emerge from the future than most *Dasein.*

At the other end of the scale were the residents who inhabited the infamous 'back wards'. These, the 'diehards', were completely different. Raised in 19th century conditions they were now immune to the concept of 'normalisation'. The long-term staff took delight in telling us stories of the callous treatment to which these people had been subjected in the past. Tales of how each

morning they would be herded from barren dormitories into walled courtyards, hosed down and imprisoned day after day. Left largely to their own devices, except for the provision of basic survival needs it was not surprising these captives now displayed the type of behaviour one would expect of that kind of treatment. And yet, after a while, it became clear from the mass of shuffling, rocking, head banging, self-mutilating, groaning, moaning, screaming, frenzy of beings - some special characters could be discerned. If it were possible to get close to any of those lost souls we did, and a genuine affection would spring up which grew over time, only to be lost as we inevitably became rostered else-where. The world of their taken-for-granted everyday lives so different from ours.

Relating my way-of-being to that of the residents and coming to understand their culture was an on-going process spanning three years, but one which caused no great difficulty. In general, the residents - affectionate, non judgmental and forgiving - were easy company to keep. Adjusting to the pervading 'general' nursing culture was a different and more onerous task. Although Schedule 5 hospitals (residential care centres for persons with psychiatric illnesses and/or intellectual disability) were generally regarded as more *laissez faire* with regard to management styles than Schedule 2 (general) hospitals, I was nevertheless, introduced to a number of rituals, myths and customs associated with traditional nursing practice. The fact that these traditions had managed to become entrenched in a Schedule 5 system, which attracted a greater number of male nurses, (traditionally more likely to stay in the job; join unions and deride the culturally sanctioned expectation of self-sacrifice among nurses (women)), is testimony to the resolute nature of such practices (Carpenter, 1980).

My first encounter with the approach to management traditionally exhibited by nurses was during my first summer at the institution. It was a warm day and I had decided to wear a pair of white socks to work instead of regulation brown pantyhose which I found uncomfortably hot. It was early in my training and I was working in the sick bay. I remember feeling especially pleased to be working there because the care was considered more acute. As I was walking back into the unit from my tea-break I was confronted by one of the nursing administrators who stopped me and asked sternly how I dared to wear socks to work? Only men were allowed to wear socks to work.

I remember feeling quite shocked at the severity of the offence. This quickly turned to dismay when the Charge Nurse of the ward was also openly chastised, because by failing to bring the transgression to my attention she had, in effect, condoned my action. (Later she confessed she had thought I had been wearing socks for medical reasons). I felt humbled and humiliated, but at the same time indignant. According to Carpenter (1980:128), 'asylums' (Schedule 5 hospitals[3]) sought to closely monitor the actions of nurses, and it is believed that 'to ensure they fulfilled their part in the plan, the asylum became a disciplinary force against subordinate staff as well as patients'. Foucault's (1977) work on disciplinary power and his concept of the 'panopticon' as a vehicle for constant observation, and penalty for the slightest infraction of the rules, elucidates this idea of hierarchical surveillance.

Street (1992a) writing about power plays in nursing, has drawn extensively on the work of Foucault, including his concept of 'technologies of power', especially in regard to discipline (Foucault, 1980 cited Street, 1992a:149). According to Rabinow (1984:17), Foucault's 'technologies' refer to joinings of knowledge and power that 'come together around the objectification of the body'. Street (1992a:154) refers to the nurse's uniform as a 'technology of power'. She claims the use of distinguishing uniforms renders a person visible in a hierarchical system, a process which facilitates control and reflects the power relations at work. She also suggests the requirement of a regulation uniform for nurses is indicative of an area 'in which nurses are subject to oppressive administrative practices' (p.154). Although conformity and the wearing of a uniform enabled the student to feel a legitimate member of the institution and to enhance self-esteem; at the same time, the seeds of subservience were sown (Jolley & Brykczynska, 1993). Dean and Bolton (1980:88) support this concept, and assert 'the nurse's sense of order was ensured by the discipline which was imposed upon her appearance'.

Now, as I reflect upon the extent of her wrath I can only assume the nurse administrator in my story had been acting out a typified role - presumably through the longevity of her being-in-the-

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[3] It is important to note that today many individuals who are physically or intellectually dis/abled have been 'placed' into the community, and institutions such as the one described in the study have been reduced considerably. This social/health change is called 'normalisation'. The adoption of the term "disabilities" and the related lexicon to describe aspects of life for people who have mental and\or physical difficulties has been wrought from generational change and while a case exists to refer to present-day convention, in this study it seemed appropriate to adopt the terminology as used in that era in order to retain the element of authenticity.

world of nursing and hence her exposure to similar acts of authoritarianism (Berger and Luckmann, 1966; Meissner, 1986; Carpenter, 1980). Jolley and Brykczynska, (1993:38), are convinced that the socialisation process by which an individual comes to appreciate and know the attitudes, values and beliefs of the organisation to which they seek to belong - is primarily a case of those understandings being 'taught and caught'. As a leader amongst an oppressed group, her characteristics and beliefs resembled those of the dominant culture, which, having been passed down over time had led to the institutionalisation of her conduct (Roberts, 1983). The dominant culture is, and always has been, the medical profession who have a powerful influence on government policies and structures relating to matters of health and illness.

In fact, it has long been believed that:

> The impact of medical practitioners on the development of professionalism and autonomy in nursing has been most marked. They have acted repeatedly to perpetuate the handmaiden role for the nurse, to oppose improved education for nurses and to restrict the role of the nurse in Australia (Jenkins, 1989:194).

Roberts (citing Kanter 1977, 1983:25), points out that leaders in powerless groups are renowned for their negative attributes which include controlling, coercive and rigid traits. It would appear these characteristics stem from wanting so much to be like the dominant group that a hatred of their 'own kind' comes about.

Much later I came to realise this earlier reprimand had been just the beginning of a devaluing process to which I was to be subjected, and which would affect my daily working life throughout my nursing career at the bedside. I recognised very early on that failing to meet expected norms of behaviour precipitated 'little punishments' intended to make an example of individual failings. If I was 'good' and did what I was told; memorised all my lessons; did not speak out, and obeyed all the rules, and codes of dress, I would be rewarded, and I did, and I was. It meant my rosters, drawn up by nursing administration, were tenable. Yet, at that stage, because I was basically unreflective and accepting and possessed no formal theoretical knowledge of it, I was unaware that the subtle power emanating from nursing administration was reinforcing my conformity, my ritualised repression and serving to maintain the status quo. In fact, Speedy (1987) points out, few nurses recognise their own oppression and this is because they have been 'acculturated' to the existing structure as well as being socialised to women's role behaviours. So, inevitably to be a 'good nurse' meant I had to be a 'good woman', (Nightingale 1881, cited Versluysen,

1980:181). Although there were quite a few male nurses in the Schedule 5 system, the norms and values of the cultural model of the medical profession still abounded and the identification of nursing as nurturing and "women's work" was quite evident. Women were not viewed as capable of leadership and so the men quickly rose to positions of power. This anomaly has not gone unnoticed in the nursing literature (Hardy, 1984;London, 1987). From that point on I entered wholeheartedly and uncritically into the 'lifeworld', the social, political and historical dynamics of the establishment, being careful to avoid any pitfalls that might draw rancour from nursing administration.

And, as I became more aware of the social constitution of the practice of nursing, I began to see that mental deficiency nursing was afforded lower status compared to psychiatric nursing; which in turn was believed inferior to general nursing. It seemed the closer one got to the practice of medicine, the greater the status awarded the position. The perception of the relative importance or unimportance of nursing differing categories of persons, has arisen in nursing because, as a group, nurses are oppressed and have internalised the image of the oppressors, the doctors, leading to a non-critical acceptance of the medical model as normative. Medical knowledge is normative knowledge, which means that medical practitioners are socially supported in their belief of the superiority of medical knowledge over the knowledge of other health-care providers (Street, 1992a;Roberts, 1983). The power relations in health work, based as they have been on the 'caring function' of the nurse, have no status in contrast to the 'curing function' of the medical officer (Beaumont, 1987:48).

Carpenter (1978), in tracing the emergence of traditional hierarchies in nursing in Britain - on which Australian nursing is modelled - describes the hegemony of general nursing over other branches of nursing and affirms that as late as the 1960s there were still some mental handicap hospitals employing matrons with general nursing qualifications but none in sub-normality. However, Carpenter (1980) points out that men and women who nurse the mentally disturbed, seldom receive public attention, whereas, there appears to be a great deal of public interest in the lives and work of general nurses. When we say 'nurse' he contends, everyone knows a general hospital nurse is signified. He situates this belief within the dominant empiricist paradigm which perceives hospital nursing as dominant in the constellation of nursing and nursing-linked occupations. He writes:

> Despite wishful thinking in high places that asylum nursing could mirror general nursing in achieving public honour and dignity, work in asylums was considered largely to be a degrading occupation, not just by nurses but by the world at large (Carpenter,1980:143).

Carpenter (1980:136) highlights this tendency in nursing with a quotation from the last century by a medical superintendent of an asylum in the United Kingdom, who, in a public lecture to an association of nurses, observed:

> I have engaged as nurses . . . daughters of military officers, clergymen, lawyers and many others connected with the liberal professions. . . [Later he admitted however] I fear . . . that the asylum nurse is rather looked down upon in some places, as if she belonged to an inferior order of the nursing profession.

According to Carpenter (1980), asylum work has historically been perceived as 'dirty work' - whereas general nurse training, despite being physically dirty and potentially degrading as well, had been partially transformed by nursing reforms, and so general nursing tasks - or rather those performing them, had come to be seen as dignified and heroic 'angels' (p143). As a mental deficiency nurse, this meant I was marginalised by nurses from other branches of nursing.

In those days, once diagnosed and interred, 'mental defectives' received scant attention from medicine. It certainly appeared the case that persons requiring care, but not cure, were marginalised from mainstream medicine and viewed as inferior together with the people doing the caring (Speedy, 1987). Indicative of the value society places on people and things, the post-modern world heralds an era of specialisation and funds are allocated accordingly. Liver transplants for example, are high profile whereas the mentally ill are not - neither are their carers. People who are mentally ill or developmentally disabled are concerned with subjective realism and cannot objectively articulate via logic, and therefore have no voice and are disempowered. Speedy (1987) says, in order to maintain power and contribute to the status quo, the primacy of the curing role over that of care, has been perpetuated within mainstream medicine and internalised by nurses. As we have seen, this has created a perceived hierarchy amongst nurses carrying out differing caring roles, leading to members of the group closest to the dominant force being afforded the most power and control. Beaumont, (1987:50) asserts 'many nurses have taken on the attitudes and values of the doctor group and look to the dominant group for positive regard'. A spin-off from this has seen not only a hierarchy of carers but also a hierarchy of cases, with nurses performing 'high tech' duties afforded more status than those doing mere 'body' work.

Beaumont (citing Browning & Lewis 1973, 1987:50), states by allowing nursing practices to be defined and taught in terms of medical specialities, nurses have traditionally played 'hand-maiden to medical mythology and machines'. She contends this has facilitated the development of a hierarchy of tasks within nursing that has seen the relegation of traditional nursing tasks (i.e.body-care work) to secondary levels of nurse. Thus, the acute-care nurse attending the liver transplant patient through recovery, is deemed more skilled than the ordinary ward nurse, and because the acute-care nurse manages additional technology, the higher the 'prestige' granted her/him.

This history was unfortunate for me because when I finally graduated with a 'gold medal' to pin on my lapel, it was no compensation. By then I had been socialised into believing if I wanted to be a 'real' nurse I would have to undertake general hospital training. With this in mind, I wasted no time in applying for a position. And so it was I moved onwards, and as I thought upwards, into the Schedule 2 system.

At the general hospital, in consideration of my having already completed three years of nursing, albeit at an 'inferior' level, and no doubt because it would be cheaper in the long run, I was given the privilege of two stripes from the outset. As a result, within the first year of my general nurse training, I was deemed a second-year trainee. I found myself mostly on day shifts in the responsible position of 'senior nurse' and the even more challenging position of 'in-charge' on night-duty. As a novice virtually thrown into the position, most of my first year was a 'sink or swim' enterprise and therefore extremely stressful.

Short et al. (1993:22) authenticate my feelings by stating 'the role of the nursing student is, and always has been, marked by high levels of stress'; and cite several studies indicating that nursing students who trained via the general hospital system were subject to higher levels of stress than those whose education was college-based. By the same token, stress does not belong only to the domain of the student. In their book, Short et al. (1993) devote almost an entire chapter to addressing the issue of stress as an ongoing phenomenon in nursing.

The task of a senior nurse was to carry out all of the prescribed medical treatments on the ward. Among the junior nurses it was a 'top' position and I can understand now it was held in high-esteem, mainly because it entailed work more closely aligned with medicine, and was therefore

more 'visible'. In spite of my preoccupation with learning the senior nurse role, I soon realised the hospital operated on a traditional autocratic system founded on the medical model, typical of most general teaching hospitals of the time. My clinical experience was acquired in a hierarchical structure featuring task oriented behaviours that viewed student nurses and patients as work-objects and usually valued nurses only in terms of the work they performed (Short et al.,1993:67).

Treacy (1989, cited Short et al., 1993:67) states that because of this practice, students ended up feeling depersonalised as low-status individuals treated with disrespect. In turn, this was reinforced by the realisation that understanding the ward routine rather than patient needs, was crucial to being able to 'fit in' to the ward. Students were also given the message that interacting with patients was not nursing work, and regardless of the patient's interpersonal needs the nurse should keep busy 'doing' other things. Treacy's (1989, cited Short et al., 1993) study of student nurses found the nursing role was undervalued, and that 'although the nurses' contribution to care was utilised, it was overlooked'. This, she suggests, led to an invisibility of the nurses' contribution to care, which reflected the invisibility of much of the work contribution of women generally in society.

The power of the medical staff was evident in the hierarchical structure of the *'system'* which had many rungs. The top, occupied most firmly by senior medical staff, were almost exclusively held by males. Somewhere towards the lower rungs could be found the registered nurses. Resplendent in maidenly white, almost exclusively female, the 'sisters' were located in the office. From my lowly perspective, their days seemed to be preoccupied with paperwork, answering telephones, and acting coyly with the medical officers. All of these activities took them away from the bedside and 'basic body care', and closer to medicine - hence affirming their 'superior' status in the nursing hierarchy. Student nurses with their 'domestic' style uniforms and anachronistic caps, did not, I suspect, occupy any rung. Like children, we most definitely, were not expected to offer an opinion. Yet, the responsibility I was assigned as a student was far from child-like. Confronted by situations where I was in a position to make a considerable difference to an outcome for any number of patients, I was considered to be, and treated as absolutely subordinate in every way.

Ashley (1976:18) writing of the North American experience, which because of its similar origins could be compared to the experience both in Australia, and in the United Kingdom, discusses the

apprenticeship mode of training for nurses. She says, that for the best part of the twentieth century this made young women voluntarily subject themselves to a period of economic servitude in which they 'were used for the good of the hospital'. In point of fact, economic reasons alone were enough to maintain these young women in a subservient position apprenticed to the hospital. Subject to stringent discipline, taught to obey all the rules and be submissive, nurse apprentices were expected to accept poor conditions of work. Along the way they picked up token rewards, akin to 'rites of passage', in the form of an extra stripe on a cap for example. And so they moved along the continuum from strictly disciplined, frightened probationers to graduates 'whose moral character' and 'sense of duty' had received the training school's seal of approval (Ashley, 1976:28).

Because as a group made up predominantly of women, nurses have lacked autonomy, accountability and control over nursing for years (Speedy, 1987) power relations at work have led them to have negative feelings about themselves as individuals. Roberts (1983) and Menzies Lyth (1986 cited Street, 1992a:45) identify these negative personality characteristics in nurses as self-hatred and low self-esteem. This devaluing of self can lead to feelings of aggression against the oppressor which need to be suppressed in the presence of the aggressor. In nursing, this results in the doctor/nurse 'game' where the various elements of the game reinforce the stereotypical roles of male dominance and female passivity (Speedy, 1987; Street, 1992a; Beaumont, 1987; Stein, 1978). Aroskar, (1980) attributes such negativity to nurses being enmeshed in a historical, social and cultural maze, which views women primarily in a submissive role[4].

One memorable incident which highlights the above, occurred when I was in the nurses' station and a doctor was asking a registered nurse the alternative name for a particular drug. When she said she was unsure I spoke up and in a small voice ventured the answer. The sister was as surprised as the doctor that a student should know the answer, and in order to cover my embarrassment I reminded them it was nearing exams hence I had been studying. Unaware of

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[4] An offshoot of this has seen the nurse, thoroughly conditioned to be passive, fail to jealously guard her professional role and practices and allow her part to be eroded and circumscribed through the development of other health care monopolies that today have come to be known under the broad heading of allied health care (Siegloff & Walker, 1992; Yeaworth, 1978).

the notion of doctor/nurse games, even at that stage in my career I was aware of the inadvisability of appearing too informed; especially if it meant a doctor appeared uninformed. Nursing has, in fact, 'a long history of debasing the 'clever' nurse who achieves highly in theoretical examinations, and who is then accused of being 'a hopeless practical' nurse regardless of evidence to the contrary' (Short et al., 1993:60).

Stein (1967, cited Short et al., 1993:22) describes the doctor-nurse game as a hierarchical one that affects how doctors and nurses communicate with one another. Within the rules of this game, even though a nurse may assist in decision-making and recommend courses of action for a patient, she must do so in a subtle and non-threatening manner.

> As the doctor is the more powerful party, the nurse is expected to communicate her or his recommendations in such a way that they *appear* to have been initiated by the doctor. The doctor, for his or her part, seeks guidance from the nurse without being seen to ask for advice (Short et al., 1993:22).

Roberts (1983:27) suggests this game goes hand in hand with the 'submissive-aggressive syndrome' in which groups of nurses spend hours bitterly complaining about the behaviour of doctors but rarely confront the medical officer with their complaints. What is more, as a legacy of the inability on the part of nurses to oppose doctors not only will doctor-nurse games be rife, but also what Friere (1981, cited Street, 1992a:45), calls horizontal violence. Horizontal violence is well documented as a phenomenon in nursing (Beaumont, 1987; Short et al., 1993; Speedy, 1987; Yeaworth, 1978; Roberts, 1983), and has been described as a kind of internal conflict that frustrated members of an oppressed group perpetrate against their peers. In reality, attests Roberts (1983:23), 'it represents a mechanism by which the status quo is maintained through a learned fear of aggression against the oppressor'. (Horizontal violence is not restricted to the discipline of nursing alone).

As student nurses we were also subjected to control from sources off the ward. It was customary in those days for students to change into and out of their uniforms before and after each shift *on* the premises. As most of my peers 'lived in', for them this was not such an inconvenience. But for myself, married and living out, it meant I had to be at work at least 15-20 minutes early in order to walk to the changing room set quite a distance from the main hospital. Shifts on cold mornings proved the most unpleasant. As a result, I decided to cut a few corners and change into

my uniform in the women's toilet in the nurses' home adjacent to the main hospital. One morning I was caught by the housekeeper of the home, who proceeded to reproach me with rancour. I got the distinct impression authoritarianism, criticism and punishment had become part of the reality of the lived world within the nurses' home. I doubt she was even a nurse herself, yet somehow, someone, had vested in her the power to discipline and repress young students such as myself.

One year on, gaining three stripes meant little in terms of my practice as I was already fulfilling the senior nurse role. As a third-year student perhaps I was regarded as more accountable and naturally it presented me with the opportunity, to feel 'superior' among students with fewer stripes. There were times of course, when I looked upon my general nurse training with passion. Yet at other times, the hospital hierarchy (which saw me at the bottom) and which pervaded the social/cultural milieu throughout the hospital, would so overpower me I would find myself detesting nursing. As Jenkins (1989:194) affirms:

> The hierarchical organisation of the typical Australian nursing service setting has contributed to nurses' sense of powerlessness. It has inhibited development of autonomy and has contributed to nurses's frustration. This frustration has been expressed in a number of ways.

In order to express my frustration towards the *'system'* that had so dominated my life for two years I acted in a manner typical of nurses, that is 'reactively'. I took heart in refusing a position as a RN at the hospital upon graduation (Clark,1989; Beaumont, 1987).

Having received the hospital 'gold medal', I left. As I did so, I was accompanied by a whole collection of traditional nursing behaviour gathered from a socialisation process perpetuated through the school of nursing and originating from nursing administration. At that point, I applied to undertake a course in advanced clinical nursing at an institution seen to be preferable to the one I had just left. The reason it was perceived among nurses as a 'better place to work', was that it was a relatively new hospital, employing essentially only registered and enrolled nurses. Due to the fact the RNs came from any number of different training hospitals it was thought the pervading nursing culture of any one traditional hospital would not dominate over another. Yet, while it was not as apparent as in the institution I had just left, I discovered there certainly was a hierarchical system and because there were no student nurses, I found myself yet again placed somewhere on the lower echelons.

Nonetheless, pleased with my white uniform displaying the badge of a RN, but minus the headgear of my student days; the *'system'* failed to have quite the same effect. As a novice, once again I was learning new skills and consolidating old ones that gave my job a focus enabling me to ignore my position within the established nursing hierarchy. The doctor-nurse 'games' continued, and because I had become socialised into a subordinate role where medicine was concerned, I would join in, guided by the rules learnt during my years as a student.

After 12 months of rotating through a variety of wards playing 'the game', I collected my`advanced nursing certificate' and moved interstate. At this point, I had recognised my interest lay in intensive-care nursing, and I looked to that area for a position. In my eyes, intensive-care nursing was where the 'real' nursing lay - which indicates to me now that I had also been processed into the 'system'. At the time I was enthusiastic about the expanded role that critical care areas have afforded nurses in appropriating areas of work that have traditionally been part of the doctor's domain (Street, 1992a; Salvage,1985). I felt more challenged in critical care areas and enjoyed the high drama. I looked forward to belonging to the 'crash team' coping with emergency situations; of mastering the high technology involved, together with enjoying the greater public and medical respect afforded the position. The heroics of medical intervention, the 'high tech' machines, were for me, at that stage, what nursing was all about. Leininger (1986:8) makes mention of the preoccupation of nurses with machines, and suggests that in many cases, technology affords the nurse, a 'legal and professional security blanket'.

Once interstate I managed to secure a position in intensive/coronary care in a smaller peripheral hospital, and worked happily 'learning the ropes' for a number of months until it was no longer satisfying. At that point, I decided I needed to undertake a post-registration course in the specialty. I applied and was accepted for a three-month, full-time coronary care course at a college of nursing after which I was convinced I needed to work in a bigger more 'high tech' unit, and so moved to a large general teaching hospital in the inner city. As there were no positions in coronary care at that time, I bided my time working as a relief nurse in various general wards, all of which I believed lacked any real nursing action as found in the specialty units.

Eventually, I was transferred to coronary care, but it was not long before it dawned on me, the unit and indeed the hospital itself, were managed in the 'old school' tradition, based on the medical model so reminiscent of my training days. Working in different wards each day had

managed to buffer the effect, but now, inscribed as a name on a permanent roster, the *'system'* had re-emerged. New and insecure, I lacked the capacity to fight it - and once again succumbed to its influence.

As time went by, I came to the conclusion the main perpetrator of the *'system'* was the Charge-Nurse of the unit, a tall, thin woman who rarely smiled, and who naturally had 'been around' for many years. She had the ability to generate an aura of oppression that hung like a mantle over the ward. Needless to say, she held the students who rotated through the unit in fear - while those on the permanent staff, (not included on her list of 'favourites') treated her with an air of indifference intermingled with a reluctant respect for her position. Undeniably, she was very knowledgeable, but unfortunately, this knowledge balanced her lack of skills when relating to human-beings. It seemed she communicated only with the most senior medical officers, or to the nurses when something negative invoked her attention. The nursing in the unit was carried out on unthinking ritualisation and habit and within this rigid framework she felt comfortable. Naturally, the senior medical staff held her in high regard because she maintained the status quo. Retaining their exulted positions meant they were at liberty to control crucial factors regarding the management of the ward. Roberts (1983) discusses nursing administrators who have been promoted because of their allegiance to maintaining the status quo and refers to these persons as 'queen bees' (Grissum & Spengler 1976, cited Roberts, 1983:29).

'Queen bee' she was. Routine was the order of the day and the patients set their watches by the tasks we were undertaking at the time. Four hourly backwashes regardless of whether the patients required, or even desired them, ensured we had absolute control over them. In addition, we were 'compelled' to use soap and water (even though considered outmoded). Nothing else was acceptable in case it negated our having to run back and forth to the panroom. Not to do so was regarded as the height of indolence. In all truth, if one wavered from routine at any stage it was deemed idle and to be regarded as a lazy nurse was the ultimate failing. Similarly, the observations of vital signs were carried out strictly four hourly and every patient was monitored on a fluid balance chart regardless of whether it was necessary to know what went into and out of the patient each hour. We were in fact, a group of mechanised nurses working non-stop by the clock.

The stultifying use of the 'Bible-like' procedure manual, and nurses 'doing' things because that was the way it had always been done are phenomena that have been well documented in nursing (Siegloff & Walker,1992:231;Short et al., 1993:58). Ritual action can be described as 'carrying out a task without thinking it through in a problem solving, logical way' (Walsh & Ford, 1989:ix). Bonawit (1989:165), describing the historical image of the nurse, cites Hughes (1980), who espouses that, 'the functions of nurses described as repetitive tasks, learned with precision and done exactly the same way each time, such as injections and bed baths, was another persistent theme that resulted in the intellectual abilities of nurses being overlooked'.

Handovers were a solemn affair when the Charge Nurse was around. It was the camaraderie and the light-hearted banter that went on, not only among ourselves, but with the patients when she was absent that kept most of us happy and in the job. She insisted we document absolutely everything about the patient in the nursing notes on every shift, even if this information was already documented on the nursing care plan or treatment charts. This meant when we were not fulfilling some ritualistic task that was of no real benefit to the patient, we would be documenting repetitious information in the nursing notes, but at least we looked busy which was important to her. Because of our status, the nurses' notes were kept separate from the combined notes of the medical and other health professionals and because ours were written on green paper as opposed to theirs on white, ours were read only by the nursing staff.

From all of these memories perhaps the single most significant factor that stands out as testimony to her repression, was her insistence that we use coloured pencils to chart the observations. A collection of coloured pencils such as children might use would be located at strategic points around the ward. Bundled together with white tape was a red one for the pulse, green for the respirations, black for the blood pressure and blue for the temperature. And, as we all 'devoutly' carried out our observations at the same time - invariably there would not be enough coloured pencils to go around and so we would have to wait until we could safely chart our findings in colour. If the coloured pencils went missing it meant even further delay, and if they were blunt, it meant leaving the bedside to search for a sharpener. Occasionally, when the ward was very busy the futility of the coloured pencils became too much and a brave nurse would use her pen instead. Suffice to say, this dissent would always be discovered, and the culprit publicly admonished. The legend of the coloured pencils remains today and many former nurses recall the humiliation suffered under them.

Not long after commencing work in the unit, I enrolled in a Diploma of Teaching (Nursing) and negotiated working three shifts a week in the unit while studying full-time. Working part-time was probably the reason I continued working in the unit for as long as I did. Studies have shown that permanent part-time staff not only obtain more global satisfaction from their work than full-time staff or casual staff, but they experience less role conflict and role ambiguity as well (Pilkington & Wood, 1986).

It was enjoyable to work with a close-knit team of nurses, and this was enhanced by the social interaction we held with patients and their families. Rounding off this positive side was the constant challenge of new knowledge and technology associated with work in the area. These factors enabled me to cope with my professional lifeworld, which in the main, consisted of an inability to use any initiative and/or make decisions, rare acknowledgment from the medical staff let alone consultation, and as I have said, the ritualistic performance of menial tasks. Intermingled with, and in sharp contrast to this existence were the moments when, armed with a 'lifepak' and heart pounding, I would fly down the stairs in response to the cardiac arrest page, and assist as a member of a highly skilled team in resuscitating patients who had arrested on other wards, and in stabilising them before transfer to an acute care area. I lost count of the number of cardiac arrests I witnessed and for which I initiated treatment whilst working as a registered nurse in the unit itself.

As time passed however, my expertise in the area became inversely proportional to the amount of anxiety I felt during emergency situations and my adrenaline rushes became less and less. I began to feel I had conquered all there was to know about nursing in coronary care, at least in that particular unit. Even the occasional drama involving a patient lacked challenge because I knew I could manage just about any nursing situation that took place. When the shift was no longer spent in anticipation of what might happen next, and whether I could cope with it if it did, inertia set in. There was not even personal conflict within the unit to stir one's interest. As RNs under siege we were a cohesive group, and because they were sanctioned as the dominant force by the most powerful nurse on the ward, there was not even conflict with the medical staff. They regarded RNs as inconsequential and rarely sought our opinion.

Working in a unit which was heavily medically dominated, managed by a Charge Nurse who survived only by maintaining the status quo, there were no more challenges because there was

nothing else I was permitted to accomplish. Instead of entering a phase where my confidence would have enabled me to become more critical and start to instigate change as one would expect from an experienced member of staff, I was locked in to more of the same. The charge nurse was unlikely to leave, comfortable in the conventions of yester-year, she would be one of the stayers. It was an unhappy situation because I enjoyed bedside nursing and appreciated the patient interaction, but the monotony of a routine that could not be questioned nor changed, became too much to bear.

By now, I had become an expert entrenched within a system that afforded me no room for further growth. Mangan (1989:16) writes:

> The unique clinical knowledge of the experienced nurse remains obscure, non-transferable and undervalued. . . . Expert nurses are increasingly driven from the bedside by the frustrations and indignations that result from a lack of recognition. This lack is evidenced by protocols and policies which do not differentiate nursing abilities and responsibilities based on experience.

This was certainly true in my case, and without a vision for the future at the bedside, I had to decide which avenues were open that would provide me with an opportunity for the intellectual stimulation I sought. I felt undervalued and believed the only worthwhile contribution I made to the wellbeing of the patient was in the area of high technology, the 'life and death' matters, hence cure rather than care for me, was the most important facet of a patient's hospitalisation.

As previously noted, such an attitude is founded on the biomedical (scientific) model. Short et al. (1993:51) describe these feelings as contributing to what has been defined and popularly described as 'burnout'. Factors contributing to this have been identified from studies and include amongst others, a lack of meaningful trusted leadership, excessive performance demands, inadequate communication, highly centralised decision-making, and lack of support for ideals. Moreover, through my tertiary studies, I was becoming aware of the foundations of the oppressive nature of the 'system', and working within it was becoming increasingly untenable. I was, as Short et al. (1993) describe (of burnout), beginning to feel totally disillusioned with the health-care system, unfulfilled, with an increasing sense of futility. It was in fact, time for me to leave.

I was not alone. Nursing has traditionally shown a higher turnover rate than most other

professional groups (Breust, 1989), and as I moved away from the clinical setting into nurse education I was probably joined by many more nurses as frustrated as I seeking new ground in areas such as administration or education. Thus ended slightly prematurely, and at times regrettably, my promising career at the bedside.

My story sheds light on my own experience of bedside nursing and in so doing accents a number of the barriers that have been erected over the years to impede the development of nursing as a profession. Inextricably linked to these developments has been the hierarchical structure of nursing divisions, which have failed to promote autonomous clinical nursing practice. Yet much of what has been addressed so far has been of another era (the 70s and 80s), and one needs to ask, what of the nursing of today? A question that takes the discussion to the purpose of the study.

The Purpose of the Study

Several years after leaving the clinical field and having completed degrees at an undergraduate and higher level, the search began for a suitable PhD topic. It could be said that even in academia this researcher had never really distanced herself from the bedside; mostly because of an involvement in teaching essential nursing skills to undergraduate students. This meant the researcher was constantly drawing upon memories of clinical days in discussion with students, yet knew little about the current situation for expert nurses. Admittedly the occasional newspaper report, together with the standard gossip via the clinical grapevine, had not painted too promising a picture. But aside from these sources and the usual job description or list of tasks - to all intents and purposes for the researcher (and as she was to discover, for nursing in general), the workworld of the CNS was all but unknown.

The past ten years have seen major (so-called) change and reform in nursing, not least of which has incorporated a move of nurse education to the higher education sector, and the establishment of a clinical career structure that now sees advanced nurses afforded the opportunity for promotion to the position of clinical nurse specialist (CNS) and clinical nurse consultant (CNC) (discussed more fully in chapter two). From the outset, it was hoped the introduction of a 'career ladder' would keep experienced nurses at the bedside, and enhance nursing's autonomy. Nevertheless, it was perceived this could only be the case if nurse administrators allowed it to happen and fostered a climate to facilitate it (Jenkins,1989). Shadbolt (1995:16) an Australian

nurse administrator, believes political and managerial forces do not see nursing as fulfilling the criteria of professionalization, and it is this attitude that has contributed to 'the perpetuation of myths and patriarchal attitudes which de-value and marginalise the central caring and academic art of nursing'. The researcher resolved therefore to go back to the field to discover if the cultural practices of the past were still shaping the nursing culture of the present (Street, 1992b). Indeed, she needed to ascertain whether or not certain socio-political constraints had been removed in order to pave the way for the CNS role to be successful.

There is no doubt, education has been an escape route from the bedside in days past. The researcher wanted to discover if today's nurses were following the same course or staying longer in the clinical environs, particularly in light of increasing economic constraints both in education and the health care sector which have resulted in openings in education and administration being significantly curtailed. If the CNS was staying, was it through choice or because of this lack of opportunity elsewhere? If she was staying what was it like at the bedside? Was she confronting a similar reality to that of a decade ago or had she a *new* reality brought about by developments in both the discipline itself and the ever changing environment of the health-care sector?

At the outset there was a suspicion that the work of the experienced nurse was not sufficiently documented, nor indeed valued, and that the role of the CNS in NSW had not been clearly defined nor consistently implemented (since confirmed by Duffield, Pelletier & Donoghue:1995b). Illuminating the work of the CNS might enable the role to be recognised and valued and even employment at higher levels of salary justified. This study sought to gain a contemporary view of advanced-level bedside nursing. By assisting a group of CNSs to recognise and document their practice, then the authenticity of their role, and the value of the advanced practitioner's service to nursing care might be revealed. To this end, a return to the wards to gather lived experiences was proposed. It was hoped the CNSs would be encouraged to relive their experiences and to tell their stories so that they could be retold. This in turn would enable an accurate representation of their work to be established in text. Such a representation would make visible the meanings and understandings of experienced nurses about their workworld and discover the nature of their experience as an essentially human one (Crotty, 1996).

-The Need for Accurate Documentation About Nurses' Work-

It has been pointed out that few efforts have been made to 'describe, document and enhance the knowledge gained by the practising nurse clinician' (Benner & Wrubel, 1982:13). And yet, the lack of documentation about the work and feelings of nurses regarding their work is a problem not altogether unfamiliar to the profession, and appeals for nurses to articulate 'nursing' are on the increase (O'Rourke, 1989; Chinn & Kramer, 1991; Street, 1992a). Benner (1984), for example, has carried out extensive research in defining what it is that nurses do, and bases her work on the premise that nurses owe it to themselves to describe their world at work. She maintains that nurses have not been 'careful record keepers of their own clinical learning', and insists there is a 'wealth of untapped knowledge' embedded in the practice and the 'know-how' of expert practitioners (p11), but this knowledge will not enlarge or fully develop unless nurses document what they learn from their experience. Benner believes the 'failure to chart our practice and clinical observations has deprived nursing theory of the uniqueness and richness of the knowledge embedded in expert clinical practice' (p2) Only when experts can describe, for example, clinical situations where their interventions made a difference can some of their accumulated knowledge become obvious. She maintains that an adequate description of practical knowledge is essential if nurses want to be recognised and compensated for their clinical knowledge, and to develop and expand nursing theory and secure professionalization of the discipline. Street (1992a:182) contends:

> Important new insights and knowledge are generated within clinical practice but are lost to the profession as a whole and, at times to the individual nurse involved through the lack of a process by which nurses can examine their own practice and create and share new knowledge with their colleagues.

D'Cruz and Bottorff (1986) agree, saying that in the new orientation of nursing, nursing knowledge becomes a legitimate body of knowledge only as nurses document their experiences. Lumby (1991b:23), urges nurses to continue to search their practice, believing if the nurse's self image is one of subservience, then oppression will remain their reality. So much of nursing knowledge has not been explored or interpreted, insists Lumby (p26). She believes that by unearthing the essence of nursing practice, aspiring nurses can be shown a way of looking at the practice of nurses in order to understand and develop an awareness of what it is really about, rather than how it is depicted by non-nurses.

Benner (1984), illustrates how nurses are often highly skilled in their practical care but unaware of the basis for their competence. As nurses practice they know more than they can communicate. While elements of what is 'known' can be expressed in words, actions, movements or sounds, much of it is unable to be fully expressed at all. Assisting nurses to express knowledge opens up the possibilities for choices in nursing practice (Chinn & Kramer, 1991).

Benner (1984:10), in support of the need for nurses to interpret their roles, describes what she calls the 'unplanned practices' of nursing whereby nurses have taken over elements of patient treatment relegated to them by medical staff. These handed down practices, she believes, have many ramifications for nurses because the knowledge gleaned from them has not been adequately described or studied. She perceives that:

> Perceptions and clinical judgments are altered as a result of acquiring a new skill, yet these changes will continue to go undocumented and unrecognized unless nurses study these changes and the resultant 'know-how' that develops in their practice (Benner, 1984:11).

Cameron (1989) adds fuel to the calls for a description of nursing practice by citing the problem of role erosion in nursing. She gives the example of an occupational therapist assuming responsibility for assessment of a patient's ability to swallow after a stroke or head injury; or a physiotherapist seeking to sponge a patient so that she can assess range of movement, and a speech pathologist taking control of feeding a post-laryngectomy patient. Pointing out it is not only non-nursing personnel who attempt to take over nursing duties, she believes it is often difficult to distinguish the difference between the care provided by the beginning registered nurse and the enrolled nurse. Contributing to the problem of delineating the differing roles of licensed nurses, there appears to be an ever increasing number of ancillary staff performing traditional nursing duties, which further clouds the picture (see ANRAC/NCAP,1990). Pratt, Burr & Leelarthaepin (1992), have reported on a number of sectors in the health service in NSW implementing programs to extend the role and functions of the enrolled nurse to save on nursing care costs. In light of such debate it especially timely for this study to document the practice of this new category of experienced nurse, the clinical nurse specialist.

To this end, the study described in the pages that follow is an interpretation of advanced practice through the lived or immediate experience of a group of advanced practice nurses designated in

this state as Clinical Nurse Specialists. It sought to assist the CNSs to become more aware of the subtle ingredients of their nursing practice; to unveil what Adams (1982, cited D'Cruz & Bottorff, 1986:60) refers to as the 'more than that' of nursing. Those aspects permeating their work that belong truly to the realm of bedside nursing and not those activities derived specifically from medicine. As a phenomenological study it goes directly to experience in the clinical field ('Phenomenology' is explored in chapter 4). Working alongside a group of experienced bedside nurses the researcher attempted to see their workworld through her own eyes. Espousing a human science view the methods of natural science were unsuitable and lived experiences sought as 'unitary' and incapable of 'being objectified or measured' (Walker & Avant, 1995:202). This involved a (re)socialisation into the nursing culture and critical reflection upon it. In addition, it required that previously held preconceptions and stereotyped views and/or attitudes be dropped so that self could be opened to the experience. Therefore, the researcher put aside 'my story' and went in to look at the reality of the everyday life of CNSs with 'fresh eyes'. Undertaking this study has culminated in the development of a phenomenological text (presented as chapters seven, eight and nine) which, for all the aforementioned reasons, is an attempt to make manifest what it is really like to be a CNS. To 'unconceal' that which has been obscured and in many cases, uncelebrated, about her being-in-the-world. To reveal what is missing from a list of functions or competencies so that an accurate representation of her practice has been documented (and from which a non-nurse *would* be able to describe in 25 words or less, the role and function of the CNS).

Shadbolt (1995:16) has suggested that in order to demonstrate that which is 'unique' to nursing action, research is the 'way forward'. However, as part of that process, she urges that the past has to be acknowledged as part of the 'truth'. And so it must be said, that portraying the CNS as she 'is' in the 'here and now', necessarily involves reflection on how it is she has *come to be*. (And, as the final chapter will reveal, necessarily involves reflection on the conditions of the possibility of *what could be*). To the former end, included in the following section, and to a further extent in chapter three, is an exposition of certain social structures emerging out of nursing's past which have helped to shape the 'coming to presence' of the CNS today.

In the following section the discussion turns firstly to gender-related issues, those which over the years have seen a 'sexual division of labour' become firmly entrenched in the health-care system, and secondly the unfavourable portrayal of nursing and nurses in the media. Combined, these

developments have had a detrimental effect on the advancement of nursing as a profession, *ipso facto* the evolution of the role of the advanced practice nurse. In addition, there are contemporary fiscal concerns that are also set to influence the practice of nurses, especially that of the more cost-related experienced nurse. These are also reviewed as a lead into a more fuller examination of the CNS role.

Situating the CNS - Nursings' Roots: Invisibility, Domination and Control

-Nurses as Women-

Nursing has a long history of being under the control of others - a position that has been well documented (Wuest,1994; Kitson,1993; Street,1992a,1992b; Doering,1992; Lawler,1991; Jenkins,1989; Speedy,1987; Roberts,1983; Muff,1982; Dingwell & MacIntosh,1978), and which is reflected in the researcher's personal story. Chinn & Jacobs (1987:20) offer proof of external professional control by pointing out that when hospital invoices are presented to patients, nursing costs are often hidden, as if nurses 'provided no identifiable services'. It is believed professional justification for the value of services provided by nurses, depends in part, on evidence that would support that services rendered by nurses make a visible, valued difference. As McCurdy (1982:363) points out, 'if activities are to enhance one's power, they must be visible and must attract notice'.

That nursing is not seen as making a visible difference which is valuable, is rooted in its ideological underpinnings and structural position. Nursing as we know it today is recognised as a product of the oppression of women in Victorian upper-class society (Beaumont, 1987; Jolley & Brykczynska, 1993). And, as a profession constituted predominantly by females, nursing has traditionally been subordinated to the male-dominated medical profession, and clinical knowledge deemed inferior to medical knowledge (Carper, 1978;Street, 1992a). A plethora of literature has been written on the oppression of nurses rooted in the dominance and power of the medical profession and stemming, as Street advocates (1992a, 1992b), from Nightingale - who made it a condition that no nurse was allowed to undertake any service without authorisation from a doctor (Jolley&Brykczynska,1993; Delacour & Short, 1992; Lawler,1991; Delacour,1991; Bonawit,1989; Speedy, 1987; Kalisch & Kalisch, 1987; Beaumont,1987; Yeaworth,1978). Quite clearly, over the years nurses have been 'cloistered, disciplined and shaped by a medically dominated authoritarian hierarchy' (Delacour,1991:430).

Fifteen years ago, Aroskar (1980), observed that perhaps more than any other profession, nursing has been influenced by social concepts regarding the nature of women and their position in society. The general socialisation of women has been associated with the renunciation of achievement and autonomy (leading to a fear of success), and the acceptance of nurturing, compliant and dependent roles - marred occasionally by bursts of irrationality. Stereotypical male traits on the other hand have included decisive behaviour, autonomy, sustained rational thinking, competitiveness and ambition (Salvage,1985;Speedy,1987). Persons who depart from these prototypes are labelled disapprovingly, hence assertive women are 'aggressive' and compassionate men are 'effeminate' (Salvage, 1985:7). Although, as Salvage (1985) points out, such behaviour in the opposite sex would be regarded as quite normal. Speedy (1987) believes society, as governed by men for men, has traditionally valued the male set of characteristics over and above the female, culminating in a view that women are subservient to men. On top of which, she believes, women have been subjected to economic exploitation, inadequate education and long standing social discrimination.

Meleis (1991:135), declares 'the history of nursing attests to how the concept of gender permeates and pervades every aspect of the discipline'. Despite attempts at attracting more males to the profession, nursing as an occupation has traditionally been female dominated and remains that way even today. Nursing, she concedes, is for women, and thus, 'continues to be saddled with all the accompanying issues related to the value of women's work, women's contributions, and the relationship between nursing and other predominantly male professions'. Pearson (1991), an Australian male nurse academic, regards gender as a significant issue in nursing's current potential power base, and supports the view that the political position of nursing is closely linked to the status of women and the influence of patriarchy. Pearson (1991) reaffirms the belief that because nursing is a profession made up almost entirely of women it is seen as women's work. In the past, legal and educational systems have contributed to the repression of nurses and nurses' subservience to doctors. Moreover, the development of nursing has been further suppressed, he claims, because in many ways the health-care system is itself paternalistic.

It is suggested, that even up to the present time, the practice of nursing could not be considered as external to the 'techniques and agencies of the forms of power' which comprise its administrative apparatus (Dean and Bolton, 1980:99). Speaking from a North American perspective, Aroskar (1980:33), has pointed out that nurse practice acts have given men the legal

right to supervise women in a paternalistic system regardless of whether these men are present or not when nursing care is delivered.

Ashley (1976:32) adds weight to this notion of domination:

> Nurses have not escaped the psychological effects of the oppressive apprenticeship system. Convinced of their inferiority and of the need for their subordination to the medical profession, many nurses identified with the system that oppressed them and worked to support its continuing existence.

Street (1992a), articulates the situation in Australia, positing that an apolitical persuasion in terms of medical knowledge such as is apparent through State legislation, disregards the ideological component of medical knowledge and the way it is exercised as social control to reproduce and support the class and gender interests of doctors. Nursing, she believes, has supported this apolitical view:

> Historically nurse scholars and educators have accepted the superiority of the technical knowledge of doctors by appropriating both the forms of knowledge and the paradigm in which this knowledge is created. Thus they have unwittingly perpetuated the oppression of nurses and of their clinical nursing knowledge (Street, 1992a:8).

Appropriation of features of the dominant group is further evidenced by tendencies in the past (which remain even today), of nurses to espouse male values, and through their attempts to masculinise nursing practice and structures in order to procure power (Pearson, 1991). At a basic level this has seen, for example, the nurse administrator appropriate medicine's 'white coat' and bedside nurses adopting the practice of draping stethoscopes across their shoulders to emulate doctors.

One of the mechanisms that reinforces the myth that appropriation of the characteristics of the dominant group will bring power, is education. Clearly nursing education, controlled largely by physicians for most of this century has been an important vehicle for the maintenance of dominant norms (Roberts, 1983).

Dean and Bolton (1980:98) point out:

> In the historical constitution of nursing practice every effort was taken to ensure that the nurse would remain the model of a disciplinary, obedient individual. This was necessary if she was to become the last link in a chain of power which sought the correction and transformation of behaviours and conditions.

If nurses' formal and informal education is controlled by the dominant group then over the years many of them will have internalised the values of physicians so much that they will have become, what Roberts (1983:26 citing Greenleaf, 1978), calls 'marginal'. The 'marginalised' nurse is one who has become successful at internalising the norms of the dominant group and yet does not belong to that group, having alienated herself from her own group, she discovers herself drifting somewhere between the two.

It can be seen therefore that for nurses, as a predominantly female group, there have been major ramifications in working alongside doctors as a predominantly male group. Modern nursing engendered as it was by the reforms of Florence Nightingale, saw Nightingale accepting the Victorian idea of divided spheres of activity for men and women. She believed that women needed to be trained to nurse by virtue of a disciplined honing of their feminine qualities. Disbelieving the germ theory she saw medical therapeutics as less important to the patient than care, which she assigned to the female sphere of nursing. Nightingale sought to organise a female hierarchy which would see orders passed down from nursing superintendent to the humble probationer. Power in the provision of health care was to be shared between this separate sphere of females and the male dominated arena of medicine (Reverby, 1987). But, as Reverby (1987:7) points out - 'commonalities of the gendered experience could not become the basis of unity since hierarchical filial relations, not equal sisterhood, lay at the basis of nursing's theoretical formulation'. Thus, she says, unbeknown to her, Nightingale's sanitarian notions and her ideas about womanhood provided some of the ideological justification for many of the dilemmas that have faced nursing in a number of Western countries over the years to come.

Chinn (1994:21) highlights some of the problems that were to plague nursing from this time on:

> For a century. . . nurses have worked with courage and persistence in roles and relationships characterized as oppressive; sometimes called handmaidens, they were more like servants than powerful healers. Throughout the twentieth century strong voices have spoken and continue to speak out against the oppressive conditions and the power imbalances that constrict what nurses do and how they do it. Typically the issue or problem is defined as lack of autonomy, or lack of professional status, or the need for recognition of the value of nurses' work. Ironically, nurses have turned to the methods and ideals of science to gain legitimacy, status, and rightful acceptance for nursing knowledge and nurses' work.

Salvage (1985:2) argues that Nightingale's reforms were subsidiary to doctors' requirements regardless of any philosophical tenets, and writes:

> Even the introduction of formal training in the 19th century had more to do with the needs of the medical profession than the notion that caring was a skill. . . [It was more a case of] the growth of 'scientific medicine' creating a need for doctors to have assistants. . .

Nursing's physical and psychological intimacy with patients and the quasi-domestic duties so closely allied to tasks traditionally regarded as the 'natural' sphere of women working within the home, were exploited by Nightingale, who was desperate to find a legitimate activity outside of it (Salvage, 1985:5). Carpenter (1980), points out that in the middle of the last century for example, the difficulty in recruiting 'respectable' rather than 'rough' attendants for asylum work was believed by some authorities to be due to the lack of material inducements and rewards. Undeterred they looked to recruit staff motivated by vocational ideals who would view asylum work as a 'calling'. This was an idea modelled on Nightingale's strategy for general nursing that had succeeded in attracting considerable numbers of better class women keen to escape the dreary drawing room, and prepared to work for minimal recompense while making a virtue of long hours. Nevertheless, in asylum work, recruiting as it did more males, it became obvious that 'only the rare individual male attendant would be likely to be motivated by high ideals of service' (Carpenter, 1980:136). Kitson (1993) is convinced that even today, Nightingale's caring-as-duty paradigm remains prevalent in some areas of nursing.

And yet, amongst middle and upper class women in Victorian times, household duties were not necessarily deemed low in status because the skills involved were more managerial and involved directing other staff to perform the menial tasks. In fact, hospital matrons built themselves quite

considerable power bases and while male authority remained unchallenged they exerted strict control over the working class women who worked under them (Salvage, 1985). Nevertheless, as Salvage (1985) points out - it was because of its link with domestic labour that nursing came to be held in such low esteem.

In her book *Behind the Screens*, Lawler (1991), addresses the notion of menial tasks in nursing, and ways in which nurses deal with the body through what she calls 'the problem of the body' - work which involves assisting others in the 'constant labour of eating, washing, grooming dressing and sleeping' (Turner, 1984 cited Lawler, 1991:3). Lawler, advocates that nurses see this as 'basic body care' but in the context of a patriarchal society it is work typical of the domain of women, and because it is viewed as classical women's work it is not appreciated. Moreover, because many of its aspects are taboo, it is difficult to talk about. She describes a study by Webster (1985) in which a number of male medical students were questioned about various aspects of nursing. Invariably they saw nurses as 'scut' workers, believing them to be low status workers who performed the cleaning up of patients, together with other lowly jobs requiring little knowledge.

From this it can be said, that patriarchal power and domination have shaped the world of nurses as 'doers' (Capra 1982, cited Short et al., 1993). Modern medicine influenced as it is by the accomplishments of the natural sciences has adopted the Cartesian-Newtonian mechanistic paradigm to conceptualise the body, disease and illness. That is to say, the patient has been objectified and rendered an object rather than a subject or person. Foucault's notion of the medical gaze as visual domination has implications in terms of the power of the gaze over its object (in Shumway, 1989). He asserts that 'even the apparently simple act of seeing is always conditioned by the discourse and practices in which it takes place' (p53). That is to say, when a doctor gazes at a patient he is doing more than just looking, 'the gaze is a matter of applying a language or a mathematics to the thing seen so that it is constituted by the observer in his terms' (Shumway, 1989:53). (Foucault carried this concept of the gaze through to his notion of the 'panopticon' referred to in earlier text).

Within the biomedical model the mind and body are separate and the body is conceptualised as a machine which can be understood in terms of its working parts. Disease is thought of as a malfunction of the machine and the doctor's role is to repair the part that has caused the

breakdown. This reductionist perspective has led to specialisation in medicine and nursing because of its tendency to break the body down into smaller and smaller fragments (Capra 1982, cited Short et al.,1993). As a result, the biomedical model has influenced medicine to focus almost exclusively on physical aspects and to ignore the emotional, social and psychological aspects of illness.

The emotional, social and psychological aspects of illness devalued as they are, fall into the realm of women and hence nurses. Since women are believed to possess inherently expressive, maternal and caring qualities, coinciding as they do with her natural biological functions, then their maternal and caring qualities have been deemed, by men (and some women), to be especially appropriate for aspects of patient care. This is apparent in such beliefs as 'woman as nurse is the natural help of man as a doctor' (Simms, 1979, cited Versluyen, 1980:182). Nursing, that is, caring, to a large extent became invisible work carried out by invisible women, and nurses have been socially overlooked, powerless and marginalised in terms of their perceived worth to society (Colliere, 1986).

Colliere (1986) posits that through Nightingale, cure versus care distinctions increased. That is, curing functions became regarded as the province of doctors (men) and caring as the province of nurses (women). Thus the seeds were sown for a gender division of labour which reflected the traditional gender stereotyping of skills and qualities (Salvage, 1985). In a critique of what she calls, (after Adorno, 1973) 'a logic of identity' - or dichotomous thought, Iris Young (1990) a feminist writer, critiques the cure/care dichotomy rampant in medicine. Dichotomies can be referred to as binary oppositions wherein man has unnecessarily segmented reality by coupling concepts and terms in pairs of polar opposites where one of them is privileged over the other. Young's work stems from the work of several postmodern writers seeking to expose and deconstruct this kind of logic found in Western philosophical and theoretical discourse which they strongly believe denies and represses difference. According to Young; dichotomies such as mind/matter, culture/nature, reason/passion, cure/care man/woman and so on, smuggle in a number of political and social values that are disadvantageous to marginalised groups. This is because the former or left-hand of the pair is always seen as desirable and the latter or right-hand value is not only seen as deviant, but also lacking the qualities of the left-hand value. Hence the right-hand value is defined only in terms of that on the left. In which case, not only is care seen as secondary to cure but it is also seen as lacking the qualities of cure, hence care has no qualities

of its own. 'The unity of the positive category is achieved only at the expense of an expelled, unaccounted for chaotic realm of the accidental' (Young, 1990:99).

Women's rising participation in the paid labour force, and the increasing recognition of the 'woman's realm' of the home and family have seen women's experiences become of more concern in socio-political discourse. Women have become less likely to enter the workforce on a short-term, intermittent, or part-time basis as was traditionally expected of them (although there are still many more women employed on a part-time basis than men). Moreover, (as nursing is discovering), less and less women are being confined to occupations which have been seen as an extension of the female domestic role into the workplace such as nursing, teaching, waitressing etc. (Curthoys, 1988). Moreover, holism and humanism are becoming valued in society in general, and as such are mirrored in changing attitudes to health and health-care. And, as has been her practice in the past - contemporary nursing is taking note of, and responding to these emerging worldviews originating as they have from the perceived needs of health care consumers (Pearson, 1991).

Nevertheless, there is some concern that these changes have not been accompanied by a concomitant enhancement of the image of nursing in the public eye. There is no doubt the public still lacks awareness of the many vital services that nurses currently provide. It is believed that this is mainly due to the failure of the media to accurately portray the changing role of the nurse.

-Media Control of Nursing's Image-

Clark (1989:175), declares 'modern media characterisations of nurses continue to reinforce an outmoded legacy of beliefs, expectations and myths[5] about nurses and nursing'. Bonawit (1989) cites Hughes (1980), who argues that the persistence of mythological beliefs about nurses has gone almost unaltered in the public press for eighty years. By and large, nurses as a group have been subjected to enormous myths and stereotyping. The traditional image of the nurse as

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Berger and Luckman (1966:128) define mythology in primitive society as 'a conception of reality that posits the ongoing penetration of the world of everyday experience by sacred forces'. Specialists in the mythological tradition limit access into the tradition and in order to safeguard the specialist's monopolistic claim the non-accessibility of their lore must be institutionally established. 'That is, "a secret" is posited, and an intrinsically exoteric body of knowledge is institutionally defined in esoteric terms'.

compassionate, sympathetic, technically competent, subordinate to the doctor with little or no autonomy still abounds. Nurse characterisations give an overwhelming impression that intelligence is not an essential quality in a nurse. The public perception is such that nurses do not need to think. What is more, nursing is still regarded by society as work peculiarly suited to women (Bonawit, 1989).

Some of the greatest stereotypical myths about nurses depict them as being 'dedicated to a mission in life'; 'born to nurse'; and essentially the 'physician's handmaiden'. Moreover nurses undertake nursing only as preparation for marriage and an opportunity to secure a desirable husband, typically a doctor. Furthermore, Jennings (1986, cited Beaumont, 1987:49) propounds that the popular press portrays them as 'waiting for romance with all of the connotations of damned whores'. Kalisch & Kalisch (1987) in their illuminating book which covers the changing image of the nurse, chart the course of the general public's misunderstanding about the nature and extent of nursing through the negative portrayal of nurses in the media. The popular image of nursing they assert, is a result of a 'cluster of nurse stereotypes' which our culture uses in daily life as well as in mass-media portrayals (Kalisch & Kalisch, 1987:5).

Kalisch and Kalisch (1987) clearly consider the media's portrayal of nursing as having a marked impact on the profession's attempts to achieve its rightful status and recognition. They report, for example, that in paperback books the nurse is frequently depicted as pre-occupied with trivial tasks, most often her appearance, seems to have a propensity to appear authoritative and undertakes minimal nursing except to set up a routine of rest and meals. Clever only in small matters such as the social white lie, she is emotional and impulsive, and acts on intuition and instinct rather than rational thought. Doctors on the other hand, are described on book jackets as 'dedicated' and 'hardworking' and portrayed as strong, calm, rational, decisive and involved with important matters (Kalisch & Kalisch, 1987:148).

Media reinforced discrepancies disallow the public knowledge of the accurate role and function of nursing, which means other health care workers especially physicians and surgeons, are accorded the credit for any positive health care outcomes (Clark, 1989; Kalisch & Kalisch, 1987). Yeaworth (1978) believes the issue is compounded by the fact that many women (nurses) do not see this as a problem. Traditional socialisation processes of women and the image of the nurse as nurturing, feminine, and self-sacrificing have resulted in the attitudes of many nurses

and non-nurses that nursing is a 'job' often to supplement the family income, rather than a career. In the past nurses have gone into nursing as an occupation to tide them over until marriage and then to return on a part-time basis because a husband's career has primacy. By and large as Yeaworth (1978) reaffirms, problem areas in nursing relate directly to the overall problem areas of women in society.

It is posited that nurses themselves contribute to the negative image of nursing held by the public, and that 'the roots of nurses rather discouraging tendency to downgrade their own profession, probably lie in the history of the nursing profession as a whole' (Clark, 1989:182). Contemporary newspaper reports about nursing remain filled with accounts depicting nurses as selflessly devoted, working under woeful conditions, badly paid and overworked with poor morale (SMH, 2.9.94; 30.11.93; Southward & Crowe, 29.10.95). The Sun-Herald (Davey, 6.11.94) recently published an article entitled 'diary of a hospital hit by crisis' which depicted nursing along those lines. To an increasing extent reports of tragic errors and/or bad practice amongst nurses are appearing, together with a growing emphasis on accountability; yet without any concurrent acknowledgment of the vital services provided by the nurse as she undertakes an increasingly complex role (Dean, 27.8.94; Papadopoulos, 3.9.94). It is true that there are more enlightening articles about nurses in terms of their roles and education, however in general, nurses continue to be depicted as 'losers' (Connolly, 20.7.94; McCarthy, 23.7.94; Ferrari, 14.12.94). Even contemporary television serials filmed 'live', (for example 'RPA' currently screening on Australian commercial TV), fail to exemplify the nurse's work in its true form, focussing instead on snippets of action that more fully highlight the doctor's role.

The consequences of a distorted image of nurses and nursing which the public receives from the media can be serious and far-reaching. It is generally agreed that public recognition is integral to the success of social, political and professional groups in achieving their goals (Kalisch & Kalisch, 1987; Clark, 1989). The medical profession's influential position in shaping health policy stems not only from its scientific background, but also from its ability to organise itself into a powerful pressure group, and from the fact that it is generally accorded high status by political decision makers and their constituents (Short et al., 1993).

A negative image influences consumers, public opinions and desires, which in turn influence the course of nursing. There is no doubt that an enlightened public can contribute to the advancement

of the nursing profession. At a time when young women are choosing traditionally male-dominated professions it is particularly worrying that nursing is still not recruiting a comparable number of young men[6]. This can in part, be attributed to the virtual absence of male nurses in mass-media portrayals of the profession, a void which only increases the barriers to recruiting from half the population (Kalisch & Kalisch, 1987)

Similarly, the media's portrayal of nursing affects the decisions of politicians and administrators relative to the profession. Decision makers who are consistently exposed to images that depict the nurse as merely an 'unintelligent handmaiden to the physician, more interested in sex than her profession' (Kalisch & Kalisch, 1987:187), will more than likely act on the basis of these perceptions. They will be much less inclined to pass legislation that gives nurses more autonomy in their practice, or to advance sufficient monies to promote the role of the nurse in health care (Kalisch & Kalisch, 1987).

Clark (1989) argues that without the public's recognition of the true nature of nursing and acceptance of the changes that have occurred and will continue to occur in nursing, it will be difficult for the discipline to reach its full potential. As she propounds, 'in particular the ability to attract (and retain) new members to the profession and to attract appropriate resource allocation, will be severely restricted' (p176). As it stands, it is society itself that ultimately sanctions the role/s of the nurse, thus it is crucial that the true value of nursing is made explicit. This is of particular concern in light of current fiscal exigencies, and the fact that job opportunities for women are increasing, meaning that nursing can no longer rely on women coming to the profession through lack of choice. By revealing what it is about the job that is attractive, nursing can sell nursing not only to all sections of the community but also to other health care workers. Lumby (1991b:18) agrees, and maintains that nursing images manipulated by the media must be challenged if nursing is to progress. Nurses must begin to 'sell' to the public the essential value of nursing.

However, as Clark (1989) goes on to suggest, the ability of nurses to market nursing on an equal

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Although, London (1987) would argue that for a number of reasons this situation is not necessarily an unfavourable one for nursing. She points out, that historically men have taken up a disproportionate number of positions of power in traditionally female occupations, and suggests that the effect of male nurses on the profession would probably 'not provide what nursing is looking for' (p80).

footing with other health workers does not only mean influencing policy makers, other health professionals and the general public concerning the need for nurses and nursing service, but also that nurses themselves, especially the neophytes, need to be convinced. In other words, nurses themselves need to believe themselves 'worthy of the status, independence and autonomy that characterize a professional ideology' (Pittman, 1985 cited Clark, 1989:180).

Negative mass-media images of nurses and nursing create problems not only with non-nurse perceptions of nursing, but also with the self image of the nurse herself. Although some nurses may not consciously recognise the impact of media depictions on their profession, on a subliminal level the effect is clear; so much so that large numbers of nurses admit they avoid exposure to media images because they find them painful to watch or read. In a sense there is a negative effect on the self-concept and aspirations of many nurses (Kalisch & Kalisch, 1987).

It can be seen that misconceptions about the nature and extent of nursing pose major difficulties for the profession. Perhaps one of the most significant problems is that this poor image affects the quantity and quality of persons who choose nursing as an occupation. A public constantly fed a demeaning, or at best, a misinformed image of nursing, is hardly likely to perceive nursing as a desirable profession. This is especially true for young people who are the main targets of commercial media (Kalisch & Kalisch, 1987). With the choices confronting school leavers (in particular women) today, why would they choose nursing? Clark (1989:175) is concerned and convinced of the need for nurses to act very quickly to improve their image. She postulates that:

> Nursing is an essential part of society. If it is to be responsive to and evolve from the society from which it grew, then, as with all professional groups, nursing must articulate and promote a positive public image.

An article published in the Sydney Morning Herald (Lewis, 19.9.94) on job prospects for university graduates reported that a shortage in specialist five-to-six year trained nurses had produced shortages elsewhere in the system, consequently, positions for graduands were readily available. At a time when employment prospects for young people were not terribly favourable this may have proved an incentive to students considering future careers. However, in 1995 when places at university were plentiful - nursing programs appeared to be the among the last courses to be filled (Delvecchio, Molotorisz & Scott, 9.2.95).

Clark (1989) advocates that because of these factors and in the context of marketing, the task ahead of nursing is to encourage others into believing that nursing is crucial to the survival of the organisation. 'Every nurse has a role to play in sensitising the lay and professional communities as to nursing's full capabilities' (p.180). While the slogan '*Nurses. We can't live without them*' clearly contains an element of truth to those in the 'know', for the layperson it may seem overstated. This is because as a rule, the general public perceive nursing as a job predominantly based on technical practices (Lumby, 1991b).

And yet, tertiary programs preparing nurses for practice are based on higher-order thinking and as such need to include knowledge pertaining to the role and function of nursing, and an education appropriate to that professional development. To date however, this necessity has been complicated by the fact that the precise nature of nursing has eluded definitive description (Meleis, 1991;Adams, 1983 cited D'Cruz & Bottorff, 1986;Benner, 1984;Lumby, 1991b;Street, 1992a). Nursing curricula based on the study of expert nursing however, may 'foster the development of a more professional identity, more confidence in nursing knowledge, more skill in practice and more commitment to nursing research' (Watson, 1982, cited D'Cruz & Bottorff, 1986:62).

-Fiscal Control-

The ever changing health-care environment necessitates that health-care settings concentrate on maintaining quality while controlling and balancing the cost of care. Organisations are looking to new ways of delivering health-care via systems that address quality patient outcomes, length of stay, and the use of resources (Weilitz & Potter, 1993:51). As a means for determining the relationship between hospital output and hospital costs the Diagnosis Related Group (DRG) system was introduced into American health-care institutions and is now well established. (Associated with DRGs are patient care maps[7] (Hampton, 1993:25)). DRGs use a system of

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According to Etheredge (cited Hampton, 1993:21), the essence of managed care is the 'organization of unit-based care so that specific patient outcomes can be achieved within fiscally responsible time frames (lengths of stay) while utilizing resources appropriate (in amount and sequence) to the specific case type and the individual patient'.

Because of the focus on the nurse, Hampton sees such frameworks having the potential to foster the advancement of the nursing profession. Others would argue however, that requiring the nursing of a patient to be provided within a predetermined time-frame and reducing care to a number of ticks in prescribed boxes, threatens nursing by deskilling and devaluing their work, and could be construed as promoting generic multi-functional health workers (Shadbolt, 1995).

coding and classifying according to the nature of the patient's illness (Reid, 1991). The DRG system is currently being implemented in Australia.

In North America, the continuing concern in regard to the quality of health care and rising costs has led to increased pressure to define what nurses do and the contribution they make to patient and family outcomes and cost of care (Naylor & Brooten, 1993). If the profession does not adequately clarify the role of the advanced practice nurse her work will not be adequately documented on managed care plans, critical pathways and similar formats for directing, controlling and measuring care, many of which are drawn up by non-nursing personnel. Because the need for nursing care is the primary reason patients are admitted to hospital, nursing costs are the largest component of hospital operating budgets. As a result, administrators direct their cost-containment efforts towards nursing service departments (Kyle and Kinder, 1990:Rizzuto, 1995). Therefore, the need to justify the cost, and thus existence of, experienced clinicians is mounting. And yet, a large percentage of a nurse's work is invisible, particularly that of the expert, and as such is unable to be costed.

In light of a rapidly changing medical-technologic environment with concomitant fiscal constraints, the profile of nursing is changing. Cheaper to employ, there is an increasing number of junior registered nurses, enrolled nurses, personal care assistants and even untrained personnel entering the system, so much so that the expert nurse is being squeezed out. As a result, the clinical career structure appears to be under threat.

Importance of the Study for Nursing

From all of these issues, it can be seen that the need for nurses to validate and describe their knowledge, arising as it does from the domain of nursing practice, is cogent. This is especially true of the practice of the experienced nurse. At this point in time, in New South Wales, 'specialty nursing vacancies are re-emerging as an issue' (KMPG Peat Marwick, 1995, abstract). A recent report entitled, *'Issues Relating to Specialty Nursing Vacancies -1995'* has been submitted to the NSW Department of Health. Prepared by a group of management consultants (KMPG Peat Marwick), it details a study conducted to identify issues affecting the supply of specialist nurses

across NSW. The study was undertaken by way of focus group interviews and comprised a mix of CNSs, CNCs, RNs and a smaller number of ENs and recently graduated RNs. The issues raised by the nurses and highlighted in this report are supported in many cases by the outcome/s of this study, discussed in chapter 10. Amongst the problems delineated by the specialist nurses in the focus groups in the KMPG study, was that they perceived 'little recognition of [their] clinical skills by management who do not appreciate the value [nurse] specialists add, nor the role they play, in maintaining patient care in an increasingly difficult environment' (p2).

In this study, the researcher believed that observing the practice of the CNSs and encouraging them to talk about their work would render their experiences recognisable. It was hoped that by illuminating the practice of a group of CNSs, the significance of their contribution to the ward would be brought into sharper focus. In exploring the immediate experience of CNSs this study has assisted in exposing the nature of nursing knowledge in order to extract meaning from it. That meaning has been crafted into a phenomenological text. This text has documented, communicated and thus preserved the lived experience of a group of advanced practice nurses designated CNSs, capturing their expertise as it appears out of the past and into the present for future reflection by nurses. In some way, it is also hoped that this text will assist in 'marketing' the 'worth' of the CNS. As van Manen (1995) propounds, to influence policy makers by getting to the core of the experience and laying it out for them to see. Kermode (1993) suggests that the power to escape the hegemony of dominant groups is being sought by nurses in the process of professionalization. In order to do so 'nurses must demonstrate the ability to define the problems which are uniquely the domain of nursing, and which the community will accept as uniquely the domain of nursing' (p107). This study offers a clearer delineation of the being (including the expertise embedded in that existence) of advanced practice nurses, and by problematising that existence has political power.

The study is based on the belief of the value of nursing knowledge as a basis for practice, and will contribute to the body of knowledge unique to the phenomena of nursing. Exploring the phenomenon CNS, raises the awareness of the clinicians regarding what it is about their practice that makes them special and how they make a difference to patient care. This in turn should foster in these and other CNSs an appreciation of the value in their work. The text clearly demonstrates there is more to the work of the CNS than a list of tasks. The text may be useful to guide the development of specialty nursing curricula in educational institutions. It may also

be a source of referral for the novice nurse seeking insight into the world she has chosen to enter as a career. Furthermore, the text draws attention to the voices of experienced and hence highly valuable nurses, who might otherwise have remained unheard (Sandelowski, 1994).

Conclusion and Overview of the Organisation of this Report

This chapter has provided an indication of certain factors influencing the advent of this study, not least of which has been the author's direct experience of advanced practice bedside nursing. Essentially the study was mounted as an 'expedition' to discover if the clinical reality for experienced nurses had changed from a decade ago, particularly in light of recent significant developments occurring both within and without of the discipline. The study was undertaken as a venture to capture the experience of these nurses, to illuminate the complexity of their world, to document it, and with State and Federal budgets in mind, to justify their existence.

In order to lay the foundation for this work, a number of key issues implicated in the construction of the social milieu in which nurses operate, have been articulated. Central to the problems encountered during the growth of nursing as a professional discipline, is the fact that it is primarily a woman's occupation, and the constraints imposed by this reality, including one of its image, have been referred to in this chapter and are revisited throughout the dissertation. In the present day, the implications for nursing of Federal labour economics based on post-Fordism which have seen a trend toward a 'fragmented, decentralised health service, finer grading of the division of labour in health care and greater specialisms' (Kenway & Watkins, 1994:9) are discussed. These features, stemming as they do from post-modernity, have heralded an era of 'restructuring' and 'repositioning' so that rationalisations (cost-cutting) can occur (Kenway & Watkins, 1994:11).

Because such events impact on the day-to-day existence of the CNS, they, together with certain events from the past, will be examined in this thesis. This will be undertaken within a process which sees the literature drawn upon in a dialogical manner from start to finish. As such, there is no chapter headed 'literature review'. Because 'she' is the focus of this work, the next chapter examines issues surrounding the creation of the Clinical Nurse Specialist role. In order to firmly 'ground' the CNS before proceeding on to an explanation of the research methodology, chapter three continues to explore pivotal issues in relation to her occupational origins and disciplinary

identity (Rafferty, 1995). Issues that include the historical, sociological and political dynamics, which over the years, have helped to fashion the discourses and practice of nursing into the form/s taken today.

Phenomenology, as the methodological key to immediate experience is encountered in chapter four. The literature alludes to a growing concern among nursing scholars of the need for caution in the use of interpretive approaches to nursing research. This has arisen because of a perception that nurses are undermining the value of nursing research by misconstruing or mixing methodologies. In order to articulate the conceptual frame of reference upon which the study was founded, chapter four provides a fairly in-depth account of the researcher's understanding of certain philosophical canons central to the use of a phenomenological approach.

Chapter five describes the processes undergone in preparation for the journey to the lived world of the CNS, and includes an explication of the 'methods' adopted to gather the qualitative 'data'. This chapter continues with a description of the researcher's own experience in the field because as will be shown, making contact with the researcher's own voice is a part of the dialectical nature of the philosophical constructs (to be clarified) underpinning the study. Chapter six draws attention to issues related to writing the phenomenological text. This text is the means through which the analysis/interpretation of this research is presented in chapters seven, eight and nine. In the final chapter, through a process of synopsis, reflection and revision, the significance of the meanings emanating from the phenomenological text are explored.

In conclusion, it should be said that this study investigates the experience of those nurses at grass roots level; the experienced nurses to whom it is believed the slogan *'Nurses. We can't live without them'* truly applies. Nurses who carry out the day-to-day bedside nursing; those at the coalface; in the frontline, the real 'common-or-garden' nurses. Those nurses who typically undervalue what they do, and have little insight into the important role they play. It is for these nurses, the stalwarts; the forgotten faces; the ones who stay behind, that this thesis, authenticating the reality of advanced practice, is written.

CHAPTER TWO

THE CLINICAL NURSE SPECIALIST

Introduction

The previous chapter concerned the purpose of the study, which to encapsulate, is to uncover the role of the CNS in order to elucidate and describe the meaning of her everyday life so that its value can be better appreciated. And, because 'the future of nursing has always been seen in its past' no discourse on clinical specialisation would be complete 'without a look at the history of the subject' (Menard, 1987:1). As such, the previous chapter and the chapter to follow provide material depicting a number of forces, past and current, which have shaped and (re)shaped the work and status of the bedside nurse of today.

This chapter continues to chart the focus and purpose of the study by exploring the development of the position that is CNS, and to this end it draws on the North American influence due to their greater experience in the development of clinical roles. The chapter provides an overview of the maturation of the career structure for clinical nurses within North America. It also raises the question of whether 'competencies' are credible indicators of real world performance.

The Australian Context From Which the CNS Evolved

The main influence on Australian nursing education and training has been the British model derived from Florence Nightingale. It was in fact a Nightingale appointee, Lucy Osborne, who arrived in Sydney in 1868 to take up her position as Lady Superintendent at the Sydney Infirmary, and began a model of training based on the Nightingale apprenticeship system which was to become firmly entrenched in Australia for the next hundred years. As previously noted, this model saw student nurses being responsible for providing most of the direct care in the hospitals while undertaking their training courses. This apprenticeship style of education suited hospitals and governments as it afforded a cheap and ready supply of labour (Russell, 1990;Creighton &Lopez, 1982).

Despite the longevity of the Nightingale system, the past ten to fifteen years have seen some major change and reform in nursing education in Australia. In 1984, the Federal Government passed legislation requiring all nurses to be educated in colleges of advanced education by the year 1993. The ensuing transfer of nurse education from hospitals to the tertiary sector was an historical achievement effected through an enduring political lobby on the part of major nursing organisations (Cochrane, 1989). In New South Wales (NSW) the Minister for Health described it as the greatest advance in nurse education in the history of nursing in Australia (Creighton & Lopez, 1982; D'Cruz & Bottorff, 1986). The move to the tertiary sector was designed to enhance the status and professionalism of nursing and to foster in students the development of skills such as the ability to think critically, to interpret, appreciate and to judge. Skills that had hitherto been undervalued, yet which were absolutely necessary if nurses were to reflectively examine current nursing care in order to bring it into line with changes in health-care practices (Creighton & Lopez, 1982; D'Cruz & Bottorff, 1986).

In NSW, this transfer to the colleges of advanced education took place in 1985 with the introduction of a Diploma in Applied Science (Nursing). Five years later saw the merger of all colleges of advanced education in Australia with universities. Shortly after this amalgamation the professional pre-registration program was upgraded to a three year degree leading to a Bachelor of Nursing.

The Clinical Career Formula which Created the Position CNS

For at least two decades, the development of clinical career structures[1] has received attention in overseas literature, and yet it was not until the late 1970s and early 1980s that Australian nurses began to pursue the development of such a concept (Silver, 1989). The impetus for a new structure became increasingly urgent as nurses began to recognise that promotion necessitated a move away from the bedside, while those who chose to remain in the clinical arena received no professional or financial recognition. In addition, losing experts from direct patient care, meant the nurses's clinical role was being eroded (Marsh, 1988). Anderson and Hicks (1986:36) sum up the concern felt at the time by many nurses who believed:

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Career structure has been defined as, a framework which enables nurses to gain career advancement and remuneration for demonstrated competence, experience and educational preparation in different roles within the discipline of nursing (Koch, 1990; Silver, 1989).

> That clinical practice was and is considered third rate among nurses and the profession in general is evidenced by the lack of career structure and financial remuneration available to clinical nurses. The profession, in a period characterized by rapid technical advances and a shortage of bedside nurses with the necessary skills to accommodate same, must acknowledge the need for a career structure which recognizes the true value of the professional clinical nurse.

It was believed that the introduction of a career structure would have a positive effect on nurses' job satisfaction, which in turn was expected to result in a decrease in turnover, absenteeism and vacancy rates. All of these factors would eventually lead to reduced orientation and recruitment costs (Koch, 1990).

In 1983, the Royal Australian Nurses Federation responded to the call of discontented nurses and formed a national committee to guide the development of clinical progression (Marsh, 1988). Unfortunately, as Silver (1989) points out, strategies for instigating clinical career ladders continued on a State rather than national level and as a result, diverging clinical career pathways appeared across Australia. As it turned out, by 1989, seven interpretations of the career structure had been developed as nurses' unions in each state and territory sought to introduce a framework that was acceptable to their respective members (Mascord, 1992). (In defence of this, it has been pointed out that amongst other things, the country's geographical situation mitigates against the orderly development of national strategies).

-The New South Wales Experience-

In NSW, in response to nursing staff shortages in acute care hospitals, a new clinical career structure for nurses was introduced in 1986. The nursing shortages which were endemic, applied particularly to specialised nurses, who it appeared, relinquished jobs in an institution after an average stay of about two years (Adams et al., 1990, cited Duffield, Donoghue, Pelletier, 1995a:14). Historically the career path for nurses working at the bedside had been in education or administration. There was no recognition or valuing of the nurse who had become an expert at the bedside. Alternatively, many nurses who became unfulfilled working in traditional health care settings left nursing altogether, and became successful utilising some of the skills acquired through nursing in other professional spheres. Needless to say the huge turnover of staff was an on-going problem. Finally, it was proving to be so costly it became the focus of government

interest and a formal career structure was posited as an avenue for retaining experienced clinicians. In its Report (1985a), the working party established to examine the plausibility of a clinical career structure in public hospitals, concluded:

> As the situation presently stands there is little or no incentive for nurses to study and gain experience necessary to become experts in a particular field and to fulfil the roles which the system is requiring of them. The lack of incentive exists because there is no formal recognition or reward for the job to be done. As a consequence, high level specialist skills acquired over the years through practice and/or formal study are often lost as nurses either leave nursing altogether or are promoted to the management or education fields. Clearly, it is in the best interests of the system to retain those skills and to reward them by promotion within a defined clinical structure (p7).

Because nursing positions and salaries in Australia are determined industrially through an arbitration process, a new industrial award was promulgated. In summarising his findings in consideration of the Award proposal, the Senior Commissioner adjudicating the case, observed:

> The evidence in this case has shown clearly that every significant development in the public hospital system in the last five years such as budget cuts, bed closures, Medicare changes, staff shortages, the AIDS patient, and the achievement of high standard accreditation have had direct, dramatic and adverse impact on the environment in which NSW public hospital nurses undertake their work (Marsh, 1986:92).

Consequently, the new classifications of clinical nurse specialist (CNS), clinical nurse consultant (CNC) and nursing unit manager (NUM) were introduced. Responsibility for managing the ward or unit was allocated to the NUM, with specialist clinical responsibility left to the CNC or CNS. Whereas the role of the CNC is more senior and incorporates institution-wide responsibilities, the CNS is based within a ward and is expected to carry out most of her duties in relation to that area alone, although on occasions she may receive calls on her expertise from other wards or units. She also has her own patient workload, and remains accountable to the NUM. A registered nurse is eligible for promotion to CNS providing she has either 12 months experience together with an appropriate post-registration qualification in her clinical area, or has four years post registration experience, three of which need to have been spent in the specialty (Duffield et al., 1995a; Dept.of Health, 1987).

Among other things, the CNS is expected to function as a clinical resource for the area and as such, is a source of expert nursing knowledge. Currently, there is no limitation on the number of nurses who can achieve the classification (NSW Health Dept.1989). In the case of a requested move from the area of specialty a CNS automatically reverts to RN; with a rate of pay commensurate with that level of nurse. A NSW Department of Health Circular (1987, no. 87/32) summarises the guidelines for consideration of CNS status and these are listed in Appendix A. While the idea of CNSs acquiring Master's degrees has been mooted, it has not been adopted. As Mascord (1992) points out, the sheer number of nurses on the rungs of the career ladder in Australia (more than 3000 in NSW alone) mitigates against sufficient full-time student places being available within the university system for post-graduate studies.

As it happens, the nomenclature of CNS has been widely adopted overseas, most significantly in the United States of America, Canada and Britain. Yet, interpretation of the role has varied quite markedly. Duffield et al. (1995a) point out, that despite the similarity of name, there is no comparable role to that of the CNS in NSW anywhere else in the world. For example, in the United States (US) and Britain, a CNS is most often someone who has an area rather than a line responsibility and who acts first and foremost as a consultant (Mascord, 1992).

The literature tracing the formation of the clinical career pathway in NSW is scarce and even fewer studies address the question of the role of CNS (Nahas,1989). Duffield, Pelletier & Donoghue (1995b) conducted a study recently that included seeking a profile of CNSs in NSW and determining their perceptions regarding CNS role competencies. The profile revealed that the majority of CNSs in this State are hospital trained and have undertaken a hospital conducted post-basic specialty certificate[2].

'The CNS role was established to retain nurses in the clinical area'. As a result, the criteria for awarding the title reflects the need for nurses to have knowledge and expertise in a particular clinical specialty (Duffield et al.,1995a:19). Nevertheless, in NSW there appears to be a broad

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In NSW (and in Australia), in the past, clinical education for nurses took place within hospital schools of nursing and post-registration certificate courses run by the same hospitals offered a range of clinical areas within which to specialize. Nowadays post-registration hospital courses are diminishing and postgraduate courses at tertiary level are taking their place.

range of roles evident in institutional job descriptions for the CNS: Mascord (1990) sets out some of the more common CNS competencies: resource person, consultant, change agent, team member, researcher, resource person, counsellor, co-ordinator, rehabilitator, teacher, assessor, planner, implementor and evaluator. As Duffield et al. (1995a) point out however, these roles represent a complex and varied set of expectations for a clinician who may only have 12 months experience in the clinical specialty. In addition to this, in the absence of the NUM, the CNS may find herself in-charge of the ward or unit.

As things stand, a large percentage of CNSs are not undertaking further study, and very few admit to professional affiliation through membership of appropriate nursing organisations. These factors led the authors to conclude therefore, that 'it may be that the expectations held for this practitioner are unrealistic considering the current educational preparation of the population' (Duffield et al. 1995b:14). And while they acknowledge that in the absence of a clinical career structure the system would again lose its best clinicians, they advocate that it is just possible the career structure might not have been effectively implemented within NSW. Also, their findings regarding role perception indicate conclusively that CNSs in NSW are unclear about their role. While the authors concede this may be due to the long history of a career path in nursing which led exclusively into management or education; they do question whether or not it may be a result of insufficient delineation of the role from the outset.

In the final analysis, Duffield et al. (1995a) maintain the current situation in NSW is one in which a new clinical role has been created with no definition of the functions to be undertaken. These authors argue that in order 'to enhance strategies and reduce role ambiguity, conflict and overload' there is an urgent need for a clear job description for the CNS (Morath, 1988 cited Duffield et al., 1995a:15). In light of the Senior Commissioner's remarks about the state of the health care system, including thinly stretched and pressured nursing resources with concomitant levels of stress, the responsibilities/duties appearing in circular 87/32 (Appendix A) appear rather a tall order for the average CNS. This is particularly so when one considers the role was established to 'retain nurses who could provide, not facilitate others to provide, clinical expertise at the bedside' (Duffield et al. 1995a:20).

To make matters worse, the development and subsequent implementation of the career structure appears to have been conducted in a fairly narrow time span. The task force was set up in 1985

and the career structure ratified by July 1986. In contrast, other Australian States appear to have considered their career structures at greater length. Certainly the South Australian and West Australian experiences have been more fully documented and subjected to much wider consultation culminating in a longer periods for the trialing and phasing-in of the structures (Silver, 1986a, 1986b; Sudano, 1986;Beaumont, Grimes & Sudano, 1986;Marsh, 1988;Attrill, 1988).

Duffield et al. (1995a:15) point out, that the health care system needs practitioners capable of applying their advanced preparation to practice and who can justify and defend the position's 'contribution to quality care and cost effectiveness'. Cost accountability is seen as a key issue and one that will ultimately affect the success of the CNS role (Tierney, Grant & Mazique, 1990, cited Duffield et al., 1995a:15). It has been suggested that wherever CNSs are positioned they must be seen to provide cost-effective, as well as high quality nursing care to patients and families. And yet, as Everson asserts (1981:16), 'in rapidly changing, highly complex health care settings this is an enormous goal to achieve'. Accountability for costs has been expedited in North America by the introduction of Diagnosis Related Groups (DRGs). Steele and Fenton (1988) forewarn of the American trend to transfer CNSs out of clinical practice roles into more administrative ones as a strategy to avoid costs.

(The KMPG 'Report on Issues Relating to Specialty Nursing Vacancies - 1995' has been referred to in the previous chapter. The results of this particular study are drawn upon in the concluding chapter of this thesis).

-The Experience of Other Australian States-

In South Australia (SA), the career ladder introduced in 1986 is based on a different model to that in NSW. CNSs in NSW are equivalent to Clinical Nurses (CNs) in SA, with a distinction being that CNs are accountable to the CNC and not the NUM, who is purely a manager (Silver, 1986a). The South Australian career structure has been based on the Royal Australian Nursing Federation (South Australian Branch) Model, which in turn, has been heavily influenced by the Dreyfus Model of Skill Acquisition as generalised to nursing by Benner (1984). The South Australian CN is described as an RN who has demonstrated competence in basic nursing practice and is developing skills in a specific area of practice and who would be defined as 'competent' using Benner's framework which moves from novice through to expert. The experience requirement

for the CN is three years. Unlike NSW, in SA there are also limitations on the number of CNs who can be promoted in any one ward. Koch (1990) reports on the trial and evaluation of the new clinical career structure in South Australia, and although she does refer to a number of constraints in the implementation of the trial, there were signs of an overall increase in job satisfaction among the CNs.

West Australia's career structure was implemented in 1987 and consists of a four stream, five-tiered structure. Level 1 is open to new graduates and continues through six salary increments on a yearly basis. Level II divides into four streams comprising Staff Development, Clinical Nursing, Management and Research. Within the clinical stream, Level 3 is designated CNS in recognition of the expert practitioner (Attrill, 1988). This position equates with assistant director of nursing in the old system and as such bears a level of authority. The position incorporates facets of advanced practice in terms of patient advocacy, liaison, clinical teaching, research, change agent and consultation. CNSs in this system are expected to concentrate on the promotion of improved standards of patient care and to act as role models (Marsh, 1988).

A recent article by Bull and Hart (1995), reports on the situation for CNSs in Queensland and makes the point that in Queensland, CNSs are the equivalent to the CNC in other States. In this case, the Queensland career pathway for the CNS would appear to resemble that of the American model. They describe the findings of a study to explore the perceptions of CNSs regarding their role and point to problems with role ambiguity, role overload and what they have called the 'paradox of power', wherein the expert power of the CNS was seen both positively and negatively by other nursing groups. These authors conclude that the role of the CNS in Queensland has been insufficiently defined, and advise that differing interpretations of the role are negatively impacting on the ability of the CNS to carry out his/her role effectively.

-The Overseas Experience-

Although, as Duffield et al. (1995a:14) have indicated; 'no clear American equivalent of the CNS exists in NSW', by all accounts, a discussion of the Australian CNS position should include comment on the context of overseas models and the extensive body of literature available, particularly from the United States. The CNS in the North American context is the most advanced nurse in the clinical pathway, not the case in NSW, hence the CNS in the United States

is more in line with the role of the CNC in this country. There is no doubt, considerable research effort has gone into evaluating the multiplicity of CNS models in America to prove their effectiveness and worth, and such a body of knowledge can be useful when considering the specialist clinical role in NSW (Duffield et al., 1995a).

In the United States, the concept of the advanced practitioner or CNS began to evolve much earlier than in Australia, most notably with the first clinical Master's programs emerging under Peplau in the 1940s, and later with Reiter (Menard, 1987). Storr (1988:265) writes:

> By the late 1960's and early 1970's it was becoming accepted that advancement within the profession should not always necessitate a move away from the bedside,. . . and definitions of the CNS role were becoming formalized both in Canada . . . and the United States.

The position is now well established. Nevertheless, judging from reports in the nursing literature, not without some problems. A number of articles propose that the role expectations for the CNS in the US even to this day, remain ill-defined. What is more there are problems concerning CNS role implementation and utilisation (Munro, 1995; Nuccio, Gunta, Riesch & Western, 1993; Fenton, 1992; Wolf, 1990; Tarsitano, Brophy, & Snyder, 1986; Calkin, 1984; Everson, 1981). Kohnke (1978 cited Silver, 1986a:46) in regard to the American experience, writes:

> The nursing profession has failed the clinical nurse specialist miserably by offering little or no assistance in defining her role. . .The role of the professional was not planned for and in most institutions, they tried to fit her into what should have been a professional role, mixed in supervision, then added the requirement of a master's degree.

Everson (1981) suggests that the difficulties surrounding the role and function of the North American CNS may be due to the diversity of roles assumed by these nurses in health care settings. For instance, in one institution, a CNS may primarily be involved in education, at another as a consultant, and yet another as a researcher or administrator. Steele & Fenton (1988) cite studies by Edlund & Hodges (1983) and Wallace & Corey (1983), which show increasing numbers of CNSs are being moved out of clinical roles into administrative positions as a result of cost cutting and effectiveness decisions. Benner (1987) argues against this, insisting that expert nurse clinicians make life saving differences to patients, and should be kept at the bedside.

Essentially however, the CNS in America is an advanced practitioner who works in a specialty area in acute care inpatient institutions. She or he has a Master's degree in nursing together with a specialty in the nursing care of the patients and their families who fall under the umbrella of that specialty (Nuccio et al., 1993). A more formal definition proposed by the American Nurses Association in 1980, described the CNS as a nurse who: 'through study and supervised clinical practice at the graduate level (Master's or doctorate) had become expert in a defined area of knowledge and practice in a selected clinical area of nursing' (Hamric & Spross, 1989; Sparacino, 1990 cited Duffield, et al. 1995a:14). The four traditional functions of the CNS in the United States are 1) patient care 2) teaching 3) consultation and 4) scholarship/research. It has been recognised that they also perform the role of change agent, patient and staff advocate, as well as being seen as administrators of nurse managed practices or settings (Nuccio et al. 1993; Girard, 1987).

CNSs in the United States are classified as advanced practitioners who are seen to be different from the expert practitioner as described by Benner (Sparacino, 1992; Duffield et al., 1995a). The advanced practice concept is due to the possession of higher educational qualifications. In 1984, Calkin developed a model to differentiate the nursing practice of Master's prepared CNSs from that of other nurses. According to her, advanced practice is the 'deliberative diagnosis and treatment of a full range of human responses to actual or potential health problems' (p27). Everson (1981) alludes to a lack of acceptance of CNSs by nurses at other levels. Storr (1988) suggests this is because nurses tend to see nurses who have a lot of clinical experience, but with lesser educational experience, as the real 'experts'.

Calkin (1984:26) points out that nurses who accrue expertise by longevity at the bedside are 'experts by experience' and earn their reputation by having 'greater or more rapid intervention skills than their colleagues'. On the other hand, she espouses, the advanced practice nurse assesses and intervenes using a process of formal education and socialisation gleaned from their pre-employment preparation more frequently than practical or technical nurses, and should therefore be considered as having advanced knowledge and skills. Nevertheless Davies and Eng (1995) are still of the opinion that advanced nursing practice should be defined according to the domains of expert nursing practice described by Benner (1984). Certainly the role of the CNS in NSW is significantly different to that in the US and more closely resembles the expert practitioner, especially as experience rather than academic qualifications is a significant factor

in their appointment (Duffield, et al.1995a).

In Canada, the CNS role was implemented in 1960, and CNSs are required to have 5-10 years post-graduate experience in a specific field of nursing (King, 1986). Reiter's (1973, cited Davies & Eng, 1995) definition of the nurse clinician still serves as a framework for contemporary role development. In Canada a CNS is therefore:

> A specialist with advanced knowledge and expertise in clinical practice, capable of demonstrating a high degree of judgment and competence for providing nursing care in a specialized clinical area (Reiter, 1973, cited Davies & Eng, 1995:23).

However, as Davies and Eng (1995) point out, the original conceptualizations of the role perceived it purely as a clinical one without administrative duties. Yet, in Canada's current economic climate it is becoming apparent that administrative responsibilities are being added to the CNS role in an attempt to justify the position.

Because of confusion about the essential clinical practice skills necessary for this advanced role, a number of studies spanning several years have been carried out in the area. Naylor & Brooten (1993) conducted an extensive literature review on studies that have focused on the role and function of the CNS in the United States. Four research topics were identified as having emerged over the past few decades. These include i) the perceptions of the role; ii) CNS's time allocation; iii) effects of the CNS on patient and family outcomes and cost of care and, iv) the functions of the CNS. Many of these studies have been based on objective quantitative modes of data collection and analysis (For example, McGee, Powell, Broadwell & Clark, 1987; Taristano, Brophy, Snyder, 1986).

Nuccio et al. (1993) report on an empirical study to determine the perception of staff nurses regarding functions important to the CNS role. The role expectations that were identified included the four traditional elements, (those of clinical work, research, education and consultation), in addition to other factors such as the ability to apply the nursing process in complex cases, maintaining visibility and establishing credibility, certain leadership functions, facilitation and dissemination of research activities and participation in clinical leadership activities versus management activities. McGee et al. (1987) found caring, commitment and

professionalism ranked the highest in their study of CNSs in the oncology field. Despite prolific literature in the area, Davies & Eng (1995:28) believe many studies both quantitative and qualitative have difficulty getting at the essence of what the CNS really does, and propound:.

> The functional components are inherent in promoting professional nursing practice, but alone, the components do not describe the broader concept. They are the parts that make up the whole, but advanced practice is greater than the sum of those parts.

Davies & Eng (1995) conducted a study that highlights what has consistently been reported in the literature; a lack of clarity surrounding the CNS role. This is believed to be an impediment to the implementation of advanced nursing practice. The authors firmly believe that to 'document their actions is vital to the survival of the CNS role and to the evolving definition of advanced practice nursing' (p28). They concede that contributing to the difficulties in defining the CNS role might well be the numerous definitions of areas of specialisation. It became evident there was a great range in the areas of specialisation defined by the respondents in their study (Davies and Eng, 1995).

Traditionally, the career pathway for nurses wherever they have been working required longevity, loyalty and expert clinical skills. Nowadays, the North American experience has shown that many hospitals are insisting on Master's degrees, business skills and experience in areas other than nursing, particularly for promotion in managerial areas. This has resulted in job descriptions and their accompanying criteria rapidly changing, making career planning problematic (Wintz, 1987). It is suggested that this situation will become the reality in Australia some time in the future, if this is the case, then now is the time to learn from the North American experience.

Clinical Nurse Specialists as Expert Clinicians

In North America the advanced practice nurse is seen to be different to the expert practitioner, mainly on account of her Master's degree preparation which gives the advanced practitioner greater theoretical knowledge than the expert practitioner, who will initially have superior practical skills. In NSW, because the CNS is not expected to be educated to the level of a Master's degree, the terms 'advanced practice' and 'expert' can be used interchangeably. Advanced practice nursing, has been described as that which is 'more developed, and presumably better,

than ordinary practice' (Pearson, 1984:16). Koch (1990), writing of the South Australian experience, points out that it is assumed the advanced clinical nurse will provide better nursing care than the more junior registered nurse and because the career structure is modelled on Benner's (1984) stages of skill acquisition, an advanced practice nurse is deemed to be at least at the 'competent' stage. In NSW, Benner's descriptors are not formally applied to the position of CNS. As Duffield et al. (1995a) make clear, in NSW the title CNS is awarded to an individual who has fulfilled certain criteria, hence there is no determining on a scale such as that of Benner's as to their practical expertise. It is assumed by their eligibility to advance to the position, that they are specialists who have undergone advanced preparation in one form or another (that is, longevity at the bedside, or post graduate education or both).

Although the CNS role as it is known in NSW cannot fully be compared to the role overseas - nor indeed anywhere else in Australia, it is suggested that it can be linked through expert practice. In this study the CNS participants were all unquestionably practising at an advanced level, and the phenomenological text clearly exposes the expert in that practice (in terms of Benner's criteria). (A fuller expose of Benner's Model of Skills Acquisition and of expert practice is provided in the following chapter under the heading 'Clinical Knowing').

The Competency Movement in Nursing

-The Australasian Nurse Registering Authorities Conference (ANRAC) Competencies-

Shortly after the move of nurse education to the tertiary sector in NSW and the foreshadowing of similar moves for the remainder of the country, the Nurse Registering Authorities in each State and Territory began to acknowledge that changes in the educational preparation of nurses might well produce a different practitioner (Gray, 1991). Moreover, significant alterations to the licensing system had seen the separate register for nurses abolished (that is the registers for mental health, developmental disability, and general nursing). In NSW, graduates became eligible for employment in a variety of health-care settings based on one educational program. It was believed therefore, that the beginning practitioner (graduand) should be capable of competent practice across a number of practice settings, and that specialised expertise in any area would be at an advanced level following a post-registration course (Cameron, 1989). In order to ensure graduates were capable of such beginning level practice and most importantly that the public remained protected, the Australasian Nurse Registering Authorities perceived a need for

graduates to meet a set of required standards (Gray, 1991). In 1986, it was decided therefore that the development of a national statement of competencies for beginning registered nurses was required.

To that end, the Australian Nurse Registering Authorities set up a committee, the task of which was to develop minimal lists of competencies applicable to beginning registered nurses throughout Australia (Butler, 1990). The competencies developed by the team, following wide-spread consultation, were approved in principle in 1988 and became subject to refinement and validation in the years to follow. This work is on-going. The intention of ANRAC was for the complete set of competencies to constitute the essential core for a beginning registered nurse in a variety of clinical settings. The definition of 'competence' accepted for the purpose of the study was: 'the ability of a person to fulfil the nursing role effectively and/or expertly' (ANRAC/NCAP, 1990a:22).

The Nursing Competencies Assessment Project (NCAP) team were commissioned to validate the ANRAC competencies and utilised an approach which included a literature review; observational studies and document analysis. They set about validating the competencies on newly registered nurses in acute care settings (ANRAC/NCAP, 1990a).

NCAP expanded in the idea of competence and saw it as an:

> Inner, highly differentiated characteristic of a person which is applicable to the very demanding and very specific context of nursing. It is an ability that effectively encompasses the entire demands of the nursing role; and therefore nursing competence itself possesses a complexity that increases with experience and as responsibilities become more intricate (ANRAC/NCAP, 1990a:22).

NCAP believed that the construct 'nursing competence' was too broad and too complex to be useful as it stood, and was therefore always analysed into any number of individual nursing competencies. 'These competencies are defined as personal attributes which when taken as a whole, result in effective and/or superior performance'. Personal attributes included specialised knowledge, cognitive skills, technical skills, interpersonal skills, traits (for example, personal energy levels, and certain personality types) and finally, attitudes that elicit desirable behaviour patterns (p22). NCAP believed competencies to be more than just acquiring skills, and in turn

skills were more than psychomotor attributes. Skills consist of intellectual, interactive components and competencies integrate skills, knowledge, values and attitudes. Grussing (1984:119) states; 'one should not view competence as a visible trait, but instead, as a multi-faceted network of knowledge, attitudes, skills and real world performance that relate to each other logically'. Furthermore NCAP advocate:

> Nursing competencies are holistic entities which interact with one another in a manner determined by the nursing context. The constituents of nursing competence are not found in the nurse alone, but in the relationships that exist among the nurse, the client and the situation at any given time or place (Report to ANRAC/NCAP, 1990a:22).

Since validation and ratification in 1990, the ANRAC competencies have been seen as a 'milestone for entry to practice' reflecting as they do the standard of the profession at that level (Cameron, 1989). In addition, they have been a means of bringing together the Nurse Registering Authorities from all of the States culminating in the establishment in 1992 of the Australian Nursing Council based in Canberra (Percival, 1992a). The final Registered Nurse competencies list consisted of 75 statements about competence grouped as 18 global competencies, and are seen as a set of minimum outcomes which nursing graduates should have attained prior to registration (Percival, 1992b:1). Although prepared by a group of expert Australian nurses, the competencies are clearly influenced by the work of Benner (Gonczi, Hager & Oliver, 1990).

Since the advent of the ANRAC competencies separate consideration is being given to develop 'higher order competencies' for the specialist nurse (Heywood, Gonczi & Hager, 1992). A number of Australian nurse specialty groups have been in the process of consultation for the development of specific criteria to evaluate advanced practitioners, including the Association of Clinical Nurse Specialists. Speaking from a North American perspective, which could well encompass the situation for nurses in this country, Menard (1987:6) poses the question, 'what does the future hold for clinical nurse specialisation?' Menard believes that in these difficult economic times the pressure is on the CNS to concretely show her cost-effectiveness and maintain high levels of education and experience. Girard, (1987:12) goes so far as to state, 'the CNS today may carry the responsibility for the success and even the actual existence of future specialists'.

In Australia, tertiary programs to prepare nurses to function as clinical specialists are on the increase. And yet as Duffield et al. (1995b) argue, those questions surrounding exactly what education is required to prepare expert clinical nurses in the Australian context remain unanswered and need to be explored.

Sudano (1987) describes the debate in relation to 'generalist' versus 'specialist' nursing practice as a complex one. On the one hand, graduates are undergoing generalist programs preparing them for practice in a variety of health care settings, while on the other, pressure for nurses to specialise is being exerted by on-going medical specialisation, super-specialisation and the rapid rise in technological applications in health care institutions. Sudano (1987:40) cites Slater (1986), who says, 'the nursing profession in Australia has not yet made any definitive statement about what constitutes a nursing practice specialty' and goes on to specify:

> Defining nursing specialties on the basis of medical specialties, or the organization of services in a particular institution is inappropriate. It appears that much of the knowledge and many of the skills required by nurses are common to practice in any health care setting. Certainly the process of nursing is the same (p40).

Sudano concludes that it is timely for nurses to consider these issues if the profession is to provide quality health care. Pratt, (1994) reports that specialisation in Australia is going ahead and is already represented by an increasing array of clinical specialty organisations. She points to the existence of the Australian Nursing Federation's generic standards and of national competencies for entry to practice, together with the establishment of the Australian Nursing Council, as auguring well for 'the development of competency standards for specialty practice' (p12).

Coinciding with the move by the nursing profession to ensure an acceptable level of skill from new graduates within the workforce, has been a drive on a national level to ensure similar outcomes in all occupations. Acting for different reasons however, the Government is seeking to reform education and training by introducing the concept of competencies and competency-based standards. These moves are the result of a common view that structuring an economy to make Australia internationally competitive in the next century will not be possible without the extensive overhaul of vocational education and training foundations (NTB, 1992). Proponents

of competency-based education and training (CBET) claim that under the new scheme workers will have broader, more portable skills; will be able to adapt to new technologies and have the capacity for on-going skill formation (NTB 1992). Opposition to CBET, especially in the tertiary sector has been widespread.

In nursing, the competency movement has been widely embraced and the profession is well on the way to developing a set of national competency standards for the registered nurse. The notion of competencies has also become 'a powerful driving force in nursing education' (Walker, 1995:91). Nevertheless, the adoption of professional competencies by nursing has not been without criticism. While, Cheek, Gibson & Rudge (1995) adopt a stance that considers the issue from both sides, Maynard (1994) taking a logical-positivistic stance, raises questions regarding the validity of the NCAP research approach used to determine the competencies. Walker (1995:91), espousing a different worldview, proffers a philosophically based critique of the ANRAC competencies. He believes that by 'courting competency' uncritically, nursing is at risk of 'being colonized by powerful "Others", such as government bodies and registering authorities'. In addition, he points to the focus of competencies on outcome at the expense of process. He writes: 'By eclipsing [such] sophisticated and complex processes we diminish the 'real' work of nursing practice. . . '. Walker further critiques the ANRAC competencies by virtue of the method utilised to determine them. He states the reliance on the 'seeing eye' by the NCAP team observing the nurses at work, set up a 'politics of distance' in which the 'knowing subject' constructed knowledge about an 'object to be known' in 'very limited and limiting ways' (p94). Walker is further convinced an 'unhealthy form of positivism came to expression' in formulating the ANRAC competencies which is apparent in the language encapsulating their genesis. Walker suggests the ANRAC project 'diminishes the complexity and diversity of practice, of practice performance and the 'settings' in which it occurs (p96).

While it could be said that competencies give grounding to what nurses 'do', it could also be said that competencies are problematic because they are devoid of any reference to the social context in which the performance takes place (neither for that matter a list of functions: see page one of this thesis). 'Stripped of its social context the list of competencies ignores, amongst others, such competencies as being able to recognise and negotiate class divisions and hierarchies within workplaces such as hospitals' (Kenway & Watkins, 1994:33). Taken-for-granted issues are not encapsulated within competencies, and yet very often such issues carry with them factors relating

to ideology and social control. These concerns however, if they are acknowledged, tend to be 'swept aside and marginalised as peripheral concerns' (Kenway & Watkins, 1994:34). It has been posited that the competency movement is about 'measuring, testing and monitoring performances in the workplace' not, as it purports to be, about educative improvement and change (Collins, 1993 cited Kenway & Watkins, 1994:34). Also, the models to determine competencies fail to portray the 'invisible' aspects of a nurse's practice. Aspects, which for the expert comprise a great deal of her work. The 'more than that' of nursing; the immeasurable aspects of her caring which truly make the difference for the patient. For nursing then, the crucial questions become - do competencies get to the essence of nursing practice? Moreover:

> Is the current competency agenda for nurses up to the challenges which face nurses in the post-modern age or is it a technology of the past rooted in systems of control which nurses have been subjected to and trying to escape from for years? (Kenway & Watkins, 1994:45).

In answer to the first question, it could be said that the phenomenological text (chapters seven, eight and nine) describing the lifeworld of the CNS in this study, clearly unveils the social reality in which she works. By comparison, the list of tasks regarding her role (page one) barely even hints at real-world practice. In effect, it is disembodied - lacking richness and depth. It is doubtful that a list of specialist or advanced competencies (when they become available) would fair much better. The answer to the second remains open for nursing's continued deliberation.

Conclusion

As she is the key to the phenomenon to be addressed in the pages to follow, this chapter has drawn a profile of the CNS. It has provided a framework for understanding the impetus behind the recent changes in the career structure for nurses in NSW. Thus, historical issues leading up to the formation of the role have been examined. In addition, situating her within the wider arena of Australia and the rest of the world, especially North America, has accorded a more complete picture of the position in NSW. Although there is abundant literature on the CNS in North America, because of the comparatively recent inception of the clinical career ladder in this country, by comparison, there is very little. As discussed, the CNS role in this State does not resemble that of a CNS anywhere else, but her practice can be reconciled by virtue of it being that of an 'expert'. Few research studies have been carried out in terms of evaluating her role in

this State. It has been postulated however, that the role of the CNS in NSW has not been clearly defined and that, amongst other problems, there is role ambiguity and overload.

The issue of CNSs as expert practitioners is acknowledged in this chapter, and will be clarified to a greater extent in the one following. Finally, the discourse has turned to the current push for competency statements and considered some of the implications for nursing in adopting this particular doctrine, especially as it will eventually affect the bedside specialist, who will ultimately have her role defined for her in terms of a finite 'list' of undertakings. The next chapter explores in greater depth past social and political forces implicated in setting the agenda for the nurses of today. This background material carries through to the methodological discursive in chapter four.

CHAPTER THREE

NURSING'S WORK AND WORTH

Introduction

This chapter builds on the groundwork laid in preceding chapters relating to the changing profile of nursing, and places nursing within a sociopolitical context up to and including its encounter with the 'economic and cultural logics of post-modernity' (Kenway & Watkins, 1994:44). Specifically, the chapter examines certain theoretical developments that have structured and informed the nursing practice of the CNS. It clarifies the foundations of 'knowledge' in the nursing tradition, and defines some of the problems facing nurses in their pursuit of professionalism. Because nurses' 'ways of knowing' are linked to the socialisation of nurses, this discourse offers a clearer delineation of issues surrounding the ideology and social control of nurses.

Nursing Epistemology - Nurses as Knowers

Epistemology is described as the: 'philosophical theory of knowledge, which seeks to define it, distinguish its principal varieties, identify its sources, and establish its limits' (Bullock, Stallybrass & Trombley, 1988:279). As a practice discipline and profession, described as both a science and an 'art', articulating nursing's epistemological bases has not been an easy task (Schultz & Meleis, 1988). As it stands, the progress and development of theoretical nursing has been marked by several milestones (Meleis, 1991), each of which has evolved 'through a process of replacing one epistemological basis with another' (Retsas, 1994:20). According to Chinn and Jacobs (1987:cited Marriner-Tomey 1994:3), knowledge is 'an awareness or perception of reality acquired through learning or investigation'. And while the process of knowing is a 'common and fundamental human activity. . . processes for knowing have also been structured, formalized and systematized' (Chinn & Jacobs, 1987:2). Influencing the process of knowledge development in nursing has been the popularity of particular ideologies, together with pervading social, economic, and political factors (Marriner-Tomey, 1994).

When considering the question of nurses as knowers, it is impossible to disregard the predominance of women in the profession. Because the male model of knowing has been assumed to be *the* human model, the ways of knowing based on a male world view have been regarded as the only ones having substance (Doering, 1992). This has led past generations into believing that only male ways of knowing, that is knowledge emanating from the natural sciences or logical-positivist science, were acceptable.

This logical-positivist or empiricist concept of science, which stems from the 1920s and 30s, views the world as dichotomous due to a mind/world split. Such a view states that the knower (subject) is quite independent of the known (object). Positivist discourse is based on explanation and considers that knowledge is always deduced from general laws applied through stages of an 'accepted' scientific method.

This positivist view of scientific knowledge has enjoyed a privileged status almost entirely dominating twentieth century scientific thinking (Wolfer, 1993; Doering, 1992; Benner & Wrubel, 1989; Rowan & Reason, 1981; Giddens, 1976). And, it is fair to say, that the belief of medicine in the value of positivism to the exclusion of other types of knowledge, has had far reaching implications for nursing. The goals and values of the medical model based as they are on the concept of cure have been imbibed by the nursing profession (Altshul, 1972; Towell, 1975 cited Kitson, 1986). Thus, nursing has been subjected to the notion that abstract knowing is the highest and most desirable form of knowledge compared to skilled activity, which has been considered the least desirable and not valid (Street, 1990; Benner & Wrubel, 1989; Muff, 1982). Bernstein (1978 cited Street, 1990:4) says the practical implications of this approach is an accumulation of empirical knowledge that has widened the gap between those who 'think' and those who 'do'.

Nurses' beliefs about the nature of truth in nursing have been heavily influenced by the profession's long cultural history inextricably linked as it has been with medicine whose members have sought to control and curtail it. This has meant that in order to understand, describe and explain nursing, nurses have, in the main, demonstrated a preoccupation with the hypothetico-deductive approach to theory development convinced that the only valid and reliable knowledge was that which was 'scientifically' proven, as in medicine. As Parker (1990:39) has pointed out, nursing's search for nursing knowledge has been 'conducted not

only within social, moral, and professional uncertainty, but has also been greatly influenced, as other disciplines have, by the old worldview'.

Nightingale herself (Skeet, 1980), believed the responsibilities of nurses were different to those of medicine and that the knowledge developed and used by nurses was and should remain quite distinct from medical knowledge. And yet, beyond Nightingale for many years nursing was seen merely as a technical art to assist the doctor. This art emphasised principles and procedures intermingled with a spirit of unselfish devotion to duty (Chinn & Kramer, 1991). Nurses exhibited 'blind obedience' to medical authority and believed in the biomedical model as the theory of choice for nursing practice (Kidd and Morrison, 1988:222). This period in nursings' epistemological development has been referred to as 'silent nursing knowledge'[1], and was characterised by the 'gut' level rather than abstract knowledge of voiceless women (Kidd & Morrison, 1988; Retsas, 1994). Nightingale highlighted the ineffectual nature (on the medical profession) of the knowledge of these nurses, when she said:

> I have often seen really good nurses distressed, because they could not impress the doctor with the real danger of their patient; and quite provoked because the patient would look, either 'so much better' or so much worse than he really is, when the doctor was there (Nightingale in Skeet, 1980:96)

It was not until the 1950s, when nurse training in North America began to shift from an apprenticeship-style model to university-based educational programs that academic nurses began formulating a science of nursing itself, and as such, nursing science is relatively new.

Meleis (1991:138), discussing different processes of knowing addresses the five types of knowers identified by feminist writers Belenky, Clinchy, Goldberger & Tarule, (1986) which both she and Schultz (1988) (in addition to Kidd & Morrison, 1988) believe can be found in nurses. Belenky et al. (1986) originally identified these as women's ways of knowing while the above nurse scholars have applied them to nurses. Drawing from both sources, women and nurses, they are discussed as follows: a) silent knowers - those nurses who tend to accept voices of authority and remain silent with the result that their work, insights and wisdom remain invisible. b) received knowers - nurses who believe others are capable of producing knowledge which they can then follow and reproduce. These nurses depend on, and value the expert knowledge of others. c) subjective knowers - depend on their personal experience. Believing and depending on their own inner voices and inner feelings, these knowers have knowledge which is intuited. 'Something experienced, not thought out, something felt rather than actively pursued or constructed' (Belenky, Clinchy, Goldberger & Tarule, 1986:69). This is the knowledge Carper (1978) calls personal knowledge and Benner (1984) expert knowledge. d) Procedural knowers are dependent on careful observations and procedures. As rationalists they communicate the procedures, rules and regulations within a given situation. e) Constructed knowers - integrate all the differing ways of knowing and the different voices. For them, 'all knowledge is constructed, and the knower is an intimate part of the known' (Belenky et al. 1986:137).

Kitson (1993) points out the majority of theorists during this time attempted to define the concept of nursing and operationalise it through a particular theory, while Meleis (1991) has analysed the developments in nursing theory during the period spanning the 1950s to the early 1990s, identifying three major schools of thought comprising needs theory; interaction theories and outcome or holistic theories.

The early nursing scholars embraced traditional empiric methods from a wide range of disciplines to study areas of nursing (Chinn, 1994). As a result, this period has been referred to as a time of 'received knowledge' in which a 'borrowed view' was gleaned through listening to others (Schultz & Meleis, 1988; Kidd & Morrison, 1988; Retsas, 1994). Meleis (1991), differentiates the traditional scientific view (the received view) of knowledge with that of the perceived view, where knowledge is based on experience and incorporates ideas that are subjective. During this stage of knowledge development, notable pioneers included Henderson (1966), Abdellah (1969), and Orem (1971) (refer also Meleis, 1991; Marriner-Tomey, 1994) who attempted to define nursing and operationalise knowledge of nursing through a needs-based approach drawn from the theories of Maslow and Erickson (Kitson, 1993). In 1952 Peplau began developing the first theory for the practice of nursing. Her theory was seen to bridge the gap between the early needs-based theories and the interactionist theories that were to follow (Marriner-Tomey, 1994). Theories that rested on 'borrowed knowledge', were problematic however, not only because they derived from disciplines external to nursing, but also because the theories were drawn from nurses' assumptions about nursing rather than based on practice (Retsas, 1994).

-Changing Views-

From the 1950s and during the 60s, many nurses began to ask fundamental questions *vis-a-vis* the nature of nursing. Philosophical debates on whether nursing science was a basic science, applied science, or practical science were waged, and have continued to wage in the literature (as it has in many disciplines). Despite the lingering influence of scientism, reductive logical positivism couched in aspects of reality which views body, mind and spirit as distinct entities seemed inappropriate to those nurse scholars who saw nurses working with the sick constantly reminded that human beings are embodied beings (Chinn & Kramer, 1991). The widespread acceptance of Cartesian assumptions in regard to issues of health and illness has

resulted in an understanding of the body as an object of medical scrutiny and technical intervention, and of health as the absence of disease (Parker, 1991). It was becoming clear that this approach excluded knowledge of the patient as a human being, thus the social potential of knowledge became reduced to the 'power of technical manipulation' (Short et al., 1993:98). Philosophies of knowledge rooted in paradigms other than that of the dominant empirical-analytical one, came increasingly under consideration.

The interactionist theories of Orlando (1961), Travelbee (1966), Wiedenbach (1964), and King (1981) (refer Marriner-Tomey, 1994) began to appear from the middle of the twentieth century, originating from philosophical challenges to the positivist position. These theories considered alternative ways of knowing that offered a basis for a new perspective of science. Interaction theories concentrated on the process of nursing, how nurses 'do' what they do. A major emphasis concerned the impact of the nurse on the experiences of the patient (Kitson, 1993; Retsas, 1994). Whereas scientism views 'truth' as existing apart from or outside the person who 'knows', emergent views of how knowledge is acquired, recognised a 'fundamental unity' between the person who knows and what is known (Bleich, 1978 cited Chinn & Jacobs, 1987:3). Further, the person who perceives reality was recognised as an active participant in 'creating' what is known (discussed more fully in the section 'the social construction of reality'). This perspective assumed that knowledge is created by people, and not objectively discovered as an 'out there' reality. The emphasis focused on making sense of the world in terms of the essentials of the present and of the future, on resolving the splits and contradictions that traditional 'objective' methods could not resolve, and on seeking provisional understandings rather than absolute 'truth' (Chinn, 1985 cited Chinn & Kramer, 1991). Kitson (1993:35) points to the nursing skills deemed essential to be developed at the time:

> Sensitivity, perception, validation of the patient's experiences, being totally present for the other person, using intuition and subjective feelings to elucidate problems or situations that needed to be explored.

This stage in the development of nursing knowledge has been compared to that of Belenky et al.'s (1986) 'subjective knowledge', that is, the quest for self and the inner voice (Schultz & Meleis, 1988). Kidd and Morrison (1988:222) point out that, 'in this stage, authority was internalized, a new sense of self emerged, and negative attitudes toward borrowed theories

and science emerged'. Concepts such as encounters, lifeworlds and meanings became the focus for investigation; and these were to be explicated through analysis, interpretation and communication.

The 'final wave' of nursing theories began to emerge in the late 1960s and early 1970s, and to a certain extent, offset the 'relative liberation' of the interactionist theories (Kitson, 1993:36). These were the outcome or holistic theories in nursing including Roy's Adaptation Model (1976), and Johnson's (1980), Rogers's (1980) and Levine's (1969) models (see Marriner-Tomey, 1994). Some of these nurses comprised the grand theorists who developed conceptual models around aspects of human beings, their environment and health. All saw the nurse as more controlling and manipulative in determining patient outcomes, and focused on extra-sensory exploration of persons and the environment (Kitson, 1993). These theories prompted nurse scholars to discover scientific approaches and empirical methods that could be used to investigate holistic phenomena (Chinn & Jacobs, 1987). At about that time, Paterson & Zderad (1976), began to formulate a humanistic method of nursing which they based on a mixture of existential and phenomenological concepts, and eventually called nursology (O'Connor, 1993).

During the early and mid-80s the intensity of nursing's challenge to the medical model, with its pervasive and limiting influence over methods of study related to nursing and nursing work, increased. Methods of scholarship reflecting a very different worldview began to be readily available for nurses, as the old paradigms of knowledge began to be questioned by the new (Chinn, 1994). Prompted along by emerging feminist discourses and the works of post-structuralists such as Foucault, the challenge was mounted in terms of the construction of knowledges and concomitant power. Consequently, differing ways of knowing in nursing were being described (Doering, 1992; Lawler, 1991). This ontological and epistemological refocussing ensured nurse scholars were keeping conceptually consistent with the postmodern shifts being made by researchers across many disciplines (Watson, 1994). Kikuchi & Simmons (1992:5) attest to the fact that the scope of science as traditionally understood has been stretched.

Expanding on this notion they point out that:

> Previously limited to public, objectively verifiable knowledge, science has been expanded to include, among other things, private knowledge, subjective opinion, and descriptions of lived experience, all of which lie beyond objective verifiability.

In the late 1980s and 1990s, the philosophy of humanistic nursing resurfaced. O'Connor (1993) asserts that integral to the thoughts of such theorists is that nursing is a way of knowing, being and doing. Henderson, Abdellah, Hall, Watson and Benner are all regarded as humanistic nurses who see nursing as an art and a science. Benner is well known for her work in the domain of nursing practice and more recently a phenomenological account of caring (Benner & Wrubel, 1989). Parse (1987) focuses on humanism and drew from the work of Martha Rogers and existential phenomenological tenets and concepts in her theory of nursing. This fourth stage of theory development has been characterised by a proliferation of approaches to theory development with a major emphasis on the procedures used to acquire knowledge (Kidd & Morrison, 1988). Kidd and Morrison (1988), suggest this fourth stage of theory development which they believe to be on-going, corresponds to Belenky et al.'s (1986) 'procedural knowledge' and includes both 'separate and connected knowledge'. Separate knowers are represented by the logical-positivists, and connected knowers by the phenomenologists.

A fifth stage of knowledge development is on the horizon for nursing, but according to Kidd and Morrison (1988) has not yet been achieved. This stage would include both types of knowledge, analytical and phenomenological, and would correspond to Belenky et al.'s 'constructed knowledge' as a way of knowing (Schultz & Meleis, 1988; Kidd & Morrison, 1988; Retsas, 1994). Lumby (1991b:23) champions nursing's move toward 'constructed knowledge' and urges that 'nursing's voice must be heard' as she moves to:

> . . . a position in which women [nurses] view all knowledge as contextual, experience themselves as creators of knowledge, and value both subjective and objective strategies for knowing (Belenky et al. 1986 cited Lumby, 1991b:26).

Controversy surrounding the exact nature of nursing's knowledge continues. There are some who advocate predominantly scientific approaches to knowledge construction, others interpretive approaches and yet others who advocate an eclectic approach (see for example, Kitson (ed.), 1993; Kermode, 1993; Wolfer, 1993; Neyle and West, 1991).

- Patterns of Knowing -

The complexity of nursing's epistemology was brought to light by Carper (1978) who offers four distinct patterns of knowing which she synthesised from the nursing literature as the most valued and utilised by nurses. Describing these as *empirics, esthetics, personal knowledge* and *moral* or *ethical knowledge*, these ways of knowing have been repeatedly drawn upon by other nurse theorists over the years. More recently, Chinn and Jacobs (1987) have specified Carper's patterns of knowing within an epistemological framework

1) Empirics, as the science of nursing is based on the traditional notions of science - which includes the assumption that what is known is that which is accessible through the senses and only identifiable through the use of scientific method of hypothesis testing. The knowledge generated is objective, abstract and general.

2) Esthetics, the art of nursing is made visible through the actions, conduct, attitudes, bearing and interactions of the nurse in response to others. Chinn & Kramer (1991) view esthetic knowing as enabling a person to know what to do with the moment, instantly without conscious deliberation. Carper (1978:17) attests to empathy as being - 'the capacity for participating in or vicariously experiencing another's feelings' - and believes it an integral mode of the esthetic pattern of knowing. Polanyi (1958:51) likens the knowledge inherent in art to the touch of a gifted pianist in so far as this type of skill cannot be accounted for in terms of its particularities. He argues that to deny the feasibility of a special 'touch' simply because we cannot understand it in terms of accepted frameworks, often results in 'explaining away genuine practices or experiences'. Chinn & Jacobs, (1987:9) describe esthetics, which in itself is unable to be expressed discursively, as being expressed 'only in the moment of experience-action', in an art/act. Unique to the particular esthetic encounter, it is described as non-verbal behaviour depicting colour, form, and movement. Carper (1992:77) describes it as 'interpretive, contextual, intuitive and subjective knowledge'.

3) Personal knowing in nursing according to Carper (1978), pertains to the inner experience of becoming whole and aware of oneself, and is necessary if one is to be able to relate to others. Carper, cites Buber (1970) when she refers to personal knowledge as an 'I-thou' encounter. She describes the nurse in the therapeutic use of self refusing to approach the patient as an object - striving instead to actualise an authentic personal relationship between two individuals (p19). Polanyi (1958) considers 'personal' knowing primary to all knowing and is convinced that personal knowledge is an intellectual commitment because into every act of knowing enters a passionate contribution of the person knowing what is known. He speaks of maxims, rather than rules, to guide such art, but suggests maxims can serve as a guide to art only if they can be integrated into the practical knowledge of art.

One dimension of this pattern of knowing to receive increased attention from nurse scholars of late, has been 'intuition' (Crandall & Getchell-Reiter,1993; Agan, 1987; Benner & Tanner, 1987; Rew & Barrow, 1987). Described by Benner and Tanner (1987:23) as 'understanding without a rationale' it is also known as instinct or insight. Until recent changes in the concept of nursing as an art, intuition as a mode of knowing had not been explored; had long been devalued, and was denied being seen as a potential source for the development of new knowledge in nursing. This came about not only because it was supposedly knowledge acquired without formal reasoning and thus deemed unscientific, but also because it was seen as an 'attribute' belonging to the realm of women (Meleis, 1991; Chinn & Kramer, 1991). As it turns out, the conceptual development of a level of intuition as a notion which distinguishes nursing from other disciplines has, in the past, been powerfully blocked (Kitson, 1987;Doering, 1992). According to Rew & Barrow (1987:61), this has been a 'tragic' scenario for nursing.

Nevertheless, a number of authors have begun to argue quite strongly for the (re)cognition of intuition and the 'gut feelings' of nurse clinicians regarding their practice, as a valid source of knowledge (McMahon, 1991). According to Rew and Barrow (1987) 'intuition' is recognised as a component of the perceived view of science and considered a legitimate way of knowing in nursing.

Kitson (1987:323), in urging nursing to free itself of the traditional model and embrace new scientific methods, refers to nursing's past denial of intuition and feelings because it was seen

as 'non-scientific'. This, she believes, has led to a poverty of knowledge for nursing which, by its very nature, is concerned with personal encounters and emotions. The scientific paradigm, she argues, has inhibited nurses from getting too close to their patients. 'An alternative way of denying the need for tenderness and concern is to argue that competent practice is primarily about skills and knowledge, about learning new techniques, improving treatments'. She cites Menzies (1960), who believes that elaborate rituals have been devised in order to distance the nurse from the emotional life of the patient. Referring to this as 'detachment', it could be said that the job has been reduced to routinisation of simple self-care tasks which sees personal responsibility taken out of the hands of those delivering care - in order to distance the doer from the 'one who takes responsibility for all sorts of blame transference to take place' (p323).

Kitson (1987:325) is concerned however, that the tendency for the stereotypical notion of nursing as nurse-as-medical-technician and therefore 'more prestigious, more skilful, more desirable', lingers on. She insists, 'nurses have to find ways of getting over the 'intellectual barriers that hold that caring, and by inference nursing, is anti-intellectual.' This attitude, she ties in with the overdependence of nursing on science and technology to provide the answers; together with 'our thinly veiled disdain for our existence which relate to our emotions'. Kitson (1987) cautions that as long as nurses rely on unsubstantiated gut reactions and traditions they will feel insecure and inferior to colleagues who have moved away from such basic notions to a more scientific approach. Yet, she urges that instead of denying intuitions nurses need to start exploring them and testing their validity.

Benner (1982a&b; 1984; with Tanner, 1987; 1989) in her extensive work on expert practice (to be discussed more fully in the next section) draws on the work of Polanyi (1958) and Kuhn (1970). Polanyi (1958; also in Benner, 1982; 1984; 1987) explicates the distinction between knowing *that* and knowing *how* as kinds of knowledge. Those who possess skills not reducible to objective measurement strategies, he coined 'connoisseurs'. These 'connoisseurs' 'know many more things than they can tell'; he described this as the 'art of knowing', and skills as the 'art of doing' (p.88). Benner and Tanner (1987), using the framework developed by Dreyfus and Dreyfus (1985), demonstrated the manner in which experts in nursing use intuition in clinical judgment by describing how experts in general, analyse, judge, and make decisions. By the use of intuitive expertise, nurses are able to demonstrate an ability to make judgments by recognising patterns of relationships in situations not readily recognisable by

others. Also, they are able to detect similarities between situations through common-sense understanding, by 'knowing how' in a manner that is indefinable in common scientific terms, by having a 'sense of salience', by recognizing priorities, and by using 'deliberative rationality' - defined as shifting perspectives for greater understanding.

Polanyi (1958) and Schon (1983) have acknowledged the legitimacy of intuition or expertise as way/s of knowing but have called their own concepts 'tacit' or 'personal' knowledge. Agan (1987) identified a similar way of knowing as intuition. Unlike empirics and ethics, personal knowing is not directly communicable in the speech act (Chinn & Jacobs, 1987). Polanyi (1958:87; also cited Schultz & Meleis, 1988:218) refers to knowledge that cannot be articulated through language as 'tacit knowledge', belonging to the 'ineffable domain', and that which can, as 'explicit knowledge'. Yet, as Chinn & Kramer (1991) point out, it is possible to describe certain aspects of self, and while such discussions never completely reflect personal knowing and are limited because they only describe the self that was i.e. retrospectively, they can, nonetheless, be of great benefit.

Schon's notion of expertise (1983 cited McKee, 1991:179) embodies 'reflection-in-action' as an account of what actually happens in practice. The practitioner reflects on intuitive understandings of the phenomena stemming from his/her own repertoire of familiar examples and themes. During this process, there is an exchange of ideas, means and ends become independently framed, and knowing and doing become inseparable. When applied to the clinical setting, it could be said that in responding to the uniqueness of the patient, the practitioner uses her/his repertoire of knowledge, theory and past experiences. Schon (1983:243) points out that although practitioners do reflect-in-action, they seldom reflect on their reflection-in-action. Consequently, they may not be able to articulate the knowledge they use through the process of reflection-in-action, nevertheless, he does suggest it is possible to illuminate the knowledge used through a process of reflection-on-action. Reflection-on-action incorporates a cognitive post-mortem as the practitioner looks back on the experience. As s/he does s/he re-examines understandings brought to bear in light of the outcomes (Schon, 1987 cited Atkins & Murphy, 1993).

A determining factor in terms of personal knowledge is experiencing, that is 'an openness to life and being' (Chinn and Jacobs, 1987:8). Esthetic and personal knowing in a traditional

sense have been viewed as nonscientific belonging to the realm of the humanities or arts. And yet, as Chinn and Jacobs (1987:11) point out it has now been acknowledged that artistic or esthetic qualities are 'embodied in the very act of "doing science" and other forms of discovery'.

4) Ethics, the component of moral knowledge in nursing, focuses on matters of obligation or 'what ought to be done'. Ethical knowing has been recognised as essential in an increasingly crowded, complex technological society. Nevertheless, it has been pointed out, that to date empirically discernible factors associated with ethics have been valued above the philosophic methods needed to create new ethical knowledge in nursing (Chinn & Kramer, 1991).

Despite the fact that each type of knowing has a unique pattern of characteristics, where the act of nursing is concerned, the 'whole' of knowing is important (Huether, 1987:iii). Carper (1978), certainly draws attention to the inter-related, independent and overlapping nature of the patterns she has synthesised, and yet Smith (1992) is convinced that past practices have utilised Carper's patterns as a framework for organising discrete components of knowledge, a situation which she asserts, has had the potential to jeopardise initiative and creativity in the on-going development of nursing knowledge.

Similarly, Silva, Sorrell and Sorrell (1995), in a critique of Carper's epistemological foundations of nursing knowledge, claim her work has been misused by nurses through the adoption of discrete epistemological 'labels' without consideration of interrelated patterns. They point out that the postmodern shift from epistemological deliberation to ontological reflections on reality, meaning, and being, are beginning to reveal the ontological 'in-betweens' and 'beyonds' lacking in nursing discourse as a result of this misinterpretation.

- More Ways of Knowing -

Critiques of the handmaiden role of nurses and an explication of the doctor/nurse 'game' have resulted in a desire to develop nursing knowledge unique to nursing. Nurses, are in fact, just beginning to acknowledge the complexity and diversity of nursing knowledge (Street, 1992a), and to recognise that as they make sense of what they do, they use a variety of ways of knowing (Lumby,1991a:468). Carper (1992:77), writing in the present day, refers to nursing

as comprising an epistemological plurality and states: 'there can no longer be serious doubt that nursing requires different ways of knowing and different kinds of knowledge'. Several theorists (Schultz & Meleis, 1988; Kidd & Morrison, 1988) make the point that failing to recognise the multiplicity of ways of knowing in nursing is tantamount to overlooking the complexity and holistic nature of nursing. Wolfer (1993) too, argues that because ways of knowing depend on which aspect of reality is being considered, nursing needs multiple ways and types of knowing and knowledge. Theory that draws on multiple patterns of knowing provides a valuable link between the worlds of practice and theory so that they are not perceived as separate. Building bridges between what we know and what we do in practice, goes a long way to closing the practice-theory gap (Benner & Wrubel, 1989 cited Chinn & Kramer, 1991).

Smith (1992), believes knowledge to be discovered and created in the interaction of the knower and the known. Knowing occurs as a result of 'careful systematic research or from repeated experiences in clinical practice' (Meleis, 1991:130). Understanding, has been advocated as essential for knowledge development in nursing and includes interpretation, that is:

> A total comprehension of other human beings' responses based on their "feelings, ideas, choices, and purpose" as they experience the situation, and as they express their own meanings and understandings of the situation through their own words and through their responses (Swartz & Wiggins, 1988 cited Meleis, 1991:130).

Baker (1980), supports the concept of knowledge specific to nursing, and illustrates his belief in this idea by drawing a distinction between a patient's disease and a patient's sickness. He points to the fact that where a physician presumably has a greater knowledge of disease, nurses have more special expertise in terms of a patient's sickness. Disease being significant only because it makes people sick, he refers to an imaginary situation in which to be diseased need not necessarily mean being sick. To illustrate this he provides the example of a weightlifter suffering laryngitis in contrast to the university lecturer with the same problem. The former could be said to be suffering the disease only, whereas the latter by withdrawing from the day's lecturing would be deemed sick. Baker goes further in addressing the notion of the uniqueness of a nurse's knowledge by stating that when a patient is deemed incurable, or 'beyond help' s/he is not beyond the help of the nurse.

He maintains:

> The role of the nurse is to care for the sick in their sickness, even when the disease is incurable. . . The nurse can be, and ought to be, an expert at caring for the sick, which makes nurses separate from, and sometimes more than equal to, physicians, and certainly, therefore, superior to the physician's hands (p. 45-46).

Parker (1990) posits a view of knowledge that includes scientific information, aesthetic interpretation, and personal-intuitive experiences. This spectrum of knowledge may be conceptualised as *gnosis* from the Greek meaning knowledge. *Gnosis* is seen as augmentative knowledge or knowledge of a higher order, rather than an alternative cognitive system. *Gnosis* incorporates 'at one end the hard, bright lights of science' which give information, in the centre the 'sensuous hues of art' where the 'aesthetic shape of the world' is revealed, and at the far end the 'dark shadowy tones of religious experience' where meaning is found (Rosak, 1980 cited Parker, 1990:41). Parker believes that in nursing, caring is *gnosis* and attests that through caring, nurses can explore and address the spectrum of *gnosis* to enhance professional excellence and wholeness (Parker, 1990). She writes:

> A focus on *gnosis* could shift the goal of nursing theory from one of prediction and control to one of understanding. In addition, theory development could take place in the areas of science and aesthetics, as well as the personal and intuitive domains. . .There are many ways of knowing and many complex relationships between these ways. However, the use of the term *knowledge* seems inadequate to describe the multiple dimensions of the wisdom obtained by a caring, expert nurse (p46).

Meleis (1991) points to the literature of the 80s and 90s that began to espouse a uniqueness in women's developmental processes and women's ways of describing their experiences. She attests to the exceptional capacity of nurses as women, to know; and of the unique ways by which they demonstrate their knowing and understanding. As Street (1992a) has pointed out, the changed understandings of the roles and capacities of women within the community have been reflected within the development of nursing knowledge. The qualities of women have historically been ignored and deprecated, and yet today's nurses, by appropriating feminist notions, are beginning to celebrate those very attributes that so disadvantaged their possession of knowledge in the past. Harding (1988; cited Meleis, 1991) believes women, as agents of knowledge possessing characteristic activities, provide a grounding that is different from, and

in some respects preferable to, men's grounding. She is convinced that:

> What it means to be scientific is to be dispassionate, disinterested, impartial, concerned without abstract principles and rules, but what it means to be a woman is to be emotional (passionate), interested and partial to the welfare of family and friends, concerned with concrete practices and contextual relations (p138).

Belenky et al. (1986:3) have written:

> Our basic assumptions about the nature of truth and reality and the origins of knowledge shape the way we see the world and ourselves as participants in it. They affect our definitions of ourselves, the way we interact with others, our public and private personae, our sense of control over life events, our views of teaching and learning, and our conceptions of morality.

From their reflections on traditional patterns of knowing in nursing and on the feminist work of Belenky et al. Schultz and Meleis (1988:219) have extended Carper's original work and have identified three types of knowledge specific to nursing as a discipline. These they have termed clinical knowledge; conceptual knowledge and empirical knowledge. Clinical knowledge they assert:

> . . . is manifested primarily in the acts of practising nurses; it is individual and personal. Historically, it has often been voiceless except in descriptions of the art of nursing. . . and has been the product of a combination of personal knowing and empirics. It has usually involved intuition and subjective knowing. . . the aesthetic and ethical patterns of knowing are also contributing to the development of clinical knowledge. . .

Conceptual knowledge is derived from reflecting on aspects of nursing reality, and requires logical reasoning and the view that knowledge is constructed within a context and is an on-going process. Empirical knowledge, the authors assert, stems from the findings of all nursing research not merely from studies employing a traditional empiricist approach but also from studies utilising the new paradigm.

Clinical Knowing - Expert Practice

There can be no doubt that early nursing theories espousing views in the tradition of the classical 17th century science, embodying an atomistic, mechanistic view of a person, have not worked well when applied to the clinical environs (Benner & Wrubel, 1989). The growing emphasis has been, and continues to be, directed toward the need to develop an understanding about the practical knowledge nurses have and use in the clinical field, that is, the subjective, value laden, traditionally formed knowledge that is contextually embedded in the dynamic environment of clinical nursing practice (Street,1992a).

Clinical knowledge has been described as emerging from an engagement with the 'Gestalt of caring, from bringing to bear multiple ways of knowing in order to solve the problems of patient care' (Meleis and Schultz, 1988:219). Huether (1987:iv) points out, 'although each nursing act may have shared similarities, there is a uniqueness operating in each nursing encounter that cannot be satisfactorily explained or predicted according to the regularities assumed by empirics'. It has been postulated that nurses in clinical practice routinely encounter situations requiring decisions and actions for which there are no 'scientific' answers (Chinn & Kramer, 1991). Thus the recognition of a nurse's ability to successfully solve many problems using knowledge impossible to replicate or validate by use of the scientific approach, has led to a quest to discern alternative methods of knowing in the practice setting (Huether, 1987; Wolfer, 1993).

Benner's (1982a&b; 1983; 1984; with Tanner 1987; with Wrubel, 1989) groundbreaking work has shed new light on the practice of nursing, particularly in regard to the experienced nurse. As it turns out, her (1984) well-known descriptive study on the practice of nursing has developed 'the paradigm of expert practice in nursing' (Thompson, 1990:268). In an attempt to place more value on their practice, her extensive research has endeavoured to uncover what clinical nurses actually 'do' on a day-to-day basis. Benner (1984) claims previous studies have been conducted primarily from a sociological point of view which has led nurses to learn a great deal about role relationships, socialisation and acculturation in nursing, but very little about the 'knowledge embedded' in their actual practice (p1). Benner's initial study was a situation-based interpretive approach to describe nursing practice rooted in the work of Heidegger (1962) and Taylor (1971). Based on the Dreyfus model of skill acquisition,

Benner's early studies not only identified issues regarding how nurses begin as novices and have the potential to become experts, but also posited seven domains of expert nursing practice together with the competencies embedded within them.

The Dreyfus model proposes that in developing and acquiring a skill, the learner passes through five levels of ability: *novice, advanced beginner, competent, proficient,* and finally *expert.* The different levels reflect changes in differing aspects of skilled performance.

These include:

- a movement from a reliance on abstract principles to the use of past concrete experience as paradigms;
- a change in the learner's perception of the demand situation, in which the situation is seen less and less as a compilation of equally relevant bits, and more and more as a complete whole in which only certain parts are relevant, and
- the passage from detached observer to involved performer.

(Extracted from Benner, 1984:13)

Benner (1984) sees the acquisition and development of a skill as incorporating the passage by the nurse through the differing levels of proficiency. Progression along the continuum depends on a combination of the depth and range of clinical experience and is positively correlated with longevity in the job. Each stage implies differing strategies for teaching and learning. The fundamental difference between a beginner and an expert according to Benner can be attributed to the know-how acquired through experience. Experience being linked to knowledge which accrues over time, and experience being therefore, a requisite for expertise. Experience, she defines as 'the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of difference to theory' (p36). Benner differentiates this type of experience with the 'mere passage of time or longevity' (p36). According to Benner (p31-32), the expert:

> No longer relies on an analytic principle (rule, guideline or maxim) to connect her or his understanding of the situation to an appropriate action. The expert nurse, with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions.

Based on pattern recognition abilities, experts are able to respond and evoke the right response. The expert grasps the situation as a whole and can move in and smoothly co-ordinate the practical aspects of caring for the patient as a whole. Working with a great many patients affords a set of fine discriminations about what it means for a patient to be comfortable, and even for that particular patient to be comfortable. The expert's interventions are based on subjective judgments rather than some sort of objective science. As previously noted, Benner and Tanner (1987:23) verify intuition as an 'essential aspect of clinical judgement' particularly in the expert; as Rudge (1992:85) posits, experts make 'explicit the importance of the intuitive grasp' to be found in advanced practical knowledge.

In contrast, the novice and advanced beginner 'take-in' little about patient care situations because everything is too new and strange. Concentrating on remembering the rules taught in the classroom, their performance is rigid and inflexible. Basically beginners operate on general guidelines and are only just beginning to perceive recurrent meaningful patterns in their clinical practice. As a rule, the novice and the advanced beginner focus on the mastering of the technology surrounding the patient rather than concentrating on the patient as a whole (Benner, 1984:25).

Competent practitioners have typically been in the job two or three years and have just begun to feel mastery and the ability to cope with, and manage the many contingencies of clinical nursing. The conscious, deliberate planning characteristic of this stage helps achieve efficiency and organisation. The competent nurse has to move on and learn how to use pattern recognition in order to grasp the whole situation.

At the next stage, proficient practitioners begin to understand situations as wholes because they perceive the meaning of them in terms of long term goals. They have learnt from experience what typical events to expect in a given situation and how plans need to be adjusted in response to these events. They can now recognise when the expected normal picture does not materialise. The proficient nurse uses maxims as guide(s). Maxims would be unintelligible to the competent or novice nurse because they reflect nuances of the situation and require a deeper understanding of what the events mean. Maxims provide direction in decision-making.

Benner's work has been widely acknowledged, accepted and applied in differing ways by nurses all over the Western world (Geanellos, 1995; Darbyshire, 1994; English, 1993; Thompson, 1990; Silver, 1986a,b). As such, her work has had important ramifications for the teaching and learning of nurses. According to Aydelotte, (1984) the greatest value of Benner's work has been the provision of an understanding about the mystery of expert nursing practice which has generated an awareness that such expertise should be more fully appreciated. North American scholar, Fenton (1992; 1985; Steele & Fenton, 1988) has used Benner's seven areas of skilled performance as a framework for data collection and analysis in studies to identify the clinical competencies and skilled performance of Master's prepared CNSs functioning in advanced practice roles. Using an interpretive approach she utilised interviews and participant observation as instruments for gathering the data until a composite picture of common competencies and areas of skilled performance emerged. Fenton validates her findings by consensus of the investigators and the participants. In her biggest study (1985), the findings revealed that CNSs report and demonstrate activities in all of Benner's areas of skilled performance, in addition to the emergence of some new competencies which stressed the ability of the CNSs to build teams, influence change in the system and monitor practices and outcomes. A further domain 'the consulting role' was also perceived as important to the CNS sample. Fenton concludes from the study however, that accurate written and verbal descriptions of the competencies constitutive of advanced practice have not yet been fully effected.

Despite the popularity of Benner's work, critiques are appearing increasingly in the literature. English (1993) posits a number of concerns regarding Benner's work including the question *vis-a-vis* how and when the conversion from non-expert to expert takes place, if indeed it takes place at all (because Benner does stipulate that not all nurses will eventually become experts). English wants to know why this is the case. His most cogent concern however, revolves around Benner's assertion that expert nurses rely to a large extent on intuition or 'gut feeling'. English has problems with Benner's definition of intuition, and sees the concept as subjective and therefore a questionable entity, which until empirically validated, has limited applicability in nursing. Darbyshire (1994) however, challenges this critique, claiming that English's positivist cognitivist worldview has obstructed his vision. Purkis's (1994) critique of the work of Benner suggests she has not accounted for crucial aspects of social conduct in her considerations of practice. Benner's technique involved the use of interviews that Purkis

claims took the nurses' practice out of context. She writes:

> The constitution of experiences of practice represent complex social accomplishments. A close and critical reading of how social processes 'work' within practice settings offers a location for excavating the extent to which power interpenetrates practice (p334).

She also believes Benner has misrepresented concepts posited by Gadamer and Heidegger regarding experience, knowledge and understanding, and has overlooked the place of power in language. Crotty (1996) as will become clearer in later text, also criticises Benner for her misrepresentation of Heideggerian concepts.

Cameron (1989), in a discussion about nursing competencies, inquires whether one set of competencies can, or should be used for all nurses, or whether further sets for advanced practice need to be developed. Referring to the work of Benner and that of Fenton, she questions whether deriving competencies solely from observation of practice reflects what *is* being done to the detriment of what *should* be done. She is criticising Benner's work for its non-critical stance, seeing it essentially as maintaining the *status quo.* She concurs with Benner (1984) however, that by concentrating solely on what should be done, the discipline misses out on what *is* significant about nursing practice.

Thompson (1990:272) also argues that Benner's research 'does not sufficiently address the social and political contexts in which nurses practice'. For this reason she too beholds it lacking in critique, and likely to perpetuate the structural constraints of practising nurses. Thompson also alludes to methodological misgivings and raises a concern that Benner fails to situate herself within the study. Rudge (1992) critiques Benner's work using a critical framework espoused by Carr and Kemmis (1986), and while for the most part she views Benner's work favourably, she does raise the question of an interpretive perspective which 'does not deal with power explicitly', nor 'critically examine elements of control engendered by power relations within societal structures' (p86). Benner (1990) offers defence of these issues in a reply to Thompson's criticisms appearing in the same publication.

> We stand on the threshold of developing knowledge of the art of nursing, and aesthetic knowing in nursing (Chinn, 1994:37).

Aesthetic knowing gives life to the art of nursing and does not arise from modes of thinking that are reasoned and systematic. Rather, aesthetic knowing stems from women's ways of knowing and being in the world (Chinn, 1994). Aesthetic knowing involves:

> An embodied grasp of situations and intimate experience with the deepest and most significant life events that traditionally and cross-culturally have been associated with women's experience - birth, death, sorrow...like artists in other forms of improvisational art, nurse artists know they can perform spontaneously and with finesse only because of their practiced skill in ways of being and doing that are called for in a moment (Chinn, 1994:37).

Chinn (1994:21) believes nursing is an art and a science. But posits, 'art is not something that stands in opposition to science; it is part of science, indeed it is part of all human experience' Watson (1994:xvi) believes nursing as art is 'lived, expressed and co-created in the caring moment'. Ironically, the founder of modern nursing, Nightingale herself, saw nursing as an art rather than a science. Yet, only recently has there been a renewed attempt, albeit a powerful one toward promoting art in nursing as a medium for developing nursing knowledge. After the 1950s push to develop a scientific and hence empirical body of knowledge on which to base nursing practice, there has been a reluctance to acknowledge that nursing contains an element of artistry (Carper, 1978). Little or no effort was made to 'elaborate or make explicit this esthetic pattern of knowing in nursing' (Carper, 1978:16). Carper believes this indifference has been due to the perceived association of 'art' with a general category of manual and/or technical skills aligned with the apprenticeship style education system that nursing was trying its hardest to divest. There can be no doubt, for a long time nurses have denied their art. Lumby, (1991a:468) believes the problem may have arisen out of the reality that as 'doers', clinical nurses have not had time for 'contemplative creation'. And while art has historically not been valued as a form of knowledge, the Ancient Greeks considered it to be an important one. Aristotle (trans. 1942) believed that imitative art, for example tragedy, could arouse emotions in people leading them to understand the subjectivity of the players, and that many art forms offer the audience an awareness of life by enabling them to see 'what might be'.

In any event, the recent erosion of faith in scientific knowledge as the exemplar of all knowledge has seen those aspects of nursing that are not the result of empirical investigation being re-appraised (Chinn and Kramer, 1991). With the advent of feminism and a post structuralist worldview, art is making a come-back as something to be valued. Considerable literature is now appearing in nursing journals and books dealing with esthetics/art in nursing.

> The art of nursing is the art/act of the experience-in-the-moment. It is the direct apprehension of a situation, the intuitive and embodied knowing that arises from the practice/praxis of nursing (Chinn 1989, cited Chinn 1994:24).

Masson (1990:11) writes that unlike medicine, which is a body of knowledge with applications for the diagnosis and treatment of disease, nursing is 'first and foremost an act, a process'. It is not the problem-solving process posited in nursing jargon, but the process of healing through care and nurture. It is not learnt from books so much as from watching, listening and doing, and is above all performance art, the work of nursing. Further, art originates in the immediate embodied grasp of the situation, the instruments with which the artist works, and the intuitive knowing of what is to be produced in the act. 'The original art/act arises from a non-discursive, aesthetic knowing that is unique to the moment' (Chinn, 1994:25).

Aesthetic knowing originally, was more commonly associated with empathy. While empathy as a medium is still regarded as necessary and valuable, it is the encounters whereupon an apprehension of the meaning of the moment occurs without conscious awareness that better describes practice as art (Chinn, 1994). Chinn refers to this as 'an instantaneous grasp of the situation and a simultaneous knowing' which calls forth 'something from deep within the nurse' (Chinn, 1994:36). She says:

> When such an artistic moment occurs, it is distinct from any sense of empathic understanding. Nurse artists describe these occasions as feeling within themselves something that moves to create an act; a situation generates spontaneously a feeling of 'rightness'. These occasions are sometimes attributed to intuition, but, after reflection, their meaning seems to have been informed by experience, by literature, and by all other forms of knowing - empirical, ethical, and personal. Consistent with definitions of the meanings of other art forms, nursing as art is expressive of a deep understanding of common human experience; its expression arises from within the creative wellspring of the nurse (Chinn, 1994:36-37).

The art of nursing is closely connected to nurses' bodies (Chinn 1994). Yet, understanding the body as an active capacity to act and as a ground for knowledge, has been a neglected area. The notion of the body as a way of knowing and as integrated with a mind/body continuous with the person; has been the basis for philosophical debate. It has been proposed that much of skilled performance requires a bodily takeover of the instrument being used - refer Heidegger's (trans. 1962) ready-to-hand as distinct from his unready-to-hand or present-to-hand modes of engaging with the world. The philosopher Polanyi (1958:59), describes a person as pouring themselves out into objects and assimilating them 'as parts of our existence. We accept them existentially by dwelling in them', he says. Merleau-Ponty (trans. 1962:143) writes of being 'transplanted' into objects. These philosophers propose that a person has 'situated' freedom and 'situated' possibility (see section in later text entitled 'intentionality').

Nurses' bodies are said to constitute the 'carrier' of their art. Their bodies narrate the story, convey the message and portray the experience. The overwhelming cultural emphasis on women's bodies however, has resulted in a certain body consciousness that nurses bring when they enter situations, this is reflected in how they use their bodies in their art. A central element in the expression of nursing's bodily art is touch, both physical and symbolic (Chinn, 1994).

Contemporary nursing thought envisions the gap between nursing science and art closing, and reference is now being made to the 'science-art' of nursing, as a merging of nursing epistemology and ontology (Silva et al. 1995).

Nurses as Carers (Women's Work)

Differing worldviews have seen nurses thinking in new ways and in recent times nursing has seen care, as an art-act, reclaimed as a central domain. In fact, in the development of nursing knowledge, caring has come to be seen as the central unifying property (Astrom, Norberg, & Hallberg, 1995). Consequently, the amount of nursing literature on the importance of care as a concept in nursing is rapidly expanding (Bottorff & Morse, 1994; Kuhse, 1993; Wilkes & Wallis, 1993; Chao, 1992; Benner & Wrubel, 1989; Leininger, 1981, 1986; Rieman, 1986; Brown, 1986; Wolf, 1986; Watson, 1985). Leininger (1990) postulates that care will gradually

replace the nurse's preoccupation with medical ethics, which has seen a major focus on disease and diagnosis and symptom identification. Caring is defined as 'being concerned, involved, having an active sympathy, which manifests itself in supporting the cared-for's goals for growth, self actualisation' (Ray, 1981 cited Kelly, 1990:74). Pearson (1991:199) describes the broad, global human concept of caring as 'investing oneself in the experience of another sufficiently enough to become a participant in that person's experience'. Kelly (1990), asserts that without respect and caring nursing does not take place.

Historically, an examination of nursing practice reveals that caring is thought to have emerged from the time of the early Christians and flowed through to the development of a humanist discourse (Nelson, 1995). Nelson (1995) sees the origins of nursing as an ethos, or way of life to be found 'in a repertoire of virtuous practices of the self developed by the early Christians' (p37). Nightingale herself, sought a secular setting to discover more about nursing and subsequently modelled her own nursing school on the nursing religious orders. 'Thus nursing in the 19th century was a vocation for pious women' (p39). And so, it was the influence of Christianity that cemented women's role as care-providers in most Western countries. Nursings' beginnings were born therefore through religious order, and women's experiences and knowledge, emerging from their healing practices, constituted the art of nursing (Chinn 1994).

With nuns as carers, *to obey-to serve* became the very axiom of the care service. Care was not given any recognition and was never afforded any economic value. These consecrated women were not permitted to formulate judgments and were required to learn behaviour dictated by the rules, which were in turn, issued by men. In addition, because nuns had to face up to the condemnation of women as a source of evil, they were not allowed to learn care practices from direct experience. And so through the use of nuns, who were not permitted to touch the body, verbal communication became a tool for care until it was replaced by technological methods in modern hospitals. It was this separation, according to Colliere (1986) that spawned the *care* and *cure* dichotomy that exists even today.

Through her exploration of women's work as care providers, Colliere (1986) maintains that the exclusive use of writing by priests saw the beginning of the confiscation by men, of women's ways of knowing. Like Colliere, Chinn (1994) traces the demise of the tradition of

women as healers, and the manner in which the experience of women and women's ways of knowing have been negated and undermined. With the emergence of the science of cure as the ultimate human achievement, Chinn believes women as nurses have been subjected to a systematic elimination of the art of their healing from their consciousness. When midwives were permitted to be trained under the supervision of medicine at the end of the eighteenth century they also became dispossessed of their art by giving up control of their practice into the hands of their supervisors. In the mid-nineteenth century, with the genesis of obstetrics; 'the last area which belonged wholly to women's care practices' was forfeited. 'From then on midwives became *trained institutionalized care-providers*, in the same way as *nurses*, who had progressively replaced nuns, had done' (Colliere, 1986:102).

Tracing the notion of care in American nursing as it has been historically created from the nineteenth century through to the present day, it can be seen that caring has been universalised as an element in female identity (Reverby, 1987). Women have been expected to be self- sacrificing, altruistic, and submissive. Nurses, as women, have accepted a duty to care rather than 'demand a right to determine how they would satisfy this duty' (p5). 'Because care is associated with women and women hold less power in society', human caring and its association with womanhood have 'persistently and consistently been both publicly devalued, yet privately desired' (Pearson, 1991:200/202).

It is argued that the need for nursing to place caring as a central concept within its practice has never been greater (Pearson, 1991). Yet, at the same time, there are concerns about the problem which has seen the caring components of nursing decentralised, and deemed the least sophisticated and hence inferior to the therapeutic interventions of medicine and other paramedicals. In current debates concerning the extended role of the nurse for example, there would appear to be two distinct arguments, one advocates a more technical, diagnostic and treatment role, while the other is firmly based on the notion that nursing is about caring (Kitson, 1987). Kitson (1987), argues that if nurses choose to align themselves with care rather than cure, with the nurturing process rather than with technology and treatment, then they will need to identify how to organise and put into operation those skills they possess. Successful execution of the caring role is, she believes, 'intimately bound up with having the necessary space to practice, sufficient room to manoeuvre and to be able to explore new areas of knowledge and expertise' (p.324).

This will not be an easy task, because although caring is universally acknowledged as necessary and beneficial, it is directly opposed to any notions of autonomy. Nursing's heritage which has seen its work based on altruistic caring on the one hand, raises problems when seeking to gain autonomy and legitimate power on the other. In fact, 'nursing continues to struggle with the basis for, and the value of, caring' (Reverby, 1987:10). Searching for a way to forge a link between altruism and autonomy, nurses seek to be allowed to have, "caring with autonomy"' (p10). Kitson (1993:31) supports this notion and maintains that the 'stultification of nursing' in the early years, came about because nurses did not separate autonomy from altruism. Instead they unquestioningly accepted the duty of care rather than demanding the right to determine how they should satisfy that duty.

In addition, the demand by nurses for the right to care, questions some deeply held beliefs about gender relations in the health care hierarchy, and indeed the very structure of the hierarchy itself (Reverby, 1987). And yet, while women today have undeniably gained ground for recognition in the field of care, legacies remain that continue to hamper the development of nursing (Colliere, 1986). Parker (1991:288) gives voice to one of nursing's concerns:

> The heart of nursing lies in the quality of the care which is delivered and which is premised on a recognition of the mutuality of the nurse-patient relationship, on the moral stance of the nurses and on empathy and understanding of the human vulnerabilities and frailties of people cast into patient and client roles. Positivistic science, however, seeks to eliminate human value-laden factors in its search for objectivity.

The notion of care is not to be oversimplified, it has in fact many varied strands. Within our society, there are multiple differing connotations of the word 'care' and differing degrees of intensity in the caring act. Caring can be viewed as a moral attitude and/or disposition (Kuhse, 1993). Thus, caring can be differentiated into caring *for* and caring *about* (Jecker & Self, 1991 cited Astrom, et al. 1995). Moreover, the form of caring can vary across cultures. However, it is generally agreed that the perception of caring by the recipient is universal (Chao, 1992). Despite that the process of caring is at the core of nursing practice, the content and meaning of caring remains poorly elucidated in such practice (Astrom et al, 1995). Nevertheless, nursing continues to develop its own philosophy and ethics of care (see Leininger, ed.1990). Although Kuhse (1993), urges nursing to develop an 'adequate' foundation for its own ethics of care. And in recent times, a number of nurse theorists

Leininger (1978), Watson (1985) and Benner and Wrubel (1989) in particular, have developed a theory of nursing from the standpoint of delineating caring practices. Leininger (1986) does not see duty as the motivating factor in caring; rather, she views caring as an integral part of cultural life, which is learned behaviour. There are factors within that culture however, that either curtail or facilitate the use of care knowledge by nurses.

Watson moves from a caring-as-a-therapeutic-relationship stance to a more caring-as-ethical position in line with Benner. Watson (1985) in fact writes of a science (and practice) of caring, and draws upon phenomenological, existential and spiritual concepts to ground these theories. She sees caring as the ethical and moral ideal of nursing (Astrom et al. 1995). Watson (1981) has drawn a distinction between the science of caring which includes 'carative factors' and the science of cure which incorporates 'curative factors'. The concept of care *(Sorge)* as described by Heidegger (trans. 1962) informs Benner's conceptual framework regarding advanced practitioners (Benner & Wrubel, 1989; Benner 1984).

New developments have seen an emphasis on the notion that for nurses, 'out of care, cure can be born', and that nursing has a therapeutic role to play in the care of the sick (Nouwen, 1980 cited Pearson, 1991; also Leininger, 1986; Waterworth, 1995 support this view). Pearson (1991) discusses the historical imperatives that have seen care devalued, and urges nurses to reclaim it as a central concept that does make a difference to the outcome for a patient.

Undoubtedly, even though the sex-linked view that sees nurses as carers and doctors as curers lingers on, nurses, both male and female, are beginning to awaken to the concept of care (Leininger, 1986). It has been suggested that nurses (as women) and doctors (as men) have differing concepts of caring. Mintzberg (1994:36) observes, 'doctors cure and the good ones also care; nurses contribute to cure and they certainly care, the good ones humanely'.

Nevertheless, because of a conflicting train of thought which views nursing's rekindled interest in care as not necessarily beneficial for the profession, nurses reawakening of the concept has not gone uncontested. Holden (1991) for example, takes issue with nursings' propensity to distinguish between the caring role of the nurse and the curing role of the doctor, believing that each encompasses aspects of the other. Dunlop (1994:39/40) questions whether a science of caring is possible and resolves that if it is, it will have to take a

hermeneutical form - a 'form that in many ways does violence to our traditional ideas of science', but one that 'challenges the male hegemony of science'. Dunlop concludes with a caution of the need when considering caring, to develop concurrently 'a critical evaluation of the structures in which people are expected to care' (p40).

Kermode & Brown (1995) address the issue of caring and cite Cafferty & Cafferty (1994) who liken the caring work of nurses as a type of codependency 'in which nurses care for others at their own expense' (p12). Walker (1995) utilising a poststructural critique, discusses the problematic of nurses' attempts to represent nursing as both a discourse of science and a discourse of caring. Macdonald (1993) espouses that concepts of caring as they now stand are unrealistic as carers are unable to maintain the level of caring expected from such theories. Moreover, the question of whether caring is actually congruous with the issue/s of power, and or professionalisation in nursing is increasingly being addressed. Caring linked to the notion of altruism, asks the question: can caring individuals be politically active individuals? (Reverby, 1987;Holden, 1991;Bucknell, 1995; Kermode, 1993;Kermode & Brown, 1995; Dunlop, 1994). Moreover, having raised the realisation that there are tensions between the concepts of caring and empowerment, specifically in regard to the nurse's relationship with the patient and that of a 'basic' altruism, does the caring professional then decide what is best for the patient? An action which implies paternalism (Malin & Teasdale, 1991:657). Furthermore, it has been suggested that altruism implies self-sacrifice (Smith, 1995).

As nurses continue to mourn the dispossession of their ways of knowing taking place as it has throughout their history (Chinn, 1994; Colliere, 1986), it is becoming increasingly obvious that in the late twentieth century there are powerful ideologies afoot (together with the vested interests behind them), just waiting to refashion nursing. This would be undertaken in an effort to suit not only, 'the seemingly eternal power and prestige of doctors'; 'scientific and technological rationality', but also the push for 'efficiency' (Kenway & Watkins, 1994:44). In fact, the pace of change has been described a 'white hot' and it is posited that if nurses do not 'get on board the new health juggernaut, then they will not get on at all' (Kenway & Watkins, 1994:44). This leaves nursing with many pressing issues to debate, not least of which is the question of what a 'duty of care' means in the post-modern age (Kenway & Watkins, 1994:45).

There is no doubt, new perspectives have been emerging from within nursing, one of which has seen a renewed focus on nursing acts arising from the art of nursing. In this way other patterns of knowing have become included within theories of nursing. What is more, nursing theorists have begun to (re)address the notion of the person of the nurse and patient (Chinn & Jacobs, 1987:7).

Nursing's View of the Person (Personhood)

Many nursing theories and models include notions about the nature of human beings (see Marriner-Tomey, 1994). This is not surprising because as a human science, nursing is interested in the experiences of human beings and with health and illness concerns. As a practice-oriented discipline, its members seek knowledge of the response of human beings to health and illness in order to assist in monitoring and promoting health. Nurses also seek to assist in caring for persons, to facilitate their ability to care for themselves and to facilitate empowerment in order to develop and use resources (Meleis, 1991). Typically nursing's goal has been to assist people to their fullest potential within a given context (Mocchia, 1985 cited Chinn, 1994:24). Human beings and every human experience are seen as unique and developing over time, and experience itself characterised by development and change.

Nurses have realised the scientific approach as it stands is inadequate to solve problems closely related to human beings such as values, attitudes, beliefs, and personal interactions and expressions (Huether, 1987). Wolfer (1993) suggests while there is little doubt nursing has been influenced by traditional science in its theory development and research methods, scientism as an ideology has a very limited view of reality and how it is known:

> When we turn to the mental/symbolic realm of human discourse, the epistemology and methods of the physical sciences are inappropriate. No amount of scientific rigor and quantification can discover the meaning, intention and value of human interaction at the symbolic level (p144).

For the nurse, the 'symbolic' level is a major area of her workworld and because nurses and nursing exist within a changing social and political context so integral to human experience, interpretation, reflection and challenge have always been necessary. There is little doubt, that nurses in ever increasing numbers have recognised that the mechanistic view of what it is to

be a person is quite inadequate for explaining human activity. Intelligence cannot be separated from the subjective experience of the body. A logical hypothetico-deductive outlook that tries to explain human actions in the same manner as other events discovers that the human subject gets in the way of logical formulae (Thompson,1990). Moreover as Benner & Wrubel (1989) assert, for humanistic nurses the language of positivistic science is not nearly rich enough to give an account of the experience of everyday life.

-The Modern 'Cartesian' View of the Person-

Despite positivism having been widely challenged, Cartesian philosophy has had and continues to have a big influence on Western thought and on 'everyday' understandings. As noted, positivism with its reductionist attitude posits a particular epistemological view of a world made up of a separatist 'self'. The perception of the person in this paradigm is dualistic, embracing a conceptual division between mind and matter, observer and observed, subject and object. Persons are held to be isolated, individual egos with commodified bodies, subjects in a world of objects disengaged from their body, their world, and those around them (Parker,1991) The self is always seen as subject and the external world as object. Self is seen as an uninvolved subject made up of mind and matter who passively negotiates things in the external world through representations in the mind. People are perceived as individuals who stand over and against other individuals and the world in an impersonal way, and make judgments of concern only to themselves. Social reality is viewed as a self-regulating mechanism, and human behaviour as something that is determined by impersonal laws operating beyond the individual's control. Self can only be understood in objective terms that is looked at objectively not introspectively and accounts of self are written by an objective third person (Leonard, 1989).

Holden (1991) critiques the way in which the Cartesian view of the person has been interpreted by nurses. The commonly held view by nurses of dualism is that of the above, the notion that body and mind are separate, Holden suggests that nurses have confused their dualisms by equating the dualism of *parallelism* with that of Descartes' *interactionism.* This has damaged nursing's credibility. Parallelism (commonly attributed to Leibniz), posits a view that physical and psychical events 'run a parallel course without affecting each other' (Bullock, Stallybrass & Trombley, 1988:531). Whereas, Descartes's interactionism asserts

there are 'two interacting spheres, mind and body' (Bullock, Stalleybrass & Trombley, 1988:531). Holden points out, that this suggests the concept of holism and of Descartes's dualism are in fact congruent. She defends Cartesian dualism, and advocates the use of a hermeneutic-psychoanalytical approach as a conceptual framework upon which to secure nursing's theoretical discourse.

Lawler (1991) also points to Descartes having been 'wrongly attributed with having originated the conceptual split between mind and body', and uses a passage from his Sixth Meditation to support her observation. Lawler (1991), dismisses nursing's supposed misconception of dualism far more lightly than Holden (1991), she points to the variegations of knowledges built around dualisms and states the Cartesian variety (so-called), is but one. Putnam (1981:77) points to the fact there certainly are differing versions of interactionalism and that Descartes's was a more sophisticated, although somewhat 'obscure' one. Descartes, he states, maintained that the mind and the brain are an *essential* unity. But Descartes 'detached' the subject, or consciousness by showing that he could not possibly apprehend anything as existing unless he first experienced himself as existing in the act of apprehending it (Merleau-Ponty, 1962 trans.:ix).

In the Sixth Meditation (1968 trans.:156) Descartes wrote:

> I have a body to which I am very closely united, nevertheless, because, on the one hand, I have a clear and distinct idea of myself in so far as I am only a thinking and unextended thing, and because, on the other hand I have a distinct idea of the body in so far as it is only an extended thing but which does not think, it is certain that I, that is to say my mind, by which I am what I am, is entirely and truly distinct from my body, and may exist without it.

Descartes is said to have 'wrestled' with the 'mind-body problem' he inaugurated (Cottingham, 1995), yet his theory of dualism went on to underpin the dominant logico-positivist construction of knowledge favouring a view that studies either body *or* mind, rather than body *and* mind (Lawler, 1991).

-The Concept of Holism-

In nursing, the most consistent philosophic component of the concept of the person is the dimension of wholeness or holism[2], whereby essentially, the whole is seen to be greater than the sum of the parts, and the whole cannot be reduced to parts without losing something in the process (Chinn & Kramer, 1991). During the past twenty years, nursing has adopted the concept of holism as an intrinsic value and has begun to espouse the philosophy of humanism (Pearson, 1991). Humanistic nursing takes an existentialist perspective that views the person as an unique and unpredictable whole as well as addressing concerns from the individual's own perspective (McKee,1991). 'Gradual changes in world views held by society' have seen nursing begin to 'demonstrate a shift away from its allegiance to a technical and task oriented view towards the adoption of new value stances' (Pearson, 1991:202). Recognising the value in the concept of holism which presupposes mind and body are inextricably linked and capable of influencing each other, nursing as a human science as well as a social role, has widely addressed and accepted it (McMahon, 1991).

Parker (1990:39) explicates thus:

> The old worldview conceptualized the whole as the sum of its parts, stressed cause and effect, was reductionistic and particularistic, separated the observer from the observed, and saw knowledge as a way to control and predict nature. . .The emerging worldview proposes an expanded perspective on the term wholeness; recognizes the connectedness among all members of humanity and between humans and the universe; addresses the importance of context, values and probability; and equates knowledge with understanding.

A central tenet of holism is that 'living organisms are unified and indivisible units' (Kramer, 1990:246). The holistic unit, that is the individual, is regarded as being interrelated to larger system structures which may include a family, community, social system or universal

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[2] Kermode and Brown (1995) mount a critique of nursing's use of the term (w)holism, claiming it to have been misappropriated, and that it has become mere rhetoric in the discipline's call for professionalisation. Even, they suggest, 'a euphemism for professional imperialism'. . . (p14). O'Connell and Radloff (1995:59), question whether holism is an appropriate philosophy for nursing in view of the fact that in the clinical setting, 'the holistic idea of care is unachievable in any substantive way'. Kramer (1990:253) is not unaware of the constraints in practice and suggests that nurses rise to the challenge of 'restructuring the deeper social realities that limit the realization of the ideal' of holism.

consciousness. Thus, as Kramer (1990:246), points out:

> A common theme within various versions of holism is a *connectedness* of wholes and parts, however designated, and the recognition that any unit is *simultaneously both whole and part.*

Hickson and Holmes (1994), refer to some of the ways nursing has begun to reconceptualise its view of the person in light of postmodernism. Nursing scholars Benner (1985), Wrubel (with Benner, 1989), and Leonard (1989;1994), attest to a phenomenological view of the person as the most fitting for the discipline of nursing. Phenomenology and existentialism share an essential relationship. Central to the phenomenological stance is the idea of intentionality, which is the 'presupposition of the phenomenological method', providing the key to understanding many of its concepts (Crotty, 1996:41).

-The Concept of Intentionality-

A component of humanistic notions of the person postulates that human beings as conscious beings are 'intentional'. Intentionality, although a medieval term, emerged in modern philosophy from the work of Franz Brentano, a philosopher who linked it to the phenomena of consciousness (Crotty, 1996). The philosopher Husserl (trans. 1970), later developed this work along similar lines to Brentano. Intentionality is the 'aboutness' of one's mental state which always intends or is directed towards objects in the world (Berger & Luckmann, 1966:34).

'Intentionality' as used by Brentano and then Husserl names the fact that:

> Mental states like perceiving, believing, desiring, fearing, doubting etc. are always about something, i.e. directed at something under some description, whether the extra-mental object exists or not. The mental property that makes this directedness possible is called the representational or intentional content of the mental state (Dreyfus, 1995:2/3).

Husserl's traditional epistemologically oriented understanding of intentionality linked it to experience. Crotty (1996:40) an Australian academic and former theologian who has studied the phenomenological movement in depth, explicates that where Husserl described

consciousness as 'intentionally oriented towards its object, existential phenomenologists describe human being itself as intentionally oriented towards space and time'. Thus Heidegger seeking to get beyond the subject/object dichotomy, broadened the notion of intentionality because he viewed it in a completely different light (Dreyfus, 1995:3). In *The Basic Problems of Phenomenology* (trans. 1982:297) Heidegger wrote:

> Self and world belong together in the single entity, the Dasein. Self and world are not two beings, like subject and object, or like I and thou, but self and world are the basic determination of the Dasein itself in the unity of the structure of being-in-the-world.

Heidegger (trans. 1962), and the existential philosophers who followed on from him (for example De Beauvoir (1949), Sartre (1943), Merleau-Ponty (trans.1962)), proposed a different way of looking at 'being', because they believed human states and feelings offered a subjective colouring to intentional relations. Introducing the notion of intentional states or human actions within a schema of logical deductions, raises difficulties because people's beliefs, desires, and goals cannot necessarily be predicted and explained. Instead, contemporary thought sees interpreting/understanding the human form as a necessity. A human being has intentional relationships with those things in the world with which s/he has 'contact', and has thoughts about. In other words, an intentional being has desires; beliefs; feelings; emotions directed toward other entities. The 'intentionality' of humans, which subsumes their ways of knowing about the world, sets them apart in the natural world. Having a belief, expressed as a point of view, means a human being can act on this belief in such a way as to demonstrate there is meaning attached to it. Accordingly, human beings become actors or agents in the world and are connected to the world. Taylor (1985), a moral philosopher points out that where the foremost positivistic view regards a person as a representing subject, a more humanistic view sees a person as an agent for whom the world matters. Crotty (1996:68) states that 'for the existentialist phenomenologist, human being is being-in-the-world'. He explains:

> Existential phenomenology emphasises our embodiment (we are in the world as bodies) and our dynamic relationship with the world (we act upon the world and, in turn, are acted upon) (p68).

As human beings in the world we are unable to be defined apart from the world, and in the same way the world cannot be defined apart from us, thus in a sense there is a 'radical interdependence of subject and world' (Crotty, 1996:40).

As human beings we are co-constituted, we create reality and at the same time the 'world' creates us.

-The Concept of a Social Construction of Reality-

Husserl's distinction between *eidetic* (conceptual) and natural (empirical) knowledge produced a philosophy of knowledge that was 'rooted wholly in the *'lebenswelt'* (the everyday world) in which individuals relate to each other and share intersubjective meanings' (Hamilton, 1974:135). In an attempt to eliminate positivism from sociology, the sociologist Schutz developed the method of phenomenological analysis into hermeneutics by appropriating Husserl's approach and merging it to the Weberian concept of *verstehen*[3]. Drawing on Husserl's notion of the lifeworld, Schutz addressed it in a phenomenological manner, trying to elucidate the essential features of the social world by getting behind everyday taken-for-granted aspects of it (Psathas, 1973). A major insight of Schutz's work was his notion that in the commonsense world of actors, behaviour is based on typifications. He called these 'social recipes', which enable us to act in typical ways in given circumstances and to expect typical outcomes (Crotty, 1996:137). Social reality was to be conceived as a meaning-construct rather than any natural reality, existing only in so far as it has meaning for its participants. As knowledge changes, so too it changes the reality that it constitutes (Hamilton, 1974).

From a sociological perspective Schutz's students Berger and Luckmann (1966), sought to redefine the sociology of knowledge, and contend that the social construction of reality is inextricably linked to knowledge. One basic tenet of their work rests on the assumption that everyday reality presents itself as a socially constructed system in which people give phenomena a certain order of reality that constitutes both subjective and objective elements

[3]'The tradition of *verstehen* places emphasis on the human capacity to know and understand others through empathic introspection and reflection based on direct observation of and interaction with people' (Patton, 1990:57).

(Levesque-Lopman, 1988). That is to say, everyday life presents itself as a reality interpreted by a person and subjectively meaningful to her/him as a coherent world. Yet at the same time it is also an objective reality because society is external to the individual who is a product of it (Berger & Luckmann, 1966, also in Levesque-Lopman, 1988). Drawing on phenomenology, they too, posit that consciousness is always intentional; it always intends or is directed towards objects. Furthermore, the world of everyday life is structured both temporally and spatially, and is shared with others with whom a person is continually interacting and communicating (Berger & Luckmann, 1966). Others and the individual interact and communicate and there is an 'ongoing correspondence' between one's meanings and others' meanings in the world. Further to that, common sense knowledge is the knowledge shared with others in the normal self-evident routines of daily life, a life the reality of which is taken-for-granted (Berger & Luckmann, 1966:37).

Berger and Luckmann identify three significant processes in any social world - institutionalization, legitimation, and internalization. These are regarded as the foremost realities of a constructed social order (Berger & Luckmann, 1966 also Hamilton, 1974). Consciousness is capable of moving through differing spheres of reality, one of which is the reality of the world of work. The reality of everyday life is posited around the 'here' of the body and the 'now' of presence. Shifting from one orientation or reality to another is usually experienced as a transition between two worlds and may be experienced as a kind of 'shock' (Berger & Luckmann, 1966:35; also van Manen citing Schutz,1973, 1977:212).

Humans express their reality through the use of signs mainly in the guise of language. In point of fact, reality emerges through language because language determines how we view what we call reality. 'The very dialectic nature of society means that each person participates not only in his/her reality, but also in the realities of others' (Lumby, 1991a:465). For the naturalistic inquirer, truth focuses on multiple realities seen as layers complementing each other. Each layer provides a different perspective of reality while none is considered more true than the other. As Guba & Lincoln (1988:57) expound:

> Phenomena do not converge into a single 'truth' but diverge into many 'truths'. The layers of meaning are intricately interrelated to form a pattern of truth. The patterns are searched for the sake of *verstehen* or understanding.

It can be seen therefore, that a phenomenologically based sociology of knowledge posits that a person's perception of reality is formed by the activity of social interaction, but not, as Hamilton (1974) explicates, in some abstracted sense in which reality is external to the individual. Rather interaction is the mechanism by which reality itself is *constructed* by social actors.

Conclusion

In seeking to become a profession, nursing has recognised the need for the explication of a body of knowledge and skill specific to nursing, and this chapter has summarily traced developments in that area. Thus, the epistemological foundations of the discipline have been explored including certain key concepts in terms of nursing's dilemma regarding her position as either a science, or an art, or a combination of both. As an artistic endeavour, caring has re-emerged as central to the role of the nurse, and caring as a phenomenon belonging to the realm of the female has been discussed and critiqued. In fact, nursing's heritage as a predominantly female occupation has been a common thread throughout this reconstruction of nursing's cultural positioning.

The emergence of differing perspective/s about the nature of nursing has not been without some debate, and there are nurses who believe an epistemological alliance to concepts such as caring and holism with their concomitant rejection of the natural sciences, will do more harm than good to nursing's attempts at becoming a credible academic discipline and to the process of professionalisation. Faced with a future health care system which 'not only cares more about economics than health but which is structured in such a way as to reflect social inequalities' (Kenway & Watkins, 1994:44), nursing has undoubtedly much exploration and debate still ahead of it in terms of the epistemological tenets it will use to ground its efforts to gain equal footing with other professionals in the health care arena.

Because this study inquires into the practice of experienced nurses, the influential work of Benner on the expertise embedded in advanced practice nursing, has been reviewed. Finally, nursing's view of the person has been cross-referenced with the constructs of intentionality and the social construction of reality. This philosophical and sociological material provides a

gateway into the next chapter which investigates the phenomenological methodology upon which the study was structured. All of this background material is provided in an effort to create an understanding of how this entity the CNS is placed within the wider context of nursing, this is so that the reality of her existence as presented in the phenomenological text in later chapters is well-grounded.

CHAPTER FOUR

THE RESEARCH METHODOLOGY

Introduction

In setting out 'to make sense of a certain aspect of human existence', it is usually the case that the study is essentially 'a project of someone', and as such, is conducted within the framework of an individual's own 'particular social, and historical life circumstances' (van Manen, 1990:31).

As the previous chapters have shown, this study as 'a project' by the researcher was motivated in part, by misgivings relating to her own experience of practising as an advanced nurse. While former chapters have laid the groundwork for the study by examining issues relevant to its context, this chapter recounts the methodology underpinning the research process, and argues the use of the particular methodology determined as the most 'fitting' (Reinharz, 1979:9). Before discussing the methodology specific to this study, an examination of various methodological issues are addressed.

Reinharz (1979) supports van Manen's notion of the subjective role and considers that epistemological and methodological preferences hinge on a person's basic perception of the world, and goes on to suggest that a study should stem as much from the researcher's personal values (truths) as from an understanding of methods. Because of the researcher's background in nursing, this study was generated as a means to explore the meaning and perceived structure of experiences that CNSs live through every working day. The study sought the 'pedagogical ground' of bedside nursing (van Manen, 1990), an in-depth understanding of what it is like to be a CNS within the reality that determines contemporary nursing practice (Bartjes, 1991).

As previously noted, nursing, as a practice-based discipline, is becoming aware of the limits of empiricism for making meaning out of the workworld of a nurse. Quantifying phenomena ignores the dynamic nature of the nurse's world and does not take into account the personal, intuitive and aesthetic elements inherent in nursing practice (Johnson, 1994; Thompson, 1990). Indeed, a positivist framework appears to be incongruent with many of the practices/realities of nursing, and as Parker (1991:289) says, 'seriously limits the scope of investigation of nursing phenomena'.

Consequently, nurses, who for many years undertook quantitative positivistic research inquiries modelled around those of the dominant medical paradigm have suddenly embraced new paradigms wherein the situated meanings of human experience can be understood (Ray, 1990; Thompson, 1990). (Although some nurses still utilise the scientific method as the most appropriate model for particular studies).

To this end, an approach was sought in this study that would allow the emergence of an understanding from 'situations and actions through interpretation and explanation of behaviour, rather than through the seeking of cause and effect' (Mackenzie, 1994:775). The intention was to focus attention on the everyday lives of advanced practice nurses and determine the uniqueness of that experience. To acquire an understanding about their 'concrete' lived experience through language and observation. A methodology espousing a way of 'looking' at the world that would focus on naturally occurring ordinary events in a 'natural' setting (Miles & Huberman, 1994:10), and vision a picture of the world through the eyes of the nurses to expose their whole frame of existence (Spiegelberg, cited Psathas, 1972). A methodology that was compatible with such a study and would support a thesis of what 'real-life' was for the CNS.

With these aspirations in mind, it became clear that the key to understanding in relation to human sciences, lay in the interpretive paradigm (Thompson, 1990; van Manen, 1990). And, with a conviction that the interpretive paradigm philosophically 'fits' with the values and beliefs of nursing practice (Oiler Boyd, 1993), this study looked to that paradigm to guide its exploration into the lifeworld of the CNS.

The Interpretive Paradigm

Social scientists Carr & Kemmis (1986), tracing the history of the interpretive paradigm describe a 'new sociology' whose members adopt a radically different stand to the positivist approach. They point out that the interpretive paradigm is concerned with the conditions for the possibility of any way of knowing, that is, a concern for the ontological basis for knowledge.

The 'interpretive' view of the nature of the social sciences originated in the 17th century, and sought to develop a method whereby the meaning of the text of the Bible could be directly understood from simply reading it without the intervention of ecclesiastical explanations. These

theologians developed a technical method which they called 'hermeneutics'. The roots for the word hermeneutics lie in the Greek verb *hermeneuein* 'to interpret', and from the noun *hermeneia*, or 'interpretation' (Thompson, 1990:230). Two centuries later a succession of German theorists sought to elaborate and extend the notion of hermeneutic interpretation into an alternative epistemological basis for the social sciences (Carr & Kemmis, 1986; Crotty, 1996).

The development of 'modern' hermeneutics is attributed to Heidegger (trans. 1962), whose radical deepening of the general problem of understanding resulted in hermeneutics returning to its traditional concern with authorless texts - with an ontological emphasis rather than an epistemological one. His 'ontological' interpretation of hermeneutics emphasised a very different reality for people than that which had dominated the Western worldview since the 17th century. These rapid developments in the 18th and 19th century raised questions about the suitability of positivism in understanding human beings (Woods & Catanzaro, 1988).

Hermeneutics is therefore, the study of understanding, especially the task of understanding texts. The philosophy of hermeneutics has underpinned many interpretive approaches in research, which in turn, have given birth to qualitative data analysis (Woods and Catanzaro, 1988:24). Palmer (1969) points out that interpretation is perhaps the most basic act of human thinking, and suggests that 'existing' itself could be said to be a constant process of interpretation. Indeed, within postmodernist thinking, 'truth divorced from interpretation is fatuous' (Murphy, 1988:601).

As human beings, hermeneutics assists us to better understand ourselves. Yet understanding human beings is undertaken from the person's own frame of reference, rather than imposing the scientist's frame of reference. In which case, the 'data' is gathered from the perspective of those studied (Woods and Catanzaro, 1988:24). Any theory of human interpreting must deal with the phenomenon of language, since language shapes our seeing and our thought and reality is shaped by language. Language, is meaning in a codified set of symbols. Murphy (1988:603) argues that society should be viewed as embodied, and since 'truth' originates from and in language, language is thus a creative force. Heidegger (trans. 1962 :203) believed the 'existential-ontological foundation of language is discourse or talk', and that 'discourse is constitutive for *Dasein's*[1]

1

Dasein denotes 'that aspect of man which is concerned with the awareness of his existence' (Heidegger, trans. 1962:33). Describing *Dasein*, Heidegger (trans. 1962:36) states, 'we are it, each of us, we ourselves'.

existence' (p204). Language, according to Berger & Luckmann (1966:53):

> Originates in and has its primary reference to everyday life; it refers above all to the reality I experience in wide-awake consciousness, which is dominated by the pragmatic motive (that is, the cluster of meanings directly pertaining to present or future actions) and which I share with others in a taken-for-granted manner.

Gadamer, influenced by Heidegger, perceived language through an existentialist lens. For Gadamer (trans.1975:389) 'language is the universal medium through which understanding occurs. Understanding occurs in interpreting'. He explicates further:

> All understanding is interpretation, and all interpretation takes place in the medium of a language that allows the object to come into words and yet is at the same time the interpreter's own language (p389).

Gadamer claimed that language and culture, that is language and being, were inextricably linked, to the point where, 'we only have a world through language' (Thompson, 1990:240).

Thompson (1990:262) points to the growing emphasis on language in nursing research and the role it plays in trying to understand the inner experience and actions of others. With less emphasis on *verstehen* ('to understand') there is now a belief that entry to the mind is facilitated more through language expression and action. Murphy (1988:608) posits that postmodernists argue empathy is 'incorrectly cited as imperative for the development of rapport between researchers and their subjects'. In point of fact effective communication is possible between individuals who hold nothing in common.

In nursing, there are three major divisions within the interpretive (hermeneutic) tradition, these are phenomenology; ethnography and grounded theory (Lowenberg, 1993; Lipson, 1991). The commonality across each of these divisions involves describing the everyday events in the lives of people using their own words. Such approaches seek to uncover the complexity of human experience in its context, and rely heavily on the researcher's use of self. Because these research approaches emphasise learning from 'informants' rather than 'subjects' with preset hypotheses, society is explored from an *emic* point of view as the researcher tries to understand life from the perspective of the participants in the setting under study (Lipson, 1991; Thompson, 1990). The major difference between the three approaches is in what is described and how the self is used (Lipson, 1991).

As an interpretive study concerned with capturing and understanding the practical everyday activities of CNSs going about their work, clearly this inquiry is concerned with questions of meaning. And although the methodological foundations for this study are phenomenological, it is important to mention that because the CNSs are participative and constitutive of their social world a critical view of the complex intersubjective world of their everday lives is exhibited (it has been argued that one can not '*be*' in a culture-free way). The text created from the descriptions of their experience/s describes not only the nature of being in the CNSs' nursing but also highlights the social and political contexts in which they practice. In fact problematic aspects of their social order emerge because they are aspects of reality the CNSs tend to focus on. So, although in this study the main influencing factor is hermeneutic phenomenology and the resultant text phenomenological, these relational issues give the study a more critical perspective and it could be said that a combined perception-ethnographic-phenomenological framework underpins the study's processes.

While the phenomenological dimensions of the study will become evident through the exploration of possible-empirical experiences (as described in chapters 7,8,9), piecing together the way of life of a group of CNSs in pursuit of the nature of their reality, has been assisted through the analysis of ethnographic data, (as depicted in reported factual-empirical experiences in the text). Consequently parts of the resultant phenomenological text (chapters 7,8,9) comprises the CNSs' opinions and perceptions cast in terms of ethnographical generalisations or empirical statements. These statements come about through language, by the CNSs expressing their ideas beliefs and knowledge and by the researcher observing patterns of behaviour, customs and lifeways (Germain, 1993). Ethnographic ways of reporting explore the inside shared views of the members of a culture, in this case that of the CNSs. Describing the social reality of the CNS proffers a version of reality from the standpoint of the members of that culture as practised in a particular institution.

Through ethnography the study attempts to use the members' perspective/s in order to arrive at a valid account of how their particular sub-culture operates. Not only has the study been influenced by ethnography, but it adopts the view of human society as symbolic interaction (Blumer, 1972). This position argues that as a human being, the CNS interprets or 'defines' the actions of others, rather than merely reacting to them (Blumer, 1972). Thus her responses are based on the meaning she attaches to another's actions (her perception of the action). Because

'human beings interpret each other's action as a means of acting toward one another' (Blumer, 1972:145), the CNSs' story as outlined in the text in chapters 7,8,9 contains evidence of perception research, hence the study's somewhat eclectic approach. Notwithstanding the so called phenomenological text created from out of this study presents the 'life' of the CNS based on phenomenological ideals. And a phenomenological 'way of looking at the world' informed the study's approach.

Interest in hermeneutics within nursing, especially in North America, has grown steadily since the 1980's and a number of nurses have identified the relevance of hermeneutics as a philosophy bestowing important benefits for nursing. They advocate the use of an interpretive paradigm as one of the most, if not the most appropriate approach to nursing research, and among a rapidly growing number of such scholars, are Diekelmann, (1993); Morse, (1991); Thompson, (1990); Allen, Diekelmann & Benner, (1986); Benner, (1985, 1984); Omery, (1983); Melia,(1982); Oiler, (1982). Thompson (1990:228) advances that hermeneutics assists us in understanding the decisions we make in the process of doing research as:

> . . . value laden and interest bound. It emphasizes the social, political, and ethical dimensions of each and every step of the research process, and therefore, it can lead to more insightful, more reflective, and, hopefully, more liberating kinds of research.

Within the interpretive paradigm lies phenomenology, which Berger and Luckmann (1966) consider the best suited method to clarify the foundations of knowledge in everyday life. In recent years, the interpretive phenomenological approach has been widely accepted by nurses, especially in North America, and the nursing literature is imbued with differing ways to undertake phenomenological research. For example, Paterson and Zderad (1976), Ray (1990) describes one method which adopts almost exclusively the ideas of van Manen (1984) and Parse (1987), Parse (1987) has developed her own theoretical model.

Many nurse theorists are convinced the phenomenological approach is one which can most effectively serve nursing's goal to understand experience. In Australia, a growing interest in phenomenology is becoming manifest in the nursing literature - Koch (1995, 1994); Walters (1995, 1994); Taylor (1992, 1993, 1994); Wilkes (1991); Bartjes (1991).

Phenomenology As Part of the Interpretive Paradigm

Phenomenology is both known as a philosophical movement as well as a method and was the approach adopted for this study, Crotty, (1996) describes it as a philosophical approach to knowledge and truth that has had 'a long and tortuous history' (p29). Psathas, (1973:2) an expert on phenomenological sociology, points out the difficulty in explicating phenomenology because as a philosophy, method and approach, it is still developing, and as such 'refuses to stand still'. Macann (1993) in his text regarding four phenomenological philosophers completes his discourse by asserting that the fundamental principles of phenomenology have never been laid down in a definitive fashion, and that even Husserl - considered the fountainhead of the movement - was himself constantly redefining what he meant by phenomenology.

Merleau-Ponty (trans.1962) refers to the unfinished nature of phenomenology. In an address in 1967 entitled, 'What is phenomenology', Merleau-Ponty conceded that the question had by no means been answered (1967, cited Anderson, 1991). He believed that the central point of phenomenology was the human experience. He said, 'phenomenology is the study of essence . . . all its efforts are concentrated upon re-achieving a direct and primitive contact with the world' (Merleau-Ponty, trans.1962:vii).

Phenomenology has been described by the phenomenological historian Spiegelberg (1975:3), as the name for:

> A philosophical movement whose primary objective is the direct investigation and description of phenomena as consciously experienced, without theories about their causal explanation and as free as possible from unexamined preconceptions and presuppositions.

And points out:

> The so-called Phenomenological Movement did not get started until the first decade of the 20th century, but even this new phenomenology includes so many varieties that a fair picture requires a brief sketch of its development (Spiegelberg, 1975:3).

He refers to 'ways' into contemporary phenomenology, which implies there are a variety of phenomenologies from which to choose. He explicates some of these as 'descriptive'

phenomenology, dealing with particular phenomenon and leading to 'essential' or *eidectic* phenomenology seeking to explain essences. This is the phenomenology of appearances, which involves a deeper level of exploration; seeking *how* something appears rather than just *what* appears. 'Constitutive' phenomenology deals with how phenomena constitute themselves in consciousness and finally 'hermeneutic' phenomenology upon which this research is based, and which Spiegelberg describes as a kind of uncovering interpretation of more enigmatic or ambiguous phenomena (p15-16).

In spite of phenomenology evolving in such a way as to produce several theoretical and methodological extensions, it remains deeply rooted in the foundational writings of philosophers such as Edmund Husserl (trans.1970) Martin Heidegger (trans.1962) and Maurice Merleau-Ponty (trans.1962). From the beginning, phenomenology has been interpreted as a method involving the faithful description of phenomena in order to get 'to the things themselves!' (*Zu den Sachen*) (Crotty, 1996:3; Heidegger, trans.1962:50). Hermeneutic philosophy has evolved in contemporary times as an offshoot of Heideggerian phenomenology. Hermeneutic phenomenology in nursing circles is viewed by some as a postmodern school of thought that is basically concerned with understanding the 'meaning of our life' through interpretation of human experience (Bergum, 1991:56). According to Thompson (1990), it has increasingly moved away from the questions regarding specific interpretive method to focus more on existential-ontological questions of how people come to 'understand'.

These works have provided the groundwork for the phenomenological 'method', which a growing number of nurse scholars are introducing to the discipline, one of whom is Wilkes (1991), an Australian nurse academic. Benner (1984) a North American nursing scholar, is also a strong advocate of adopting phenomenology as a methodology for nursing. In her book based on phenomenological research, she sees phenomenology as a 'view' particularly in relation to the person. Other nurse scholars - Field and Morse (1985:27) describe it as 'a kind of thinking which guides one back from theoretical abstraction to the reality of lived experience'. Nurse researchers - Munhall and Oiler, (1986:70) are strongly influenced by Merleau-Ponty's position on phenomenology because it attempts to 'describe experience as it is lived without concern for how it came to be the way it is'.

The Debate

While there is no doubt important work has, and is, being carried out by nurses using phenomenology as a framework for undertaking research, it is becoming clear that as an approach to research it is not without some degree of controvertibility, and it is timely for nurses and this study in particular, to consider a number of issues raised in the literature. One critic is Crotty (1996), who has studied phenomenology with a special focus on the use, or as he would claim, its misuse, its 'mutation', specifically by North American nurses. In reference to these nurses he declares, 'nurse researchers yield to none in the warmth with which they have embraced this approach' (p.7). He (1996:24) says the phenomenology which the majority of North American nurses are professing to carry out is merely 'an adaptation' of mainstream phenomenology to suit nursing's own ends. In the opening line of his book he writes, 'in social research today, at least in the English-speaking world, there are two phenomenologies'. And, although aware of the many variations on the theme of phenomenology, he calls the North American nursing variation the *new* phenomenology or *nursing* phenomenology, and regards it as a distortion through misinterpretation containing none of the 'common core' concepts of the traditional approaches. (Crotty's concerns are discussed in greater depth later in this chapter).

Notwithstanding, nurses are aware of the difficulties facing nurses in their new paradigm research endeavours, particularly in North America. Morse (1991), who is a North American nurse academic, raises some central methodological concerns regarding the burgeoning interest in interpretive research. These concerns cover aspects such as the suitability of the interdisciplinary transfer of qualitative methods, the mixing of methods, and a number of conceptual confusions. In addition, she voices a concern that phenomenology is being construed as an equivalent term for qualitative research. Finally, she addresses problems regarding the quantification of qualitative data. Through her analysis of qualitative research methods in nursing, she points out that interpretive research is going through a period of change which she likens to 'adolescence'. One of the ramifications of this, is that naturalistic studies in nursing are suffering because of insufficient protocol that has seen them become increasingly unstructured She believes researchers, particularly novice ones, are tending to combine or adapt qualitative methods, and points out, 'if the goal of a study is phenomenological, then clearly, phenomenological methods must be used if the goal is to be attained' (p.15). She states:

> This conceptual confusion extends beyond the methods to the nomenclature used when describing methods. For example, phenomenology may be used to refer to a philosophical stance or to the research method. However, some authors are using phenomenology as an equivalent term for qualitative research (Morse, 1991:16).

Further concerns are raised by other North Americans, for example Baker, Wuest & Stern (1992) discuss the method slurring between grounded theory and phenomenology. They perceive this problem has resulted in a body of nursing research that is either mislabelled or is classified broadly as qualitative and hence open to incrimination pertaining to the lack of rigour in such research. Lowenberg (1993), a nurse academic, in a critique of interpretive research methodology, claims that along with the surge of interest in these research strategies among nurses; many questions and controversies have arisen. In part she believes this is due to a lack of shared meanings and terminology in nursing discourse, which increases the 'political and potentially arbitrary nature of the evaluation of research conducted within the interpretive position' (p.62). She also believes the word 'phenomenology' is associated with different approaches and nuances, and states: 'there is a definite lack of clarity in distinguishing between phenomenological assumptions underlying research approaches and the phenomenological method' (p.64).

Lowenberg (1993) relates many of the problems in regard to the interpretive approach primarily to the evolution and diffusion of the meanings between the epistemology or philosophy of knowledge, the methodology and methods, together with the ensuing confusion caused by such misconceptions. She believes nursing is increasingly assimilating interpretive approaches into studies exploring nurse/patient positions and stresses the need for more careful examination of the terminology and for researchers to make explicit the underlying assumptions on complex issues surrounding such methodological concerns.

Because the conclusions of Husserl (trans. 1970) and Heidegger (trans. 1962) involve divergent epistemological and ontological assumptions, the term phenomenological is less useful in epistemological or methodological debates unless the specific meaning and assumptions of the term in that context are made explicit (Thompson, 1990). Thompson (1990) suggests, that as a general rule when North American nurse authors use the term 'hermeneutic philosophy' or 'Heideggerian philosophy' they are distinguishing hermeneutics from 'transcendental' or

'Husserlian' phenomenology. She points to the significant differences that exist between these two influential schools of thought, (the most fundamental being the turn from consciousness to existence). To add to the confusion, hermeneutics and phenomenology are terms often used interchangeably.

It would appear that one of the biggest challenges for nurse researchers in using hermeneutic phenomenology, is to remain true to its philosophical underpinnings (Plager, 1994; Koch, 1995; Walters, 1995). It was important therefore, as a researcher about to adopt the phenomenological approach, to be quite clear about the construct 'phenomenology'. Crotty's critique shows the philosophical tenets of phenomenology have to be acknowledged if one is to remain true to their original intent. As will become apparent in the discussion that follows, a phenomenological approach stemming from van Manen in the human sciences was eventually adopted for this study. But, in order that firm foundations could be laid for the research process, it seemed appropriate to look at the phenomenological movement that spawned van Manen's interpretive art.

Nurse scholars support a commitment to a greater understanding of the philosophical underpinnings to research practice (Thompson, 1990; Lowenberg, 1993; Omery, 1983). As it turned out, exploring the issues regarding the phenomenological school of thought was a continuous undertaking throughout this research, and is on-going.

An exploration of the history of phenomenology was begun early in the research process, and yet as Spiegelberg (1975:22) points out *vis-a-vis* phenomenological history:

> . . .it can certainly overawe the phenomenological novice if he is told at once how much has already been said and written about the subject and how much he has to read before he is allowed to test his own wings.

He refers to the original texts of phenomenological philosophers as;

> . . . not always self-explanatory. Even if they were so at the time of writing, they no longer will be for a different readership than the one to which they were originally addressed. This is one reason why even the classic texts are in increasing need of commentaries (Spiegelberg, 1975:21).

Similarly, van Manen (1990:17) while discussing the great scholars of phenomenological philosophy, suggests their writing styles are possibly - 'evasive even poetic'. Crotty too (1996:75) acknowledges, 'given the abstruseness of Heidegger's thought, there is plenty of room within Heideggerian scholarship for conflicting interpretations on a broad range of issues'. Benner (1994:15) in a book devoted to interpretive phenomenology for nurses, states she makes no attempt at a detailed exposition on Heidegger's work, proclaiming it is 'far from easy to understand' and hence she restricts herself to stressing only certain critical points.

It was certainly the case, that in reading seminal phenomenological texts the need to verify on-going interpretations became apparent. *Ipso facto,* in addition to exploring the seminal works, it proved helpful to seek the aid of recognised commentaries (eg Spiegelberg, Kockelmans, Palmer, Crotty, Dreyfus and so on) and adjunctive work by other eminent scholars in the field. Moreover, by turning to experts in the nursing research literature e.g. Thompson, Benner, Morse, Diekelmann etc. an insight into nursing's view of phenomenology was revealed.

This text in this chapter, containing as it does, a 'brief sketch' of the development of the phenomenological movement, begins with an overview of the phenomenological ideas of Edmund Husserl generally regarded as pivotal in phenomenological thought, and continues with a similar resume of the work of his protege, Heidegger. It is important to differentiate between the two schools of thought of these founding members of phenomenology because the various interpretations of the approach are generally associated with either one or the other of their diverging perspectives. At this point it seems appropriate to remind the reader, that the understanding of phenomenology developed in this study while grounded on extensive reading of seminal texts, commentaries to seminal works, works by renowned scholars in the field, nursing theorists in the field, together with Crotty's informed appraisal, and by attending philosophy lectures, is by no means meant to be a definitive account of phenomenological discourse.

The Origins and Evolution of Phenomenology

Although the term phenomenology had appeared earlier in the work of Hegel in 1807 in *The Phenomenology of the Spirit,* as a philosophical movement, phenomenology is generally taken to have originated from the foundational writings of a group of German philosophers stemming

from Edmund Husserl in the 19th century (Harre' & Lamb, 1986:260). There have been a number of distinct phases in the development of phenomenological philosophy in the twentieth century. Two of these are presented in the text that follows.

-Husserl's *Transcendental* Phenomenology - (Edmund Husserl 1859-1938)-

Husserl's final work the *'The Crisis of European Sciences and Transcendental Phenomenology'* (trans. 1970) formed the basis for a great deal of future phenomenological discourse. In this work Husserl states his opposition to objectivism and the mathematisation of Nature, which he saw as a false interpretation of reason. And while his claim was not that the sciences were failing, nor that the crisis was related to the legitimacy of scientific activity, what concerned him was the enigma of subjectivity and human existence. He believed, that in spite of its successes, science had little to pass on about the deepest of human needs - the meaning or meaninglessness of human existence. The purpose of 'being' had not been adequately explored by science and so it was to a crisis of purpose, of misguided rationalism Husserl alluded.

Husserl used the term 'lifeworld' to describe the everyday world, the real world as given to us in experience (not the world of mathematical idealities), and in which we live in a natural taken-for-granted attitude. This is the pre-theoretical world, a world revealed to people in relation to their subjective relative concerns. It is a world which is presupposed in all human praxis (Husserl, trans.1970). Husserl's problem centred on the devaluing of the subjective relative world by objective science. Objective science looks to transcending the lifeworld in order to ascertain true being in itself, that is objective being, and perceives the subjective relative world as a domain of possible deceit, of 'mere' subjectivity. Yet, for Husserl the fact that the scientific activities of the objective world could only ever be verified by reference to the subjective world posed a difficulty. Given that scientists themselves with all of their products, are 'things' within the lifeworld, how could the claims by science about the world, be true? These were after all, claims made by scientists utilising consciousness, in which case, for Husserl, scientific sets of meanings become just another 'thing' in the lifeworld.

According to Husserl (trans.1970), to be able to say anything about the world objectively through science, the lifeworld itself had to be taken-for-granted. In his view, the world of experience had always been presupposed by scientific investigation and had never been the object of its

investigations. Objective science offers only a determination of another kind of being, the kind of being that exists apart from the lifeworld. To give an example, one could examine a piece of chalk and objective science would describe it using its physical properties as parameters, yet the fact that the piece of chalk exists is never questioned. But Husserl would ask how in fact we come to 'know' that piece of chalk? How it is given to us through, what he termed 'a continuous synthesis' (trans.1970:157), a flux of manifold difference? How does it appear to us through our experiencing of it? He believed the 'being' of things in the world had never been questioned, and sought to discover how certain beings or phenomena had come to be known with the set of meanings they had. He discerned that everything that can be given as phenomena can be constituted by a consciousness, but how does this thing come about? Why do things hold the meaning they have? He was concerned with the phenomenon of perception, the experiencing of a phenomenon (Husserl, trans. 1970).

The investigator using Husserlian phenomenology 'always asks about the meaning of human experience' - how has that come to be for 'me'? (Koch, 1995: 828). Husserl was convinced in order to understand and explain 'reality' he needed to take a fresh look at it, and to ground his knowledge about reality he looked to reality itself through the catchcry 'back to the things themselves' (Crotty, 1996:30). For Husserl (trans.1970:143) reality was the lifeworld, a world which he believed was taken-for-granted in what he saw as a person's 'natural attitude'. In order to purify the apperception of mental phenomena i.e. by returning to the objects as they originally present themselves to our consciousness, he advocated the 'bracketing off" of the everyday life-world, of the 'natural attitude' and concentrating upon the consciousness of the individual ego (reduction) (Husserl, trans.1970;Crotty, 1996).

Husserl's concept of the lifeworld has been further developed in more existentially oriented phenomenology. Existential phenomenology aims at describing how phenomena present themselves to lived experience in human existence and began with the work of Heidegger. Heidegger refuted Husserl's transcendental phenomenology and proposed a radically different view.

By virtue of the fact that Heidegger draws from the work of Husserl, and van Manen has drawn from Heidegger, this study is grounded in certain traditional phenomenological concepts. It was deemed essential therefore, to become acquainted with the central tenets of the work of both of

these phenomenologists in order to be able to proceed into human science phenomenology. (Due to certain restrictions on the presentation of this thesis, a more in-depth exposition of phenomenological thought is not feasible).

-Heidegger's Ontological Phenomenology (Martin Heidegger 1889-1976)-

Heidegger was identified as an 'existentialist'; a philosophical position that is concerned with personal inwardness and personal integrity, with the self in its struggle to be itself (Grene, 1957). Although he is widely considered the chief exponent of existentialism, Heidegger did not see himself as one, and actually rejected the view because of what he saw as its preoccupation with self (Crotty, 1996). This position, he believed, centred the entire world on the individual and for Heidegger, it was the world that existed before anything else (Heidegger, trans.1962). Thus, where pre-Heideggerian ontology was concerned with what *kinds of things* exist, and on the act of experiencing those things, Heidegger proposed a more crucial fundamental question in what does it mean *to exist (to be) at all* (Gelven, 1989; Heidegger, trans.1962).

According to Dreyfus (1995:1), in *Being and Time*, Heidegger, sought to undermine the Cartesian tradition of the priority of knowledge over practice. Heidegger believed that practical activity is the essential way subjects give meaning to objects, that human activity plays a role in a person's constitution of the world. He appeared to be advocating that the 'detached, meaning-giving, *knowing* subject, still at the center of Husserlian phenomenology, must be replaced by an involved, meaning-giving, *doing* subject' (Dreyfus, 1995:1). Thus *Being and Time* is an interpretation of what it means to 'be'. In the opening remarks to this early work published in 1927, Heidegger explains his treatise is to work out the question of the meaning of Being and uses the interpretation of time as the possible horizon for understanding the question (Heidegger, trans. 1962;Gelven, 1989). According to the philosophy scholar Grene (1957:11), Heidegger occupies 'a unique place in the intellectual history of our time'. This is because in his work he advances a philosophy of Being (to be) which had never before been attempted.

For Heidegger, therefore, the ontological question took precedence over the epistemological one. Before everything else, we *exist, ipso facto* the question of the meaning of Being is prior to the question of knowing. Moreover, the answer to the question of knowing arises out of the question of Being (Gelven, 1989; Heidegger, trans.1962; Benner & Wrubel, 1989; Dreyfus, 1993).

Heidegger transposed Descartes's *res cogitans* to become *I am therefore I think*. We exist to know. 'Being', allowed everything else to come into existence including people or beings. Being is the most universal concept of Heidegger's phenomenology. 'Being is always the Being of an entity' thus to enquire as to the Being of something is to inquire into the nature or meaning of that phenomenon (Heidegger, trans. 1962:29; also van Manen, 1990). Being is the most fundamental aspect of reality and is viewed as a source of all other reality. The question concerning the meaning of Being Heidegger dealt with in ontology, a term derived from *logos* (an account) and *onta* (of the Being of beings), (Kockelmans, 1987:334). For Heidegger, phenomenology is ontology, that is a study of modes of Being-in-the World. He reserves the term 'ontology' for that theoretical inquiry which is explicitly devoted to the meaning of entities 'being in such a way that one has an understanding of Being' (p32).

Heidegger rejected Husserl's transcendental reduction or bracketing. For Heidegger, hermeneutic phenomenology means making manifest that which manifests itself - 'to let that which shows itself be seen from itself in the very way in which it shows itself from itself" (p.58). In order to understand the background upon which all our understanding takes place one does not 'bracket' existence (Heidegger, trans.1962; Crotty, 1996; Dreyfus, 1993). He claims that our existence is embodied in such as way as to make it impossible for us to free ourselves from prejudice (Dreyfus, 1993). Nevertheless, as Crotty (1996) points out, while Heidegger rejected Husserl's notions of 'bracketing off' and *eidetic* reduction he still believed the answers to the phenomenological question were to be found in the 'shadowy primordial pre-understanding of Being' (p79). Crotty refers to this as 'reduction' (not in a Husserlian sense however), from naturalistic and cultural prejudices relating to the life-world.

Heidegger (trans.1962) distinguishes between what he calls the ontic type of inquiry and the ontological type of inquiry. Ontical inquiries he explicates are about entities (dealing with 'real life' issues and circumstances, the concrete acts of day-to-day existence), they make use of categories and are factual. To study the meaning of Being ontically, makes the whole question meaningless because the inquiry revolves around particular *things*. Whereas ontological inquiry (pertaining to a deeper level of intelligibility where the underlying structures of being are to be found) makes use of *existentials* and is factical and explores the *what* and *how* of Being (Heidegger, trans.1962; Gelven, 1989; Crotty, 1996).

Heidegger (trans.1962:32) stated, 'that kind of Being towards which *Dasein*[2] can comport itself in one way or another, and always does comport itself somehow, we call "*existence*" (*existenz*)'. '*Dasein* always understands itself in terms of its existence', a possibility of itself (p33). Heidegger therefore is concerned with what he calls existential-ontological *(existenzial)* issues rather than existentialist-ontical *(existentiall)* issues (Crotty, 1996:78; Heidegger, trans.1962:34). Because *Dasein's* characters of Being are defined in terms of existentiality he called them 'existentialia' (p70). *Existentials* are those modes of existence whose analysis, Heidegger believed, reveal what it means to 'be' (Gelven, 1989:15; Heidegger, trans.1962:33:70). An existential designates 'the Being of a possible way of Being-in-the world' (Heidegger, trans.1962:83). *Existentials* are the result of an abstraction from an experience but are presupposed in an experience and make that experience possible: hence they logically come prior to any experience and are *a priori* (Gelven, 1989:15). As will become clearer in the chapters that follow, this study attempts to interpret the average everydayness of the CNSs by reference to their existence-structures or 'existentialia'.

-Heidegger's Hermeneutic Phenomenology-

In an effort to undertake his analytic of man's Being, Heidegger applies 'hermeneutic phenomenology', and in *Being and Time* explains the sense in which hermeneutic phenomenology is to be understood (Kockelmans, 1987:333). Because *Being and Time* is an interpretation of what it means 'to be', the meaning of Heidegger's phenomenological description as a method lies in interpretation (Heidegger, trans.1962; van Manen, 1990). 'Interpretation' means the function of understanding that makes explicit what we, as existing beings, already are, simply because we do exist (Gelven, 1989:94). Interpretation is the 'working out' of the possibilities projected by understanding. Heidegger (trans.1962:195) stipulated that 'all interpretation is grounded on understanding'. The main function of interpretation is to make explicit what is already within the range of human awareness. What is interpreted is the world ready-at-hand, the world as something to *use*, as we see it, as it is available to us (Gelven, 1989; Crotty, 1996).

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'*Dasein* when understood ontologically is care (Sorge). Because Being-in-the-world belongs essentially to *Dasein*, its Being towards the world is essentially concern' (Heidegger, trans. 1962:84). Crotty (1996) points out that care in Heidegger's terms is different from the care as used by nurses, and that when referring to people, Heidegger uses the word 'concernful solicitude' (Fursorge) (Heidegger, trans. 1962:161).

Interpretation, Heidegger says is the 'working out' of the possibilities projected by understanding, and its chief concern is to make explicit what is already within the range of human awareness, that is within one's experience. He points out, the more one looks at an object and does not 'use' it, the further away one becomes from its 'proper' meaning. When there is interpretation one does not add on to an experience an external meaning or significance but makes clear what is already there (Gelven, 1989:95). Interpretation therefore, is simply articulating or emphasising the in-order-to of a particular object, which is, to see the object as that object. Hermeneutic analysis does not set out to discover something brand new, but focuses upon what is already 'known' or 'felt' and the 'everyday perspective is never abandoned; it is transcended' (Gelven, 1989:175). For Gelven (1989:42), Heidegger's hermeneutic phenomenology is:

> That analysis by which the meaning of the various ways in which we exist can be translated from the vague language of everyday existence into the understandable and explicit language of ontology *without destroying the way in which these meanings manifest themselves to us in our everyday lives!*

From this, one can say that Heidegger's phenomenology contains the conception of truth as a process of unconcealment (Kockelmans 1975:76). A description of the lived-through quality of lived experience in addition to being 'descriptive of meaning *of the expressions'* of lived experience (van Manen, 1990:25). An 'interpretation of human beings as essentially self-interpreting, thereby showing that interpretation is the proper method for studying human beings' (Dreyfus, 1993:34). Since people are basically self-interpreting individuals for whom things have significance, understanding human action also involves an interpretation by the researcher of the interpretations being made by the persons being studied. This involves a process which is referred to as the hermeneutic circle (Leonard, 1989).

Several hermeneutic thinkers (particularly the early ones), have proposed that the actual practice of hermeneutics, that is understanding, occurs through a complex experience labelled the 'hermeneutic circle'. Kockelmans (1975) describes the hermeneutic circle as the development of human knowledge through dialectic procedures, which Thompson (1990:243) posits is a constant 'toing and froing' between part and whole. Because this movement begins where it will end, it is referred to as circular (Howard, 1982).

To conclude

This overview of phenomenology (and it is an overview), informs this study and enables an examination and understanding of the critique that follows. Crotty's analysis on the use of the phenomenological approach to nursing research, specifically by North American nurses, is important because it highlights the necessity to clarify certain key notions in the development of research purporting to be grounded in traditional phenomenological philosophy. In this study, such an understanding fostered a more informed evaluation of contemporary phenomenological approaches, and facilitated decision-making on the part of the researcher as to which phenomenological approach to take.

In this study, the researcher's personal history - her story, has been included not only to expose her existence, but also the whole of her knowledge about the phenomenon. This knowing represents the 'fore-structure' upon which constituent parts were then grafted to form a part-whole-relationship which became re-visioned as the study progressed. The final chapter in this thesis represents a whole 'new' understanding of the phenomenon CNS upon which parts will continue to be grafted in the future.

Crotty's *New* Phenomenology

As pointed out in an earlier section, Crotty (1996) believes North American nurses to have misappropriated traditional phenomenology. In his view there are two fundamental problems with *new* phenomenology or *nursing's* phenomenology, and he describes them as such. The first problem is that the nurses do not appear to be cognisant that their practice is incongruent with traditional methodology, and second, in bypassing mainstream phenomenology, nurses have failed to comprehend the value of what they are *not* doing. And, while he concedes there is benefit in the research being carried out by nurses, he does emphasise these deficiencies. Crotty has critically appraised 30 nursing studies and written an extensive account of his appraisal. In his opinion, *new* phenomenology is overwhelmingly subjective. In seeking to discover the subjective experience of the people it studies, that is by merely describing the subject's feelings, thoughts and perceptions as opposed to the objective phenomena revealed in and through them, *new* phenomenology he asserts, is essentially 'illustrative rather than critical'.

As far as he can ascertain, the North American nurses' task is about identifying subjective experience, describing it and understanding it. In other words, *new* phenomenology 'looks to what is taken-for-granted but fails to call it into question' (p.7). Describing states of affair instead of problematising them. Therefore it merely perpetuates traditional meanings and reinforces current understandings. It remains preoccupied with what *is*, rather than striving for what *might be*. Thus for him, it loses the objectivity and critique of mainstream phenomenology. On the other hand he attests, mainstream phenomenology is about what is perceived, the emotion felt, or the object towards which an attitude is taken, and so it is about describing phenomena. It is a search for objective reality and studies the objects of individual experience by elucidating *what* people experience, that is, the phenomenon, the experienced world they are experiencing rather than the subjective reactions of the experiencing person. Crotty (1996:31) points out, that if Husserl turned to the subject, to consciousness, it was 'because it was there he expected to encounter the object he was after'. Mainstream phenomenology aims to illuminate precisely, as human phenomena, the feelings themselves which people experience. It pursues not the sense people make of things, but what they are making sense *of*. Being more objective it is also more critical because it calls into question meanings that have been taken-for-granted. In other words, it is a search for reality and not just a study of subjects. What it studies in the subjects *is* the object of their experience. And so, posits Crotty, there is an objectivity about phenomenological research (p.36).

He believes that in cases where the nursing authors have professed to adopting an Husserlian or an Heideggerian approach to their study, some original concepts have been misconstrued. For example, he cites Husserl's notion of intentionality, which in its original form could be conceived as an 'in-tending' or *reaching into*, that is, the human mind (subject) reaches out and into the objects of which it is conscious. Heidegger still espoused intentionality but gave it a less epistemological focus and turned it into one that was more ontological. Thus for Heidegger, not only is consciousness intentional, but human beings as such, are intentionally related to their world, most specifically through time and space. Intentionality means that human experience always points to something beyond itself, and as such, is essentially related to the phenomenon - to the object of experience, what is experienced. As a result, subject and object, 'distinguishable as they are, are always united' (Crotty, 1996:40). In contrast to these views, according to Crotty, the North American nurses have interpreted the everyday meaning of intentionality as conscious deliberation or goal-oriented purposeful behaviour. Hence, in effect, they have separated subject

and object which is not the original conception.

For phenomenologists there is no such thing as meaning that resides in an object independently of any subject. Rather there is only meaning *for* someone (Crotty 1996:46). This is diametrically opposite to the Cartesian-Locke body/mind dualist outlook. No object in any meaningful sense exists apart from a subject and similarly no fact stands alone, free of interpretation. Likewise no thing exists independently of consciousness. Therefore, according to Crotty, it makes sense to seek object in subject, fact in interpretation and thing in consciousness. He says, 'the journey back to the things themselves is a return to the objectivities enshrined in human experience itself' (p48). Merleau-Ponty (trans.1962 cited Crotty, 1996:48) describes this as 'looking to a universe whose milieu is consciousness'. Yet, says Crotty, the contents of consciousness do not all have equal status and as such not all of them will give us access to what we are after. Phenomenologists are required to return to a 'special class' or 'level of experience', known for many years as 'immediate experience' but today it is more commonly called 'lived experience'.

Phenomenologists, by their insistence on getting back 'to the things themselves', are urging that experience be the guide and not taken-for-granted concepts or principles that have been handed down. For example, the taken-for-granted role of the nurse in the health-care system. Phenomenology looks to experience as the source of knowledge but has 'a broad and very rich concept of what experience is' (Crotty, 1996:52). Husserl points to 'original' phenomena that 'present' themselves to our consciousness in a 'prepredicative way', that is before we engage in any reasoning about them, and so for him, there is no induction or deduction, purely intuition. Husserl's phenomenology is in the field of primordial phenomena in which presuppositions are simply inconceivable (Crotty, 1996:52). For him and many phenomenologists who followed him, the phenomena were sought as they appear in their unmediated and originary manifestation to consciousness. That is, as they appear pre-reflexively. Experience as it is before it is thought about. The focus should therefore lie with what 'manifests' itself in experience rather than with what the subject has made of it (Crotty, 1996:56).

Crotty says:

> Quite clearly, what phenomenologists are targeting is not the everyday, taken-for-granted assumptions and understandings of people. In fact, it is precisely these everyday, 'commonsense' presuppositions and preconceptions - the 'natural attitude', Husserl likes to style them - that phenomenology in general calls upon us to set aside. We need to move from common sense to pre-reflection, from prediction to prepredication, from the taken-for-granted to the immediate and primordial (p55).

Mainstream phenomenology does not invite exploration of everyday meanings as they stand. Rather, it seeks to lay those meanings aside in order to open up to the phenomena to see what emerges. It is irrelevant whether new meaning or old meaning with new life breathed into it, is discovered, because either way it will no longer be borrowed meaning handed down through culture, but 'authentic' meaning gleaned from direct experience. Furthermore, Crotty advocates it is the subject and not the researcher who intuits the phenomena (Crotty, 1996).

The primary focus of phenomenology is not found in the contradictions and conflict discernible in a person's interpretation of their everyday world:

> To the contrary, its focus is precisely those aspects of social understanding that appear quite uncontrovertible - the taken-for-granted features. Far from seizing upon that which is problematic, phenomenology takes what is unproblematic and problematises it (Crotty, 1996:133).

Crotty cites Natanson (1974, 1996:133) who describes this as a 'transformation of familiarity into strangeness'. Such transformation comes about by holding taken-for-granted understandings in abeyance and taking a fresh look at the phenomena to which they attach. Crotty (p.142) explicates this is 'an attempt to lay aside the 'natural attitude', get behind it and clarify the grounds on which it is based'. He cites Zaner (1970, 1996:142), who points out that this is an attempt to 'bring out or make explicit those structures that remain merely implicit or taken-for-granted, in order to make possible a critical understanding of them and permit their assessment'. In this study, the taken-for-grantedness of the everyday work lives of nurses was sought in order to somehow lay it aside and give the phenomenon fresh meaning.

In regard to Heideggerian phenomenology or hermeneutics, Crotty (1996:75) believes that a number of nursing scholars appear to use three principal assertions:

i) it is said to be a way of discovering meanings in day-to-day experiences,
ii) meanings sought are not idiosyncratic but 'shared' or 'common',
iii) to discern these meanings it is necessary to take a holistic view and look at people in context.

According to Crotty, however, Heidegger's project was different because he was not looking at the 'being of beings', rather he wanted to get beyond the being of individual beings to Being itself. In *Being and Time* he gives an in-depth analysis of human being as *Dasein* but only because his true quarry the meaning of Being manifests itself there. He advocates the need to get behind the mundane to the immediate experience, so the emphasis should be on what 'manifests' itself in experience rather than what the subject has made of it. Neither was Heidegger looking to bring to light shared, culture-bound meanings (p84), nor the prevailing understandings in 'idle talk' (p88). While the North American nurses purport to be carrying out research utilising either a Husserlian or Heideggerian approach, *New* phenomenology, as Crotty (1996:76) sees it, is informed by the humanism of humanistic psychology, and the nurse researchers are conducting studies in the tradition of pragmatic philosophy, symbolic interactionism and humanistic psychology.

Having examined the concept phenomenology and sketched its development during this century, it can be seen the approach is clearly suited to studies emanating from the discipline of nursing. Nevertheless, as Crotty points out, there are major concerns regarding its implementation. There is a difference for example, between describing the subjective experiences of the informants, and actually getting to the object of their experience deemed the phenomenon or phenomena. With these issues in mind, this study sought to explore the world of the CNS, and yet it was not for their subjective feelings about being a CNS, nor the taken-for-granted aspects of their existence, the stereotypical rhetoric of the job description and list of tasks, that it looked. Not for example, whether they liked or disliked being a CNS, but *what* they liked and disliked about being a CNS. (This issue is discussed in more depth in the section entitled 'Experience and Phenomenon as Concepts' in chapter six). With these concepts clarified, the question became which variegation of phenomenology would be most suitable for the study in hand.

Which approach for this Study?

It has been said, that while Husserl's three introductions to phenomenology contain a number of models for direct phenomenological research, their primary emphasis is on developing the *idea* of phenomenology, (especially transcendental phenomenology) (Spiegelberg, 1975:20). Husserlians bracket existence and purport to describe the phenomenon as it appears while separating their description from their own interpretation, and yet, it is difficult to conceive of uninterpreted observation (Koch, 1995:832/3). In fact modern hermeneutics argues we can never totally transcend our historical position, and so there is 'no point in appealing to notions of a transcendental ego' (Rowan & Reason, 1981:132). On the other hand, Heidegger's phenomenology is hermeneutic, that is, interpretive. But Heidegger's method is one that strives to reveal the meaning of Being, and as such, method cannot be separated from content. Intent on finding the meaning of Being, his method is meant to apply only to the question of 'existence'. Looking beyond the being of individual beings to Being itself, for Heidegger phenomenology was a method of philosophising (Crotty, 1996; Heidegger, trans. 1962). In that case, this study could not claim to be 'doing' Heideggerian phenomenology.

Looking instead to the human sciences, guidance was sought in the 'method' espoused by van Manen (1990), (although as will be clarified shortly van Manen would say there is no method). Van Manen, an internationally renowned scholar and educator within the human sciences, has a special interest in phenomenological pedagogy. His book, published in 1990, explicates a hermeneutic phenomenological approach to human science research and writing. While the methodology draws heavily on the spirit of the European phenomenology movements he has also been influenced by certain North American developments (van Manen, 1990). Morse (1991:15) a North American nurse academic, describes him as a 'leader in phenomenology'. Bartjes (1991) invites Australian nurses to consider his method in research endeavours.

Van Manen's (1990) phenomenology has evolved from, and been heavily influenced by the philosophical tenets just explored, and in turn has been adopted and modified by the human sciences. It was to this phenomenological approach the study turned, and the central premises of his approach are discussed in the following section.

The Nature of Human Science Phenomenology - van Manen

For van Manen (1995), the whole project of phenomenology is to return us to the world for a reawakening of our experience of human life in a reflective manner which inevitably leads us to become more thoughtful and more understanding individuals. Hermeneutic phenomenology for him, is 'a human science which studies persons' (1990:6), and entails a certain attitude, a way of looking at and thinking about the world. He asserts (1990:4) phenomenology describes how one 'orients to lived experience', hermeneutics to how one 'interprets the 'texts' of life', and semiotics facilitates a practical writing or linguistic approach to phenomenology and hermeneutics. The task of phenomenological research and writing for van Manen (1990:41), is 'to construct a possible interpretation of the nature of a certain human experience'.

In explicating the nature of hermeneutic phenomenological human science, van Manen (1990:8-13) upholds a number of basic principles. Extracted from the text the following descriptions illustrate his perceptions of human science phenomenology as the :

a) *Explication of phenomena as they present themselves to consciousness*: that is, whatever falls outside of consciousness, falls outside the bounds of our possible lived experience by virtue of the fact that all we can ever know must present itself to consciousness. Phenomenological reflection therefore is not introspective but retrospective because essentially a person cannot reflect on lived experience while living through the experience.

b) *Study of essences*: comprising a systematic attempt to uncover and describe the structures, the internal meaning structures of lived experience. The essence of a phenomenon is a universal that can be described through a study of the structure that oversees instances or particular manifestations of the essence of that phenomenon (the hermeneutic circle from whole to part to whole). The essence or nature of an experience becomes adequately described if the description reawakens or shows us the lived quality and significance of the experience in a fuller or deeper manner.

c) *Description of the experiential meanings we live as we live them*: it attempts to explicate the meanings as we live them in our everyday existence, our lifeworld. Unlike other disciplines which aim to explore meanings specific to certain cultures (ethnography) social groups

(sociology) mental types (psychology) and so on.

d) *Human scientific study of phenomena*: phenomenology is a systematic, explicit, self-critical, and intersubjective study of our lived experience. Systematic because it uses specially practised modes of questioning, reflecting, focusing and intuiting etc. explicit because it attempts to articulate, through the content and form of the text, the structures of the meaning embedded in lived experience. Self-critical in the manner that it continually examines its own goals and methods in an attempt to come to terms with the strengths and shortcomings of its approach and achievements. Intersubjective in that the human science researcher needs the other (for example, the reader) in order to develop a dialogic relation with the phenomenon, and thus validate the phenomenon as described. It is a human science rather than a natural science due to the fact that the subject matter of phenomenological research is always the structures of meanings of the lived human world.

e) *Attentive practice of thoughtfulness*: a heedful, mindful wondering about the project of life. of living, what it means to live a life. Heidegger, (trans.1962 cited van Manen) described this as being involved with entities within the world.

f) *Search for what it means to be human*: taking into account the sociocultural and the historical traditions that have given meaning to our ways of being in the world. In phenomenological research, descriptions carry a moral force because as its ultimate aim, phenomenological research has the fulfilment of our human nature, that is to become more fully who we are.

g) *Poetizing or thinking on original experience and speaking in a more primal sense*: Merleau-Ponty (1973, cited van Manen, 1990:13) describes this as a language that 'sings to the world'. 'What we must do is discover what lies at the ontological core of our being. So that *in* the words or *in spite* of the words, we find "memories" that paradoxically we never thought of felt before' (p.13).

h) *Study of lived experience*: Aiming to gain a deeper understanding of the nature or meaning of our everyday experiences - it asks 'what is this or that kind of experience like?' (p.9).

-The Nature of Lived Experience-

'Phenomenological human science begins in lived experience and eventually turns back to it' (van Manen, 1990:35). Bergum (1991:56), a nurse scholar and former student of van Manen's, cites Ermarth (1978) who describes lived experience as:

> . . . the 'originary' way in which we perceive reality. As living persons we have an awareness of things and ourselves which is immediate, direct, and nonabstractive. We 'live through' (*erleben*) life with an intimate sense of its concrete, qualitative features and myriad patterns, meanings, values, and relations.

To come to terms with lived-through experience requires us to go beyond the taken-for-granted aspects of life. It is necessary to 'uncover meanings in everyday practice in such a way that they are not destroyed, distorted, decontextualised, trivialised or sentimentalized' (Benner, 1985:6 also cited Bergum, 1991:57). Dilthey (1985 cited van Manen, 1990:35) proffers an explanation of lived experience (*Erlebnis*), which posits that in 'its most basic form it involves our immediate, pre-reflective consciousness of life: a reflexive or self-given awareness which is, as awareness, unaware of itself'. It is believed that lived experience has a temporal structure that determines it can never be grasped in its immediate manifestation, but only reflectively from the past. The interpretive examination of lived experience has the methodological feature of relating the particular to the universal, part to whole, episode to totality. 'A good phenomenological description is collected by lived experience and recollects lived experience - is validated by lived experience and it validates lived experience' (van Manen, 1990:27).

Van Manen (1990) says, that while the methodology of phenomenology offers an approach toward research that aims at being 'pre-suppositionless', that is, it tends to avoid 'constructing a predetermined set of fixed procedures or techniques and concepts that would rule-govern the research project' (p29), it nevertheless has a certain *methodos*-a way. And he (1990:29) points out, that although recent thinkers such as Gadamer (1975) and Rorty (1979) have taken the position that there is no method to phenomenology, for him there is a 'tradition, a body of knowledge and insights, a history of lives and thinkers and authors which, taken as an example, constitutes both a source and a methodological ground for present human science research practices' (p30). In view of which he offers a set of guidelines and recommendations to enable

a principled form of inquiry; that 'neither simply rejects or ignores tradition, nor slavishly follows or kneels in front of it' (van Manen, 1990:30).

According to van Manen (1990), the process of phenomenological reflection and analysis includes six related activities:

- turning to a phenomenon which seriously interests us and commits us to the world;
- investigating experience as we live it rather than as we conceptualize it;
- reflecting on essential themes which characterize the phenomenon;
- describing the phenomenon through the art of writing and rewriting;
- maintaining a strong and oriented pedagogical relation to the phenomenon;
- balancing the research context by considering parts and whole.
(Extracted from van Manen, 1990:30-31).

-Being-in-the-lived-world-

One main feature of phenomenological research is that it always begins in the lifeworld with all its multifarious aspects (van Manen, 1990). Within the lifeworld are situated human beings who are naturally engaged in their worlds. Most of the fundamental beliefs posited within a phenomenological perspective have stemmed from the views of Heidegger about human beings and the existentials, that is the being of a possible way of Being-in-the-world (Heidegger, trans.1962). For Heidegger, to-be-in-the-world is the ultimate presupposition of knowledge. He was convinced the epistemological tenets of the knower and the known overlook the fact that before the distinction between knower and known (or subject and object), the subject is able to *relate* to a known. Furthermore, he espouses that knowledge does not occur in isolation from one's world of concern and environment and it is never the case I simply know something. Nor is it the case that knowing is the only possible way to exist. Where Husserl believed that human beings encounter objects by perception or prediction, for Heidegger objects are encountered by virtue of a person's being-in-the-world (Crotty, 1996). As has been shown, Heidegger's main concern centred around what sort of beings we are and how our being is linked to the intelligibility of the world (Dreyfus, 1993; Gelven, 1989). 'Knowing is a mode of Dasein founded upon Being-in-the-world. Thus Being-in-the-world, as a basic state, must be Interpreted *beforehand*' (Heidegger, trans.1962:90).

As a basic state of *Dasein,* lived experience involves Being-in-the-world. It refers to the way human beings exist, act or are otherwise involved in the world, for example as a nurse, a mother, woman and so on. Being-in-the-world is defined as the place in which one finds oneself *in,* the world we have to live in. Being is about what it means to be-in-the-world because the world is not 'outside' of a person, but rather a person is *in* the world. A key idea behind this concept is that one's environment is not simply there, but that it affects one and one, it (Gelven, 1989) - (refer section headed 'The Social Construction of Reality' in chapter three).

Being-in 'is a state of *Dasein's* Being; it is an existentiale' posits Heidegger, trans.1962:79). Van Manen, (1990:101) explicates the lived world as the world 'experienced in everyday situations and relations'. That is not to say that we may only inhabit one lifeworld, on the contrary each of us may inhabit different lifeworlds at different times of the day, for example 'the lived world of work and the lived world of the home' (Schutz & Luckmann, 1973 cited van Manen, 1990:101). Regardless of which lifeworld we inhabit, there are existential themes that ground our existence within them. The most basic of these comprise the social, historical, spatial and bodily condition of the situated person. Van Manen (1990:105) cautions however, that although these existentials can be differentiated, they cannot be separated as they all constitute an 'intricate unity' which phenomenologically is called 'the lifeworld; our lived world'.

The basics about our lifeworld (such as the experience of lived time, lived space, lived body, and lived human relation) are 'preverbal and therefore hard to describe' (van Manen, 1990:18). As previously noted, hermeneutic inquiry is that in which the 'implicit meaning of an existential fact is made explicit' (Gelven, 1989:40). In order to make explicit the meaning of the particular existential fact it is necessary to show how it relates to the whole of one's existence. In other words, it is necessary to analyse the particular ways of existing as a totality. And, as previously explained, this is a circular exercise proceeding from a whole to a part and then from a part back to a new whole. Therefore, to make explicit the meaning of what it means to be a CNS necessarily involved proceeding from the 'whole of a total, vague, and unanalyzed awareness of their existence and proceeding to the part/s the existential facts and then seeing how they relate to the whole - to an ontological understanding' (Gelven, 1989:42 Heidegger, trans.1962:27).

Van Manen (1990:101) offers four of these existentials as guides for phenomenological questioning, reflecting and writing during the research process. These existentials (Lived: time, space, body and Other) have been included in this study to encapsulate the experiences of the CNSs in a phenomenological text presented in chapters seven, eight and nine.

The Existentials

-Lived Human Relation (Relationality or Communality)-

The sociality of our experience and behaviour is another phenomenologically essential feature of human existence. We are born into a world of other people and of things which we have learnt to name and to deal with by the mediation of others. Relationality then, is 'the lived relation we maintain with others in the interpersonal space that we share with them' (van Manen, 1990:104).

Heidegger (trans.1962:153) states that for a *Dasein* in a 'particular' world there are many other *Dasein* who are already there too. In the workworld for example there are Others for whom 'the "work" is destined and "encountered" too'. By Others he does not mean everyone else except the individual, but all those others with whom an individual identifies as a reference group, that is to say, "those among whom one is too" (p.154). 'The world is always the one that I share with others" (Heidegger, trans.1962:155). *Dasein* as Being-with-in-the-world comports itself towards other *Dasein* with 'solicitude' (Heidegger, trans.1962:157). Solicitude characterises everyday, average Being-with-one-another (Heidegger, trans.1962:158). This kind of being of everydayness Heidegger calls the "they" - the Self of everyday *Dasein* is the *'they-self'* (Heidegger, trans.1962:167).

-Lived Space (Spatiality)-

Lived space according to van Manen (1990:102), is 'felt' space. This spatiality of human existence is the infrastructure which facilitates or inhibits behaviour. For example, 'home' is very often a space where we can be who we really are, whereas other spaces may make us feel ill-at- ease. In general, 'lived space is the existential theme that refers us to the world or landscape in which human beings move and find themselves at home' (van Manen, 1990:102)

Van den Berg (1972:75) writes: 'we take possession of space:we travel, fly, enter or leave a place'. Lived space is a category for inquiring into the ways we experience the concerns of our day-to-day lives: moreover it assists us to discover 'more fundamental meaning dimensions of lived life' (van Manen, 1990:103). No analysis of behaviour is complete without an adequate description of the place in which and with respect to which behaviour 'takes place'. This spatiality of human existence is the infrastructure which serves to facilitate or inhibit behaviour (Harre & Lamb, 1986:26).

-Lived Body (Corporeality)-

It is a phenomenological fact that we are always bodily in the world, that is we are embodied as individuals. Corporeality concerns the bodily nature of the behaving subject. 'Whether a person perceives or acts, the world is encountered within the potentialities and limits of the body, articulated in perspectives, within or beyond our reach, etc.' (Schutz, 1962 cited Harre & Lamb, 1986:263). For example, depending on our emotions and/or whether we believe we are being watched or are alone, our bodies will differ in their modality of being (van Manen, 1990). Van den Berg (1972) believes 'talking about one's body means talking about oneself' (p50), and 'world and body are interrelated' (p56). He says, 'we use our body as if we are this body; we move, we bathe, we lie in the sun. Without thinking, we shake hands, we talk' (p75). Merleau-Ponty (trans.1962) espouses that our bodies belong to, and include, space and time.

-Lived Time (Temporality)-

'Everything has time, future and past' (van den Berg, 1972:59). 'Time is our possession. We live in it. We flow with it' (van den Berg, 1972:74). Lived time is subjective time as opposed to objective or clock time. Time as another existential becomes the most important aspect of reality and time comes to reality through the existence of man. Time is revealed as the Being of *Dasein* and *Dasein's* existence is grounded in time (Heidegger, trans.1962; Gelven, 1989). 'The temporal dimensions of past, present, and future constitute the horizons of a person's temporal landscape' (van Manen, 1990:104). We live toward a future that 'we already see taking shape', and as we live under the pressures and influences of the present, the past may also change (Linschoten, 1953 cited van Manen, 1990:104).

Van den Berg (1972:91) describes time:

> Past and future are not two distinctive spheres touching one another in a zero point called 'present'. Indeed, past and present differ: the past is there, behind us; the future yonder, before us. Yet both have an actual value; future and past are embodied in a present. . .The past is within this present: what was is the *way* it is appearing now. The *future:* what comes, the *way* it is meeting us now. This appearing and meeting are closely connected. The past appears in what is coming to meet us; if it does not appear, it is absent. So that, indeed, the past is that which lies there behind us, but only because a future permits it to lie there. And the future is indeed yonder, before us, but only because it is fed by a past. The present is an invitation from out of the future to gain mastery over bygone times.

The Phenomenological Question

Having identified an interest in the nature of the human experience of nursing as a CNS, and using van Manen (1990) as a guide, the next phase of the study called for the phenomenological question to be formed and answered. It has been stipulated that to carry out phenomenological research is *to question* what something is 'really' like. To ask 'what is the nature of this lived experience?' (van Manen, 1990:42). Van Manen (1990) refers to Gadamer (trans.1975:362), who, in the phenomenological search for knowledge recalls the 'importance of the concept of the question', and yet, the question is not definitive, because as Oiler (1982) emphasises, in phenomenology a very general question is posed which gives the barest minimum of direction.

As an educator, van Manen (1990:42), puts the question: what is it like to be a teacher? Pointing to literature regarding research on teaching with its concomitant production of theoretical material, he posits that having read it, a teacher would be hard pressed to answer the question: what is teaching? It could be argued the same holds true of nursing. If one were to ask a CNS what it is like to be a CNS, that is, to be an experienced bedside nurse, it is not inconceivable the answer would be forthcoming only with considerable effort, if at all. (A common response would be 'I don't know, I've never really thought about it').

Nursing literature abounds with theory on the subject of the discipline of nursing. Yet, van Manen's assertions about teachers and teaching, could similarly be applied to nursing: What exactly is experienced nursing? What does it mean to be an experienced nurse? What is it about

her relationship with the patients that makes her an experienced nurse? What is it about nursing that makes it possible for it to be what it is in its essence (is-ness)?

In consideration of the 'essence' of the question (Gadamer, trans. 1975:362), van Manen (1990:43) maintains we should orient ourselves in a strong way almost has if we are 'living' or 'becoming' it. He suggests we need to repeatedly revisit the things themselves until 'that which is put to the question begins to reveal something of its essential nature'. To answer the question of the nature of experienced nursing, immersion in the question seemed essential. To that end, this study addresses the phenomenological question of: what is the Being of the CNS? What is it like to be a CNS? The Being of the CNS should manifest itself in her experience of the phenomena of the job.

Conclusion

In this chapter, the route leading to the adoption of van Manen's human science framework to researching lived experience has been mapped. In the first instance, attention focused on a brief dialogue with the phenomenological position undergirding the study. An examination of Husserlian and Heideggerian thought, together with Crotty's evaluative work have led to a better appreciation of van Manen's human science formula. In light of recent debate regarding the 'misappropriation' of nurses adopting new paradigms for research, the inclusion of this material was seen as especially important. Van Manen's 'way' into phenomenology was then presented, and the phenomenological question made manifest. In pursuit of an outcome to that question, the following chapter describes the processes involved in undertaking this hermeneutic phenomenological study into the lifeworld of a group of CNSs.

CHAPTER FIVE

THE RESEARCH PROCESS

Introduction

Because it offers a description of experience, an account of the world as we 'live' it, together with the potential for understanding the lived structures of meaning associated with that lifeworld, phenomenology seemed the key to answering the question asked of this study (Merleau-Ponty, 1962; van Manen, 1990). And, it is hermeneutic phenomenology that has generated the infrastructure on which this study is based. As such, the previous chapter provided an overview of a number of the fundamental ideas associated with the emergence of this approach to research.

This study sought to grasp a fuller understanding of the lived experience of the workworld of the CNS in the 1990s. And yet, in order to access and interrogate the lifeways of these advanced practice nurses; their being-in-the-world, their values, beliefs and practices, it was necessary to return to the bedside 'to get back to the things themselves'. To this end, the researcher entered the clinical world as an observer to study the CNSs in their work setting over a period of time. Furthermore, in an effort to gain impressions about their role in differing ways, she sought to dialogue not only with the CNSs as a group, but also to the patients as recipients of their care.

This chapter describes the processes undertaken in order to effect this interpretive journey. The periods of fieldwork are described in three phases corresponding to the number of field trips conducted over the period of one year.

Proceeding to the Nature of Lived Experience

As addressed in earlier chapters, the researcher's 'certain interest' in, or 'orientation' to this phenomenon (van Manen, 1990:40) stemmed from a personal belief in the value of experienced nurses and a concern that experienced nurses's workworlds might not be as satisfying as has been presumed since the inception of the clinical career structure. From the researcher's own experience, it was known that much of the work of the advanced practice bedside nurse was invisible, and as such neither recognised nor valued. Having left bedside nursing due to some discomfort with a medical hegemony that engendered a perception of powerlessness and futility

in clinical nursing practice, the researcher was uncertain as to whether the position for the CNS had improved or not.

In an odd sort of way, she believed she was partaking of the 'fruits of their labour' inasmuch as she was working within the stimulating and challenging environs of nursing academia, busily preparing novices for eventual accession to CNS; espousing at length about working in the clinical environs, and yet all the while personally removed from, and thus out-of-touch with the 'real' and on-going world of the experienced bedside nurse. Had reality for the advanced practice nurse changed, and if so, how had that changed reality, changed her?

-Setting up the Research - Gaining Entree to the Clinical Field-

In order to enter the living world of the CNS, the researcher sought to return to the hospital at which she had last worked (referred to in the opening passages of this work). The desire to go back to that particular territory was essentially to see if 'things' had changed and because the researcher felt a certain empathy for the CNSs who had 'come up behind her'. That is not to say other factors were not involved in the decision to return to homeground. As it happened, the researcher believed gaining Ethics approval might prove less arduous if she was at least in some way known to the hospital, and in terms of practicality, the hospital was the most conveniently situated in regard to child-care arrangements and proximity to her own world of work.

A research proposal was submitted to the Ethics Review Committee of this large inner city teaching hospital. But, before presenting the proposal the researcher felt it advisable to approach Nursing Services to seek their endorsement of the planned study. In addition, she sought the advice of a member of the Ethics Committee who was said to have the most expertise in qualitative approaches to research. While he himself professed little knowledge regarding phenomenology, he imparted sound advice *vis-a-vis* the proposal itself, that is, in terms of its layout, terminology etc.. (It is believed this strategy of networking before lodging the application, proved beneficial). For a committee known for its conservatism regarding non-positivistic research, it was pleasing that the study was considered and approved in the first instance.

However, there were a number of suggestions proposed by the Committee for consideration. These ranged from relatively minor aspects such as changing the wording on one section of the

paperwork, to more major concerns such as a recommendation for the inclusion of registered and enrolled nurses into the study. In addition, there was a proviso that a 'pilot study' be undertaken using five CNSs in the first instance, but by insisting on a 'pilot study' the committee showed it did not understand this particular research paradigm. For an interpretive study, in which the need for testing statistical tools for data gathering is not an issue, the notion of a 'pilot study' is unusual. As it turned out, the view was taken that since the researcher was to be the instrument for gathering the data/narratives from the CNSs, the 'pilot study' would be used as a period of personal preparation, and so in a sense the researcher would be testing herself as a 'valid' and 'reliable' research agent.

Reference is made to the researcher as an 'instrument' by Chenitz and Swanson (1986:56) for example, who assert that the researcher has to learn to use the self in interaction within the dynamics of the social context to the benefit of the research process. The 'pilot study' provided a special opportunity for such learning. From the beginning, the researcher wanted to be able to discern if she was capable of ascertaining the lived experience of the CNSs using the methods chosen. Furthermore, a trial period would allow her to discover whether she was able to research in the clinical environment in the manner chosen, and if she felt comfortable with such an undertaking. Did in fact, the methods chosen, 'fit', what the study sought to look at? Reinharz (1979:239) has pointed out that participant observation relies on the uniquely human qualities of the observer, and that 'the first field experiences begin the processes of exploring the self and method'. This is exactly how the 'pilot study' was envisaged.

The proposal for inclusion of registered nurses as suggested by the Ethics Review Committee was considered at length. However, after discussions with the research supervisor/s and a senior member of the hospital administrative nursing staff, it was decided not to include RNs. It was believed that to do so would have changed the nature of the study almost along the lines of a comparative analysis, which would have been 'antithetical' to a phenomenological approach. The 'knowledge' and 'truth' sought was known to be embedded within the CNSs and the study was not looking to compare their lived experiences with that of any other group in a formal sense. To include a number of others would dilute the study and at the same time did not seem to offer any benefits to the original purpose of the study. It would also result in some loss in the 'thickness' of description in the data. (Enrolled nurses were not considered, because of the perceived diversity of their role compared to that of advanced practice registered nurses).

Selecting the Participants

The next step involved recruiting CNSs. In this endeavour, the assistance of Nursing Services was sought, who then supplied the names of nursing personnel in administration who could be contacted to nominate certain surgical wards where potential participants might be found. Meetings with each of the Nursing Units Managers (NUMs) on these wards were organised and the proposal explained. The NUMs agreed to relay the information to their senior nurses, and arrangements were made for those CNSs who were interested in the proposal to attend a further meeting.

As the gatekeepers to the clinical environs, it was recognised early in the course of this study that the NUMs were important people with regard to its success, and care was taken to foster their interest in, and for them to see the potential benefits of the study. It was an anxious time because although the hurdle of the Ethics Board had been passed, without respondents it would have been to no avail. It was realised the study was going to be asking quite a lot of the participants in terms of their input, and it was feared this might prove a deterrent.

Fortunately, several CNSs expressed interest in attending a meeting, and it was pleasing when seven of these signed consent forms to be a part of the study (See appendix B). From the beginning, a *purposeful* selection approach was planned (see Streubert & Carpenter, 1995). Although there were certain limitations on how selection took place, these were not considered to have affected the quality of the composition of the participants. The main limiting factor was being designated a ward or wards and another was the actual number of respondents. The study deserved ongoing commitment by the CNSs to being observed, taking part in discussions, diarysing and reading transcripts over a prolonged period, and so rather than a surface view of many participants, the researcher chose to seek 'thick' data that was multilayered and gathered from a few. That there was one male was because he was 'a' respondent (and in terms of percentages of the study population, the ratio of one male to six females reflects the normal male/female ratio found in the profession). The sample was one of convenience and was opportunistic in the theoretical limits of sampling.

The Ethics Review Board was approached with a request to increase the number of participating CNSs (which was approved). Liaising again with Nursing Services, a date was set for a two week

'pilot study' to commence in the field early in the new year. A period of approximately eight months had passed since initial contact with the Director of Nursing, requesting approval for the study. Access to the field had been gained, albeit at this stage for a limited period, and a number of CNSs had indicated their willingness to share the subjective character of their experiences[1].

Preparation was begun for the journey into the field. This task involved writing to each of the NUMs informing them of the impending visit, provision of a diary to each of the participants, together with instructions on how it was hoped it might be used, and finally, the acquisition of a number of nurse's uniforms for researcher immersion into the participant observer role.

Ethical and Practical Considerations for Nurses

This study was founded on the notion of co-operative inquiry which meant that the researcher interacted with the participants in such a way as to ensure they were fully informed of the research propositions at all stages, as well as being at liberty to assent or dissent at any stage. Dissent, which never occurred, would have led to re-negotiation (Heron, 1981). Heron (1981) sees traditional research strategies, those normally found in the natural sciences, as a way of exercising power. Because knowledge fuels power, he argues that power should be shared not only in the application of knowledge about persons, but also in the generation of such knowledge. To this end, the researcher sought to establish an openness and rapport through mutual trust and respect with each of the CNSs, an approach whereby they would feel confident that their thoughts and perceptions would remain confidential and uncriticised.

It was hoped the participants would become as involved in the research as possible, even to the

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Crotty (1996:174) advocates selecting informants very carefully because he believes the participants themselves perform the phenomenological endeavour of 'bracketing' and 'seeing'. Following van Manen's framework however, the CNSs in this study were not being asked to undertake a phenomenological interpretation of their own lived experience. Rather, it was the researcher who would fulfil that component of the research. The study was looking for lived experience material from the CNSs that could be interpreted in order to create a phenomenological text as a plausible account of their life-world.

Carrying out the role of researcher as nurse in the clinical field could be seen as being at the vanguard in such research endeavours in Australia. Working in a contemporary health-care climate with concomitant understaffing and financial constraints, the researcher believes herself fortunate to have attracted the astute and committed group of nurses she did. It would have been impractical if not impossible to canvas the entire hospital, interview numerous potential participants and then hand pick a select few whom it was perceived were capable of adopting a phenomenological perspective.

point of becoming co-researchers. In a sense, they were invited to be collaborators and to critique. Such a position upholds the belief that an inquiry has little validity unless it is rooted in the experiential knowledge of those actually involved. As Rowan & Reason, (1981:134) have pointed out, 'a valid interpretation involves knowing *with* as well as knowing *about'*. Patton (1990), also makes reference to an empathy toward the people encountered during field work, (yet stresses that neutrality is the stance taken towards the findings). Reinharz (1979:319), believes researchers are responsible for understanding the impact of their behaviour in the research act. She claims, because the researcher 'intervenes, interferes and meddles with what otherwise might have occurred' in the research setting, it is their task to identify and marshal these reactions. To that end, the researcher sought to maintain a non-judgmental, but nonetheless caring and empathic stance toward each of the CNSs, (as a nurse it was not difficult to adopt either of these positions) and over the year a rapport was established with each of them which still stands.

There were seven CNSs initially interested in participating in the study. Each signed a form consenting to being 'followed' around and observed on the ward as they went about their day-to-day duties. And, although various events took place during the year that changed the circumstances for at least two, none actually withdrew. One of the CNSs seemed to lose interest towards the end of the third phase but never officially retracted her consent. The remaining CNSs exhibited a commitment to the study that was totally unexpected, but essential.

Having been socialised as a woman, nurse and mother into relating to, and internalising concern for the feelings of others, it was important to make it clear to the participants from the outset that the researcher had every intention of ensuring some benefit from the study for them as well as for herself. It was felt that this study should not be seen to be *taking* everything from them without *returning* anything (discussed more fully in the last section of this chapter). And, although there were times when the researcher perceived the study to be taking more than it gave, she now believes, as did Bergum in her study (1991), that the fact that the CNSs talked about their experiences made a difference in their lives. And, as Bergum (1991) points out, to raise one's awareness of experience results in a reflection that may not otherwise have occurred. While this reflection may have been, in part, a catalyst for the turmoil that was to erupt later among the core group of CNSs (on [Rose Ward], described in later text), in the final analysis, it could be said that such consciousness raising proved a worthwhile exercise.

Like Bergum (1991), the researcher took seriously the ethical commitments made to the CNSs and acknowledges this issue as an on-going concern. In much the same way as Reinharz (1979) describes her feelings towards the people she studied, even as this thesis is written and the interpretations of the stories given to text, thought is given to the participants. Bergum too (1991), felt a positive regard for 'her' women. Yet, because she believes her study was beneficial for them, some of her feelings of commitment towards them have been alleviated. As she handed back the transcripts of conversations, the stories and her interpretations of them to her informants, she recognises she presented them with a unique opportunity to focus on their experiences, to compare with others and to reflect on the meanings generated from them. Sentiments that could equally apply to this study.

By handing back their words in the form of the transcripts and diaries, the CNSs were presented with an opportunity to look back, or re-vision the study at a future date. Committing the interpretations of their stories to this thesis, albeit in a way that masks their identities, does not mean they will not be able discover themselves within the text. In so doing, the meaningful richness and depth of complexity in the world of their advanced nursing practice will be seen and reflected upon. This in turn should foster their personal growth and a valuing of themselves in their nursing role (Bergum, 1991).
(The last section of this chapter entitled 'Researcher as Nurse: Nurse as Researcher', describes a number of issues emerging from the periods of participative observation, including ethical considerations concerning not only the CNSs, but also the patients).

Investigating Experience as it is Lived

The study was planned in three stages with an initial two week 'pilot study' or 'trial' period, as suggested by the Ethics Review Board, followed by two x four week field trips during the year (set for April-May and September). Thus a total of ten weeks fieldwork was envisaged. In addition, the CNSs were asked to share with the researcher and the other participants their ideas and thoughts about life as a clinical nurse specialist in individual and small group interviews to be arranged at convenient times. Additionally, they were asked to make regular journal entries about events in their worklives that seemed significant and meaningful. Finally, so that aspects could be clarified and interpretations validated, confirmation was sought that the researcher would be able to maintain contact with each participant once the fieldwork was over.

Four of the participating CNSs were employed on a surgical oncology ward specialising in the treatment of melanoma [Rose Ward], while the other three were situated on a surgical ward specialising in urology [Daffodil Ward]. These wards were situated in the same wing of the hospital. One of the CNSs who initially volunteered left the urology ward the week before phase one of the study began and so this phase involved six CNSs. The participants, (who are referred to as respondents and/or informants interchangeably) included five females and one male. These first informants were later joined by three others.

In gaining participants for this study, it was carefully emphasised that some considerable commitment was expected of the CNSs, together with their full participation. As it turned out a core of people who were able to put themselves in touch with their own immediate experience and relay that experience in the form of stories and anecdotes, was secured. Each of them, to varying degrees, exhibited an openness, candour and a remarkable ability for self-understanding (Crotty, 1996).

Involvement with the CNSs was for the sake of illumining the phenomenon of their world of work (their job). The researcher was looking for the ways in which they understood their everyday experience/s, and so in effect the CNSs were the vehicle through which it was hoped to reach advanced practice nursing.

As previously addressed, Crotty (1996), emphasises that it is not the subjective experiences of a group of people the phenomenologist wants to elucidate, rather it is the object of their experience that is of concern. He would therefore have no description made of the individual CNSs. Yet, it has 'long been established that no two people can have one and the same perception of things' (Chladenius, 1986:67), which Chladenius (1986:67) says is captured in the saying: *'quot capita, tot sensus'*, meaning, 'as many heads, as many options'. In uncovering lived experience, the viewpoints of a specific group of individuals were sought, all of whom perceived things happening in the world in their own different way. The perspectives of the participants in this study were determined by certain conditions including how close they were to things and events. They were located in a world of things to which they acted intentionally, and so their ways of talking and ways of seeing the workworld were individualised. Each construed their own world and the intentions with which they acted in it (although they shared many things in common)

(Chladenius, 1986). The phenomenological text which emerged as a result of this study, has been generated from their accounts of things or events, and is interpreted from and through their language. The researcher therefore, deems it essential to present a perceptual picture of these individuals and to describe something about each person whose Being constitutes the text.

The Key Study Informants

On Rose Ward :

1. **Anne**: (31 y.o) 13 years nursing experience with 6 years on the current ward and 3.5 years as a CNS. Highest qualification: BA. Originally a high school teacher who came to nursing; re-presented to teaching only to return to nursing.

2. **Debra:** (29 y.o.) 11 years nursing experience with 8 years in that specialty area and 3 years as a CNS. Highest qualification RGN certificate with post basic cert. in oncology. Has always been a nurse. (Halfway through the study Debra was promoted to oncology CNC - throughout the study her role was never that of everyday bedside nurse but a more specialised one).

3. **Jay** (38 y.o.) 6.5 years of nursing experience with 5 years on current ward and 2 years as a CNS. Highest qualification B. App. Sc. (Nursing). Had a number of jobs before nursing.

4. **Carol:** (40+y.o.) 7 years nursing experience with 6 years on current ward and 3 years as a CNS. Highest qualification B.Sc. Had been a high school science teacher who gave up working for many years to raise a family. Had turned to nursing later in life. (B. App. Sc. (Nursing)).

On Daffodil Ward:

5. **Jayne**:(31 y.o) 12 years nursing experience with 6 years on current ward and 18 months as a CNS. Highest qualification: RGN certificate. Has always been a nurse.

6. **Bo:** (30+y.o.) RGN certificate. Post-basic certificate in the specialty.
Had been a NUM at another hospital.

Strategies for Gathering Lived Experience Material : 'Methods'.

Strategies for collecting lived experience material included: interviewing; diarising, and participant observation.

- Entering the Lifeworld of the CNS - Participant Observation:

> *I will never know the experience of others, but I can know of my own, and I can approximate theirs by entering their world* (Reinharz, 1979:365).

'If we want to know about human beings in their natural 'habit' we have to study them in their normal surroundings' (Barker, 1968 cited Tesch, 1990:37/8). This is because a fundamental premise of the field method states that 'since the meanings that objects hold for people cannot be divorced from the settings in which the objects are experienced, it is vital to first gain an understanding of an object by studying it in its natural setting' (Chenitz & Swanson, 1986:60). Indeed, human behaviour is 'influenced quite complexly by the context in which it occurs' (Wilson, 1977:253), and the physical environment not only unremittingly offers us possibilities of experience, but it also curtails them. In addition, 'our behaviour is a function of our experience [and] we act according to the way we see things' (Laing,1967:24). As Merleau-Ponty, (trans. 1962:xi) has suggested, a person is in the world and only in the world does s/he know him or herself. From this self awareness of where as individuals we are situated in the world we can then approximate where others are, through shared experience. In consideration of these assertions, fieldwork has become the 'central activity' of qualitative inquiry (Patton, 1990:46).

It was decided therefore, that in order to present a 'full picture' of the world of the CNS, the researcher had to be in that world and participate in it. Entering into the field affords a direct and personal contact with the subjects in their own environment, so that one can get 'close' to them and their work situation in order to understand the 'realities and minutiae' of their daily life (Patton, 1990:46). For the phenomenologist, the 'lifeworld, the world of lived experience is both the source and the object' of research (van Manen, 1990:53).

To explore the daily lived reality of these nurses required entry to the knowing of their Being by virtue of their very Being-in-the-world (Heidegger, trans. 1962:88). As a phenomenologist the

researcher was committed to understanding social phenomena from the actor's own frame of reference, to examine how the world is experienced by the CNSs (Taylor & Bogdan, 1975), through their 'ready-to-hand', or pre-reflective mode of involvement in the world (Walters, 1995).

With this in mind, permission was secured to enter the field to work in a supernumerary capacity alongside the CNSs. Determined to become 'involved' and 'affected', the researcher went into the field to 'live' amongst them - to be part of the ward, and absorbed into it as part of them. In other words, the totality of their experiences was looked to. This can be likened to an holistic approach, wherein one reaches into and understands the world of the subject (Dewey, 1956 cited Patton, 1990:51). Thus through participation the researcher could observe and experience the meanings and interactions of the CNSs from the position of 'insider'; to see what they were saying and doing and how they act in their world (Jorgensen, 1989).

-A Way of Seeing - The Phenomenological Perspective-

Phenomenology as a method, has been said to incorporate what could be called 'an attitude'. 'The method is a 'way of observing' leading to an interpretation of what the phenomenologist, 'observes, hears, sees, smells and feels' (van den Berg 1972:77). Van Manen (1995) supports this idea and describes the phenomenological attitude as 'a way of looking at the world' and a phenomenological perspective as the way in which we always try to understand someone from their perception of something. For him (1990:44), the phenomenological attitude is the 'kind of thinking which guides us back from theoretical abstractions to the reality of lived experiences'. He suggests such a view should consistently remind one that 'the question of knowledge always refers us back to our world, to our lives, to who we are, and to what makes us write, read, and talk together', as nurses for example. Moreover, it is what stands iconically behind the words, the speaking and the language that one seeks to understand. In effect, we should always 'refer questions of knowledge back to the lifeworld where knowledge speaks through our lived experiences' (van Manen, 1990:46).

Crotty (1996:47) claims phenomenology invites us to adopt the phenomenological attitude which makes a difference to how we view the world.

Citing Bossert (1985), he says:

> The first major change upon adopting the phenomenological attitude is that one no longer just sees things and lives through events in the world; rather, one notices that one is having experiences which are meaningful or 'make sense' and that 'things' and 'events' are the meanings (the sense made) of experiences.

The phenomenological perspective is to 'see the world through another person's eyes', and consider the 'whole frame of existence which the other occupies', (Spiegelberg 1953, cited Psathas, 1972:138). To 'open' ourselves to experience (Howard, 1982:18) which then allows us to see 'facts that were there all the time' (Psathas, 1973:17). Bartjes (1991:248) cites Wagner (1983), who says 'phenomenology is a way of viewing ourselves, of viewing others, and of viewing all else that comes in contact with our lives'. Merleau-Ponty (1962 trans.:xiv), wants us to recognise that 'in order to see the world and grasp it as paradoxical, we must break with our familiar acceptance of it'.

Oiler (1982:178-179), provides a summary of the phenomenological perspective beginning with a definition of the term *phenomena* as objects and events as they appear in the world. Secondly, she states that for phenomenologists, *reality* is a matter of appearances and is *subjective* and *perspectival.* Reality hinges on individual perspective, hence the researcher's view is dependent upon her/his position in the world. Thirdly, *subjectivity* is construed as being-in-the-world, meaning that the world becomes real through contact with it. Knowing shapes experience, therefore the researcher needs to understand her own perspective and realise the way in which it constitutes the reality found and presented. Finally, Oiler speaks of truth as a composite of realities and that access to realities is by locating and using any number of forms of human expression eg poetry, diaries etc.

-The Process of Participant Observation-

The methodology of participant observation seeks to 'uncover, make accessible, and reveal the meanings (realities) people use to make sense out of their daily lives' (Jorgensen, 1989:15). And, observation has been described as a 'complex process of interweaving the activities of looking, listening and asking' (Lofland, cited Chenitz & Swanson, 1986:54). By virtue of her nursing background, the researcher was versed in some aspects of the participant observer role, and yet

in others she was not. For example, she had little difficulty discerning what Swanson & Chenitz (1986:62) refer to as the 'spatial, social and temporal dimensions of the observational site', however, there were aspects about this new role which had to be learnt. For example, in the beginning when accompanying the CNS to the bedside to undertake a procedure, if for some reason the CNS was called away, being nurse, and also not wishing to appear overly zealous in the trailing of her, the researcher would stay at the bedside and chat to the patient. This was in the expectation that the CNS would reappear almost immediately. However after a few occasions of this happening, it became obvious that the CNS was not returning straightaway, and the patient and researcher would be left waiting (often long enough to necessitate the latter going off to find out what was causing the delay). Eventually, it was realised these delays were caused by all sorts of distractions and were part of the nurse's immediate experience of being an advanced practice nurse. After that, it was deemed unwise to assume the whereabouts of the CNS and (within reason), she was followed wherever she went in order to discover what was happening at each moment of the observed shift.

This position however, required a good deal of concentration. And, although mention is made of fatigue (Chenitz & Swanson, 1986), the fact that the fieldwork proved as physically and emotionally draining as it did, came unexpectedly. It had been planned to spend time with a different CNS each day of the fieldwork and initially it was anticipated that it would be for the entire shift. The unrealistic nature of this expectation soon became clear. Not only was it too tiring *for* the researcher, but it was discovered that after about four to five hours of being observed, the CNSs tired *of* the researcher, who was overly conscious of not alienating them in any way, especially in the early stages before she had come to know them.

The busiest periods for the CNSs occurred in the mornings, after lunch it was time mostly for report writing and handing over to the afternoon staff. That is not to say, that these activities were deemed unimportant and did not warrant observation. On a number of occasions the CNS would be rostered on an afternoon shift and the ward would be visited at that time. But, in the main, the field trips were undertaken in the mornings when their workworld was most active, and the afternoons would be spent back on campus writing up field notes. The schedule was flexible however, for as Patton (1990:61) has pointed out, 'a qualitative design unfolds as fieldwork unfolds'. That is to say, 'the design is partially emergent as the study occurs'.

One oversight in the study design saw the researcher (having been out of bedside nursing for so many years), overlook the reality of the CNSs being assigned to varying shifts as well as having days-off during the week, stints of night duty and annual leave, and so organising the periods of observation was not as straightforward as envisaged. As it turned out, planning for periods in the field revolved very much around the rosters of the nurses rather than around the availability of the researcher, as had been hoped. (As a mother of two small children it was difficult for the researcher to organise participant observation outside of normal working hours).

During the periods of participant observation, the researcher was overly conscious that her presence may have been influencing the situation/s she was observing and the data obtained. Strategies were thus employed to try and avoid this happening, especially in the early stages. She endeavoured for example, to be unobtrusive and not interfere in any way with the interactions between the nurses and the patients around her. At times this proved difficult (as described in the last section of this chapter).

As it turned out, observing the CNSs 'doing' their job, enabled a certain 'closeness' and their footsteps became literally those of the researcher's. In an effort to try and explore those scenarios which accessed their lived experience, aspects of their day's work would be selected for discussion in later conversations. Van Manen (1990:69) describes this type of participation in a person's lifeworld as the method of 'close observation': a method requiring that one be a participant and an observer simultaneously. Pointing out that 'close observation' is more than just a variant of participant observation he explains it involves an attitude that assumes a relation as close as possible, while retaining a hermeneutic alertness to situations which enable one to constantly 'step back and reflect on the meaning of those situations'.

Mewett (1989:82), contends that field research is a 'social process constructed between the researcher and the people being studied'. The researcher sought to develop a rapport with the CNSs, and it is thought that being a nurse herself assisted this process. Having some fore-knowledge; an understanding of the advanced nurse role, facilitated its more effective exploration. As part of their culture albeit some time ago, the researcher had experienced similar phenomena, and so Reinharz (1983a), would consider that given the context, the researcher was an 'appropriate' phenomenological investigator. Mewett (1989:82) describes problems during his anthropological study because he entered his field as a stranger, an 'outsider', and subsequently

discovered his informants played games with him in order to conceal even apparently trivial aspects of everyday life. He likens their behaviour to being on 'the defensive'.

By way of contrast, because of the researcher's own background, and the fact that she was a part of, and understood the culture into which she ventured, she could be deemed an 'insider'. As a result, the CNSs learnt to trust her more quickly than they would have an 'outsider', which in turn facilitated the ability to communicate (this applied to the patients as well). Had she not been a nurse, it is probable there would not have been the same sharing of stories and inner most thoughts that there was.

On the whole, the informants were keen to impart their knowledge and to recount their stories, so it was not difficult to elicit information. Debra for example, opened up in great depth about her job caring for oncology patients; some of whom were quite young. Yet, in her initial interview she stated, 'I'm not the sort of person that talks a lot about it. This is probably the most I've talked about my job, certainly myself, definitely, in a long time'.

- Use of Self -

> *We are caught up in the world and we do not succeed in extricating ourselves from it in order to achieve consciousness of the world* (Merleau-Ponty, trans. 1962:5).

As discussed in the preceding chapters, the traditional empirical analytical view that alienates the knower from the known has recently been challenged. Developments in methodology including those adopted by feminist researchers have identified the shortcomings of positivistic, objectivist attempts to measure and count all aspects of human behaviour. Moreover, the interpreter's intuitive and empirical knowledge of their own individual experience has been acknowledged and the interpreter's situation has become included in the task of understanding (Levesque-Lopman, 1988).

Contemporary thought now leans toward methods that promote empathy and give the researcher an empirical basis for describing the viewpoints of others while at the same time legitimately reporting his or her own feelings, perceptions, experiences, and insights as part of the research process (Patton, 1990). Reinharz (1979:237) describes the stress she experienced while

undertaking detached fieldwork stemming mainly from the fact that as a fieldworker from the social sciences, she was virtually compelled to 'deny' her own existence. In view of this experience, she reached the conclusion early in her career that any future research endeavours must include her own research experience. For her, recognising 'self' avoids what she calls a 'conflict between competing identities'. She cites Mann (1951, 1979:238) who has pointed out that in denying the personal input on the part of the researcher, 'a whole area of methodological skills, namely the human relation skills that go with the role,' are overlooked. Accordingly, self formed an essential ingredient in the making of this study.

One aspect of this use of self came about during the fieldwork when the researcher put herself into an 'open' and 'ready' state to enter another reality so that the experience/s of others could become the focus of her world (this experience is related in a section of this chapter entitled 'Researcher as Nurse:Nurse as Researcher'). Heideggerian phenomenologists propose that 'all knowledge emanates from persons who are already in the world, seeking to understand persons who are also already in the world' (Leonard, 1994:55). This is a result of being permanently placed within the hermeneutic circle of interpretation. A researcher has a world and exists in historical time just as the subjects do (Leonard, 1994:55). And, as Leonard propounds (1994:57), 'to have an "objectively valid" interpretation would have the researcher understanding from a position outside of history'. A stance that would render a phenomenological view impossible.

Hermeneutic understanding therefore cannot be 'applied, as it were, from the outside, as in the case of an 'objectivist' perspective'. Rather, there is an assumption that the interpreter 'knows' something about the phenomenon s/he seeks to understand. In a sense a researcher is provoked by the subject matter in terms of his/her own historicity and finitude (Rowan and Reason, 1981:133). As Gadamer (trans. 1976) has espoused, to recognise the historicity of the knower does not contest the importance of attempts at critical interpretation. Because the past already functions in and shapes the present horizon, the past is necessarily conveyed into the present. In effect, according to Gadamer, the process of understanding the phenomenon results in a fusion of horizons wherein dialogue between a researcher and the CNSs for example, would involve equality and reciprocity. As conversational partners, the CNSs and the researcher were concerned with a common subject matter - a common question (Gadamer, trans. 1976:xxi).

Merleau-Ponty (1962:xx) writes in a similar vein:

> The phenomenological world is not pure being, but the sense which is revealed where the paths of my various experiences intersect, and also where my own and other people's intersect and engage each other like gears. It is thus inseparable from subjectivity and intersubjectivity, which find their unity when I either take up my past experiences in those of the present, or other people's in my own.

Clearly, in interpretive work the researcher brings certain aspects of his/her background to the inquiry, it was conceded therefore that it would be impossible to entirely disown or discard all of one's latent propositional knowledge (Heron, 1981), and therefore it should be acknowledged as an essential ingredient of the study. This study sought to grasp the meaning of advanced practice nursing in the role of the CNS, and in order to do that the researcher had to reflect phenomenologically on the experiences of nursing as a nurse herself (van Manen, 1990).

-Discerning Presuppositions-

'In every case interpretation is grounded in *something we have in advance* - in a *fore-having*. . . *something we see in advance* - in a *fore-sight*, and *something we grasp in advance* - in a *fore-conception'*. The three comprise the forestructure of understanding that Heidegger refers to as that which 'has been "taken-for-granted" (*gesetzt*)' (Heidegger, trans. 1962:191/2). Plager (1994:72) explicates this notion:

> We all have everyday circumspective interpretations, as in transparent coping in day-to-day life, in which the taken-for-granted remains in the background. This is true for the investigator and participant alike. However, in interpretation as a method of inquiry, two senses of the forestructure need to be brought forward more explicitly. First, as part of the credibility of the project, the investigator lays out preconceptions, biases, past experiences, and perhaps even hypotheses that make the project significant for the investigator and that may affect how the interpretation takes shape. Second, the investigator may bring forth the forestructure of understanding for the study participants. This may be part of the narrative that the investigator elicits in the study in order to make sense of the participants' situation.

Whereas Husserlian phenomenology seeks to bracket out the interpreter's preconceptions from the interpretation, Heideggerian phenomenology views the forestructure as integral to

interpretation and 'should be acknowledged for any possible influence it has on the process of interpreting the text' (Plager, 1994:77). Such a position requires that one be 'attuned', not only to the text as narrative (that is to the lived experience material), but also to one's own narrative, one's own 'forestructure of understanding' (Plager,1994:77). In light of these beliefs, in conducting the interviews, the researcher did not bracket herself off in the 'Husserlian' - *new* phenomenology sense of thinking away the natural attitude. Reinharz (1979:251), supports this view when she points out, 'presuppositions cannot be entirely stripped'. They cannot be suspended because they are embedded in one's very language and make up one's epistemology. She concedes they can be altered by experience and may change over time, but cannot be suspended. She writes:

> Membership in the human race and one's social origins cannot be suspended for the sake of pure observation. . . We cannot completely divorce ourselves from our work, nor our work from ourselves. . . Sociologists know and interpret everyday life precisely because they are social members. They have access to the 'inside track' and are capable of *verstehen* (Reinharz, 1979:252/3).

As a person immersed in the essence and nature of Being, the researcher's interpretation of the participants experiences was bound to be influenced in some way, and this was recognised. Van Manen (1984, cited Bergum, 1991:62), has pointed out that 'common-sense preunderstandings, suppositions, assumptions, and the existing bodies of scientific knowledge predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological questions'. Being a hermeneutic phenomenologist, van Manen (1990) does not advocate bracketing for the researcher in its original transcendental intent. Rather, he concedes it necessary for the researcher to be informed about the phenomenon through literature and pre-conceived notions, so that there is awareness of taken-for-granted assumptions, and conceptions. In which case, these can either be avoided or explicated in a phenomenological way for the essential meaning behind them. In other words, the researcher enters the field with an open mind but is nevertheless informed about the contextual basis of the phenomenon (van Manen, 1995). The researcher was aware that at least one's own assumptions about the experience had to be acknowledged, and that one had to be conscious of the presuppositions and interests carried by the informants (Bergum, 1991).

In view of this, it was necessary for this researcher to renounce certain assumptions and to question the 'taken for grantedness' of what she believed was known about the experience in order to discover what was truly being said in the conversations. Through a critical self-consciousness she became aware of her prejudices, biases and subjective interpretation of the phenomenon. In feminist studies this position has been designated 'conscious partiality' (Meis, 1983 cited King, 1994:21). 'Attentiveness to self-questioning of common-place knowledge or assumptions allows for new understandings and possibilities that may go beyond the reality of the presuppositions' (Bergum, 1991:62).

In line with the advice of van Manen (1995) and others (Chenitz and Swanson, 1986), a conscious effort was made to be aware of any biases and sensitivities about the subject matter under study. Many presuppositions on the researcher's behalf have been exposed in chapter one of this thesis, and as can be seen, their inclusion is essential to the methodological approach adopted by the study.

-Sharing Conversations - Hermeneutic Interviewing-

The goal of interpretive phenomenology is understanding (Benner, 1994:107).

As well as the periods of observation each day, the CNS and the researcher would sit down and talk about her actual clinical practice and the day's or past events which would illuminate some aspects of what it was like for her to be a CNS. Sometimes the meetings could be accommodated during the hours of the field visit, and at other times, it was necessary for the researcher to return to the ward at the end of the shift. By and large, these discussions are referred to as 'conversations', but the term is readily interchanged with 'interview'. The participants themselves called them interviews, but they were not interviews in the traditional sense of the word. They were more like conversations, less one-sided and less formal.

In a conversation, a researcher attempts to transpose him or her self into the other person in order to understand their point of view. And so in effect, a 'conversation is a process of coming to an understanding' (Gadamer, trans. 1975:385/6). As noted, Gadamer (trans. 1975:388) believes the act of understanding (and therefore interpreting), is brought about by a fusion of horizons springing from the dialogue between subject and object. Similarly Merleau-Ponty (trans. 1962

cited Crotty, 1996:152), states that what appears to us in our perception of the world does not come resplendent with ready-made meaning. Meanings are not merely encountered and gathered along the way, but created and come into being as subject and object relate to each other, as in dialogue or conversation.

As a phenomenologist, the task was to encourage the CNSs to get 'in touch' with the phenomenon so that the meaning of 'CNSing' could be found in and out of their particular group. By sharing conversations an attempt was made to get the participants back to their immediate experience. To assist them to explore themselves and to 'return to' and focus on the phenomenon as it appeared to them. In his description of the phenomenal interview, Massarik (1981:203), touches on some of the aspects believed to characterise phenomenological conversations and these have been extrapolated to describe those shared with the informants in this study. Initially, a maximal mutuality of trust is established which eventually encompasses a genuine caring between the two parties. Aligned with this is a shared commitment for a mutual searching to generate collective understanding. In addition, there is an important emphasis on *verstehen* ('to understand') of the interviewee's world, yet at the same time the participant's are cognisant of the realities of the researcher's world. Essentially, this interview style acknowledges the *humanness* of both parties.

Van Manen (1990:66) calls conversations, interviews, but specifies they are phenomenological hermeneutic human science interviews and as such have specific intentions. One of those being that by exploring and gathering experiential narrative material they can be used as a resource for 'developing a richer and deeper understanding of a human phenomenon'. What is more, they can be viewed as a strategy to attain a conversational relation with an informant regarding the meaning of an experience. Van Manen (1990) believes that conducting the interviews necessitates that one remain open to the original question i.e. the meaning of the phenomenon, and so the interviewee must orient to the substance of the thing being questioned. Furthermore, van Manen (1990) sees the hermeneutic interview as a means of easing the transition of the interviewees into the roles of participants and collaborators of the study. Depending on the stage of the inquiry, the conversations can serve as a means to gather lived experience material, or later on, as an avenue for reflection with the informants about the topic at hand.

Following van Manen's (1990) framework, the researcher would try to get the participants to search for the meaning of CNS as a phenomenon they were experiencing. During these

encounters attempts would be made to get behind the everyday meanings of their role to make new sense, new meaning out of the being in a CNS. In a sense, their advanced nursing was examined in a new light by calling into question taken-for-granted assumptions about it. The researcher tried to facilitate an opening up to the phenomena so that its intricacies and secrets could be explored. In so doing she was heightening their awareness of, and restructuring their ordinary perception of their work. To make them see things they had never thought about before or if they had, to see them again with renewed vision. The researcher sought to get not only to the lived experience of the CNS, but to what it means to be a CNS as they lived it (Crotty, 1994).

There is no doubt the researcher entered into the conversations with pre-reflective questions, and so the interviews could possibly be called semi-structured. This however, did not preclude exploring issues as they came up (termed 'interactive interviews' by Morse, (1991:19)). Through a process of discussion, reflection and debate, the individual nurses were encouraged to explore their practice. They were asked to dialogue around anecdotes, stories, experiences, incidents (van Manen, 1990:67). The conversations were collaborative, for together an effort was made to make sense of and interpret the phenomenon, as is common in interpretive work (Miles & Huberman, 1994).

It was noticeable that the CNSs cared about the subject and about the research question. Many of them felt undervalued in their roles and the conversations presented a rare opportunity for them to relate their actual experiences to an interested party. The vast majority of the CNSs were quite willing to find the time for the conversations even on busy shifts and a number of them offered their lunch breaks or time outside of work hours to converse. As the year progressed and the CNSs became more involved with the researcher, the conversations tended more towards 'talking together like friends' (van Manen,1990:98).

The conversations ranged in length from approximately twenty minutes to one hour or more, depending on how much time was available. Like Bergum (1991), who recounts a phenomenological study on the experience of childbirth, the researcher was conscious of the interaction between each CNS and herself, and perceived herself not merely as a privileged observer of the lived experience of these participants, but 'involved'.

The atmosphere of the conversations was candid and each was tape recorded and transcribed verbatim. Between field visits the tapes of the interviews were played over and transcribed, and the researcher's fieldnotes read. During this process, themes would emerge from the 'data' which would be followed-up and reflected upon in subsequent conversations with the CNSs. The CNSs would be asked to verify the interpretations of their experiences to see if these reflected what it was 'really' like for them. The transcripts would also be handed back to the CNSs so they could make sure their intended meanings had come through the transcription process. While most of them added nothing to these transcripts, some added a number of comments clarifying or altering their original statements.

-The Focus of the Conversations-

The researcher was aware that her own life experiences would always play a part in the study. She went into the field and related to the participants, and yet, tried not to become involved in the interviews in so far as she sought to get to the CNSs own experiences and did not enunciate her own. That is not to say, she had not explained her own preconceptions to the CNSs at some point before the conversations. The main concern however, was to get at the nurses' stories, their oral narratives regarding their worklives in order to capture the richness and reality of the experience as it was told and retold. In other words, it was a storytelling exercise which served as a 'creative process' offering the nurses the opportunity for release from their experience (Reason, 1988 cited Lumby, 1994:20).

The interviewer was searching for 'lived experience descriptions' as data, or material on which to work (van Manen, 1990:54). That is to say, 'a personal description of a lived experience in which the experience is described as much as possible in experiential terms focusing on a particular situation or event'. As Merleau-Ponty (trans. 1962:vii/viii) explicates, phenomenology seeks 'a direct description of our experience as it is', and what is more, it is 'a matter of describing, not of explaining or analysing'. Crotty (1996:53), describes it as experience before we have developed or applied ways of understanding and explaining it. Put more simply, 'experience as it is before we have thought about it'.

Van Manen (1990) looks to stories and anecdotes from which to pull out the hidden aspects of the phenomenon. In order to get to these a question would be posed, for example -'tell me about

that time this morning when such and such happened'. What was it like? What were you thinking? And, as Benner (1984) has suggested, the participants were asked to think of specific instances of nursing which brought to light the experience of being a CNS. To that end, questions would be asked such as: 'tell me a story about a time, one you will never forget, that stands out for you because it illustrates what it means to be' a CNS. Not forgetting that the original broader question was always lingering in the wings waiting to be pulled back into the spotlight to illuminate the phenomenon as necessary - that is, what is it like to be a CNS in today's nursing world? As it turned out, the questions differed with each stage of the research. Initially the focus was on very general questions such as:

How did you feel about today?
Tell me about your role as a CNS?
What is advanced practice nursing?
What does the future hold for you?
What gives you pleasure in your job?
What do you dislike about your job
What did that incident today mean for you..how did you interpret that act?
Tell me about the patients and what they mean for you?

Subsequent interviews asked questions relating to specific aspects which had appeared as significant in previous interviews as well as aspects pertinent to the existing field visit.

How do the doctors make a difference to your world?
What is the difference between being a registered nurse and being a CNS?
What does 'busyness' mean for you?
Tell me about what being a CNS means for you?
Tell me a story about an incident that really illustrates what it means to be a CNS.
Tell me about a time you took a risk as a CNS?
Tell me about any significant incidents that have happened since we last met.
Tell me about what it means for you to 'know' patients.
What does being 'in control' mean for you?
What for you is advanced practice nursing all about?

By examining interpretations about the phenomenon gathered from the CNSs (the parts) and relating them back to the provisional conceptions brought to the study by the researcher (the whole), a new understanding began to be unfurled to which other components were added as the study progressed. In this way a 'perpetual oscillation of interpretations' took place within a circle of understanding (Rowan & Reason, 1981:135).

-Group Discussions-

On [Rose Ward], following van Manen's (1990) framework, focused group interviews were held in which the participants shared their views about whether or not the descriptions and/or insights gathered from one or other of them, resonated with their own experiences. In addition, the themes or understandings about the lived experiences gleaned from the conversations were fed-back, and the CNSs were asked to verify, clarify and/or shed new light on them. The first group interview was held on Faculty campus after work, which meant the CNSs were not 'on call' and not immediately obliged to return to the bedside. This allowed discussion and debate without the distraction of alarm bells and telephones and the group were more relaxed and amenable to disclosure knowing they were detached from the ward. The second group interview was less successful however, because a rift between the members of this particular group was settling in (to be clarified in a later section), and to make matters worse it was held in the ward area. Nevertheless, each group discussion generated lengthy and lively conversation which revealed valuable 'flashes of insight' into the lived world of this fascinating group of CNSs (Leonard, 1994:59).

-Returning to the Field-

Returning to the field for separate and distinct periods during the year facilitated the process of getting to know the respondents. As the field visits progressed, the CNSs were becoming more open and the role of researcher as nurse proving less awkward. Returning to the field offered an opportunity to track down some 'clue' or 'hunch' for further clarification or explanation after the fieldnotes had been written up, or the interview transcribed (Davis, 1986:58). Numerous interviews and observations assist in revealing 'conflicts, contradictions, or surprises that might not have been present in earlier visits' (Benner 1985, cited Plager, 1994:76). In point of fact, due to the repeated visits to the field in addition to the disclosing nature of the CNSs, a wealth of anecdotal data was collected. Benner (1994:107) points out however, that despite the amount of time it takes to read large quantities of text it actually 'makes interpretation easier because of the richness and redundancy' whereby meanings and patterns are more easily seen. She goes on to assert (p107) 'a large text that provides redundancy and clarity and confidence in the text is more plausible and reliable than a small text covering an inadequate range of situations'.

Following van Manen's framework (1990), the researcher would return to the participants and discuss her interpretations of their descriptions as a starting point for further sharing in terms of what the experience was really like. Moreover, returning to the field allowed time between visits to transcribe the recordings of taped conversations so that they could be mulled over prior to the next visit. As previously stated, this allowed identification of the themes for future dialogue as well as of any issues which had not been addressed, but needed to be. Concentrating on themes facilitated a refocussing on the complexity of the CNSs' practice and their perceived experience or meaning of their world. Multiple visits not only facilitate the emergence of patterns and themes, but also provides confidence in their interpretation (Plager, 1994).

In much the same way, Patton (1990) describes a working back and forth between parts and wholes. For example, the statement from Anne that she was more inclined to see herself as a *Clinical Nurse Survivor,* would have been explored in a subsequent interview. In a 'global' sense discovery of the central characteristics of the phenomenon of advanced nursing were sought. What is it about being a CNS that keeps a CNS being a CNS? (A response to that question might reveal the answer to a question the researcher has long asked: what *is it* about nursing that keeps experienced nurses at the bedside?).

In summary, consecutive field trips facilitated the discovery of the taken-for-granted aspects of the job, which necessarily had to be laid aside in order to get to more in-depth layers, the real meaning, and so reveal fresh insights into the being of a CNS. Each visit presented an opportunity to delve more deeply and more widely into the CNS's experiences in an effort to grasp a fuller understanding of the phenomenon. One, or even two trips, would not have allowed this to be followed through sufficiently. As it turned out, the last field trip began to see repetition creeping into the CNS's dialogue, in addition to which, the researcher found herself anticipating certain actions by the CNSs in the field. As noted, Benner (1985:11) refers to this as 'redundancy'. By the final week the researcher was satisfied that the original question (the phenomenon) had been sufficiently explored.

- Personal Journals-

Each CNS was given a journal (also referred to as a diary), in which to inscribe their reflections about significant aspects of their past and current working lives. In the diaries a notation explaining their use was included (see appendix C). The researcher also maintained a journal in which incidents, observations and thoughts were inscribed on a daily basis. According to van Manen (1990:73), the material imparted to a diary is likely to contain 'reflective accounts of human experiences that are of phenomenological value'. Although, he does also point out that writing can be constraining in terms of lived experience material as it tends to force the person into a 'reflective attitude' (p64). The CNSs were also asked to journal significant or critical incidents that occurred during their working days - a technique described by Benner (1984), wherein aspects that 'stand out' for them are documented. The journals were used as a source for reflection upon practice. Despite a number of colleagues cautioning that the CNSs were unlikely to use their diaries, they were found to be a rich source of material in terms of revealing immediate experience.

Further to that, during the fieldwork, the researcher herself wrote lengthy fieldnotes which encompassed activities in the field, unique experiences and various matters of interest which were later transcribed on to a word processor.

Phase I

These initial weeks in the field proved invaluable in proving the effectiveness of the proposed strategies for gathering lived experience material for the study. Within two weeks the clinical environs had been entered and a beginning rapport with the CNSs established, (although it was realised there was significant work still to be done in that area). The researcher's presence had also been made known to other senior personnel involved in the workworld of the CNSs; so that they would 'know' her as she walked on and off the wards. Invaluable insights into the working lives of the informants had also been gained. The 'pilot study' afforded the opportunity to discover that as the sole human instrument for 'gathering' this information, the researcher was in fact capable of collecting it. Furthermore, the experience led to a realisation that an exploration of the patient's perspective about the phenomenon needed to be conducted as well. It had been noted that some of the patients, particularly those who were chronically ill had developed a deep

rapport with the CNSs and it was believed the patients may be a source of further insight into the phenomenon. The inability to question patients about the CNSs when there had certainly been opportunity to do so, proved frustrating on the 'pilot study'.

The original decision to include patients in the study was thwarted for practical reasons. Patients while in hospital are disinclined to comment negatively on nurses looking after them. Patients are often too sick to interview or are in hospital for a brief period only. As to why to include the patients in this study, the answer is that it would be incomplete, to say the least, without them. The patient is the nurse's focus and barometer. The patient's acknowledgement of his\her predicament and his\her expression of it, combined with his/her first-hand view of nursing care, serves to underscore the "uniqueness" of the profession. The inclusion of the patient as respondent also lends to the text a further "human touch", in addition to that endowed by the CNSs. It provides a link or bridge between the profession and its raison d'etre - to care for the sick, i.e. the patient, and to assist in empowering or better restoring individuality to the patient which may have been curtailed through hospitalisation. Having the patient offer his or her thoughts completes the cycle of hospital care. Other reference groups were felt to have less relevance in terms of the immediate experience of the CNS and were not included.

The selection rationale behind the patients was again based on a *purposeful* selection approach. Those who chose to contribute shared a commonality of purpose in that they had a desire to share and to contribute (and perhaps to break the monotony of ward life). There was never any pressure brought to bear on any respondent to become a respondent or to remain one.

At the completion of the initial two weeks, it became crucial that access to the wards be sustained and the relationship with the informants maintained (Jorgensen, 1989). There was also a concern that six CNSs might be insufficient for the study in view of the fact there may be some attrition, or that the rosters would make it impossible to see some of the CNSs during subsequent field visits. Due to the plan to conduct the study over the period of one year, losing any of the CNSs was also a distinct possibility.

Phase II

As a result, a letter was sent to the Ethics Review Committee seeking approval to continue the study with a request to include patients as potential interviewees and to seek at least two or three additional CNS respondents These requests were granted. Once again advice regarding suitable wards from which to canvas volunteers was sought. A further list was furnished and two CNSs on the same cardio-thoracic ward [Violet Ward] and willing to participate, were found. In addition, a CNS (Wolley) from [Rose Ward] was approached and agreed to participate from the point of view of what it was like to be a CNS on night duty. It was felt that her perspective was important because Phase I interviews had revealed night duty as a very different realm to that of day duty.

Wolley stipulated however that she was reluctant to be observed on night duty, as she explained in her diary:

> *Because people do not often sleep at night especially if they have something bothering them. This is where the night duty sister comes into play. . . If you come on night duty with me you may not see my full role because at the same time my relationship with my patients is personal, and I would not allow you to be a part of my counselling. Therefore the dilemma of asking you to leave was my main concern. Please do not take offence at this. I am sure you would 'read the signs' and withdraw, but I did not want to take the risk of ruining a moment for a patient who may not have too many moments left.*

She agreed however, to sharing conversations and wrote a journal filled with stories about the world of the CNS during hours when most other beings are asleep.

At this point into the study (re)access to the wards had been secured and three additional informants negotiated. All that remained, was to hope that in the period between field trips the CNSs would remain on the wards and retain their enthusiasm to be involved. Phase II comprised a 4 week visit to the field. By now the researcher was getting to know the CNSs. Furthermore the patient interviews had begun.

Participants for Phase II: (8 in total)

Debra, Anne, Jay, Carol - Rose Ward

Jayne - Daffodil Ward

(Exit Bo - Daffodil Ward Maternity Leave).

Additions:

Annabelle & Sarah - Violet Ward

Wolley - Night Duty - Rose Ward

Annabelle: (40+y.o.) 20+ years of nursing with 8 years on current ward and 5 years as a CNS. Highest qualification RGN plus 2 specialty certificates. Has always been a nurse with time-out for raising children. (Part-time position).

Sarah: (31y.o.) 5 years on current ward and 3 years as a CNS. Has always been a nurse with time-out for travelling. Highest qualification RGN certificate.

Wolley: (35y.o.) 16 years of nursing with 7 years on current ward and 2 years as a CNS. Highest qualification MA (anthropology) RGN with post basic cert. (Permanent night-duty position).

-Conversations with Patients-

In phase II of the study a number of patients were interviewed (see Appendix D). Essentially all that was sought was a ten to fifteen minute conversation in an informal manner at the bedside. As it happens there were some concerns experienced in interviewing the patients (to be clarified shortly). Questions put to the patients included:

> Do you see any of the nurses here as being more expert than others?
> What does this nurse do for you that is special?
> What do you look for in these advanced nurses that you do not look for in any other health care professional? (With acknowledgment to Lawler, 1994).
> What is expert nursing care for you?
> What does the 'busyness' of the nurse mean for you?
> Tell me about a time a nurse did something for you that you thought was special.

Phase III

Comprised a further 4 week visit to the field. Involving:

Debra (now a CNC)

Anne, Jay, Carol, Wolley - Rose Ward

Jayne - (now an RN) Daffodil Ward

Annabelle - Violet Ward

(Sarah unofficially withdraw) - Violet Ward

Phase III was carried out along similar lines to the previous field trips. By now the study had explored numerous inroads to the CNSs' experience/s and many of the conversations would end in silence as if the subject were sated. This was found to be quite satisfying although it was understood that it by no means signalled the phenomenon fully explicated, and in part may have been due to 'the stillness of reflection' (van Manen, 1990:99). During this phase, each of the NUMs on the wards and three of the medical staff were interviewed (with Ethics approval). This was because material gathered from the CNSs had placed the medical staff, for the most part, in a negative light, and there was interest in discerning if medicine's perspectives leaned towards a similar view of the CNSs. The NUMs it was thought, might give additional insight into the CNSs' world.

Because lived experience material may be found in differing media (van Manen, 1990;Crotty, 1996), each CNS was approached during this phase to write a poem about their workworlds; to draw conceptual maps of the culture of this world; to trace their footsteps by recording their activities into a tape recorder, and to describe their lived experience by analogy using metaphor with a prize being offered for the best one. Furthermore, their footsteps were traced and displayed on maps by the researcher, and attempts were made to sketch them at work. These strategies were undertaken in an effort to visually display their world as well as textually display it (refer appendices E, F, G, H). They were also asked to wear pedometers to see how far they walked in a shift. All in all, phase III saw the researcher begin to relax and enjoy the role of participant observer in the clinical field.

During each of the periods between field visits, contact with the CNSs and the NUMs of the wards was preserved, so that they were all aware of when the return visit would be taking place and at what stage the research was at and so on. Apart from etiquette, this was undertaken

because the researcher was conscious of the privileged position afforded her as researcher in the clinical environs and she wished to maintain it. At the conclusion of the field visits negotiation took place to remain in contact with the participants so that they could be called upon to verify aspects of the research - most significantly, the interpretation of their lived experiences.

Disengagement from the Field

It was anticipated that leaving the field would not be easy. The researcher had 'lived' with the CNSs for a period of 10 weeks, and had known and kept in touch with them for more than a year. Their reality had been observed, their discourse heeded and their private thoughts read. There can be no doubt the researcher had related to, and liked the CNSs; she would miss them and the milieu of the wards. As Jorgensen (1989:118) asserts 'leaving the field is an emotional experience'. And yet, for all that, it was time to go. The phenomenon had, for now, been 'saturated'.

Nevertheless, it was deemed important to leave in such a way that the study would be remembered as a positive thing and not something that came in, appropriated, and vanished. The researcher's final journal entries were imbued with mixed feelings; both of regret and yet at the same time of enormous relief. There was concern that the political issue with Carol (described in the next section) had not been resolved and the researcher did not want to leave with some of the CNSs in turmoil.

Encouragement was taken however, in the words of Anne, who, when asked about the research process in her last interview, said:

> *I've thoroughly enjoyed it. It's made me think of issues that I hadn't considered before. When you first came in about six months ago I was so incredibly angry about nursing. I felt really angry and I thought why am I here? I hate it. I obviously hate it. And now I just sort of feel that I've come full circle back to normal.*

Even after leaving the field it was the researcher's intention to return for periodic visits and to remain in touch with the CNSs, and it is hoped this will continue to be the case.

Methodological Constraints

As it turned out, conducting the research over a fairly prolonged period (one year since time of the CNSs agreeing to participate - 18 months since time of first approaching Ethics Review Committee) saw a number of 'events' take place. Debra, who was a CNS at the beginning of the year was promoted to a clinical nurse consultant (CNC) half way through the study. Jayne a CNS of eighteen months, took holiday leave towards the end of phase II and returned having decided to rescind her CNS status and revert to being a registered nurse (RN). Carol, as will become clear, resigned her position at the end of the year and moved to another area. Anne was looking for another job throughout the year. Sarah appeared to make herself unavailable for the final field visit. (Arriving at the scheduled time the researcher would discover she had been 'sent away' or 'swapped' a shift).

It was not surprising therefore, that at each departure from the field the researcher would be hoping that the CNSs would still be working on the ward for the occasion of the next visit. In view of these considerations it was deemed fortunate that the study was able to be completed with out the major disruption of losing many participants. As it turned out, there were a core of committed CNSs who took a keen interest in this study and to whom the researcher is indebted. As it was, Debra and Jayne's perceptions of their new roles threw more light on the phenomenon. In effect as nurses, Debra 'went up' and Jayne 'went down', and so perspectives on being a CNS when one is no longer a CNS were forthcoming. Carol's discontent and the dissent amongst the CNSs on [RoseWard], which became more apparent as the year progressed, unfortunate as it was, revealed a number of aspects about being a CNS which might otherwise have remained hidden had things remained in *status quo*. It is assumed that Sarah 'just lost interest'.

Many of the difficulties confronted in the field are described in the following section in which perceptions about the role of researcher as nurse in the clinical field are brought into focus. One constraint worthy of mention was the impossibility of getting all of the participants to attend group discussions at the same time, due to the differing shifts upon which they were rostered. As it happens, a number of the limitations of the study bear a resemblance to those mentioned by Street (1992:17) in regard to her critical ethnography of clinical practice. It would appear that these stem from the fact that researching in the 'dynamic environment of clinical nursing practice' is fraught with bureaucratic contingencies. These in turn, are related to 'multifaceted' power

relations which at times, serve to support the study, yet at others 'to limit and shape' it.

Researcher as Nurse: Nurse as Researcher - The Experience of Self in the Field

Millen (1989:140), describing his experience of fieldwork, points out that 'in any research project there is fear, torment and joy'. Reinharz (1979:237) addresses the same issue, regarding fieldwork as a 'frustrating, anxiety provoking, yet personally fulfilling process that is experienced' - and states, it is certainly 'not a technology'.

In order to make explicit the impact the periods of fieldwork had upon myself as a novice researcher, yet experienced nurse, some of the 'fears, torments and joys' ensuing from my own experience are described in the passages that follow. During my first excursion to the field I remember being overly conscious not to miss a thing, which meant it took a great deal of concentration on my part to get through the 'shift'.
One of my first journal entries read as follows:

> *So awkward; standing writing notes in my book. . . I try to be unobtrusive but I can tell sometimes the CNS is aware of me, the patients too. A few of them ask me outright - what are you doing? But as soon as I explain they accept it. Sometimes, if I gauge the situation warrants it, I put the notebook away and try instead to consciously remember every detail and then at the end of the interaction I seek an isolated area trying to get it all down.*
>
> *The CNSs seem to cope with me trailing around after them. I see everything, positioned 'in the wings', watching them - soaking it all up. Sometimes I feel a bit like a voyeur, I suppose, as if I'm observing everything about them, but they don't see me. I enjoy the nurses' interactions with the patients - many times I see myself in them. And yet, at other times I am surprised to see things I've never seen before.*

As it happened, I found the experience of being a participant observer, that is researcher as opposed to nurse, quite unusual. One aspect of this, as referred to in the excerpt above, was the sensation of being 'all-seeing', a phenomenon I called my 'bird's eye-view'. As a researcher, not only did I appear to be getting a more expansive view of nursing, but a differing one as well. I went into a culture believing I knew, and ended up seeing it differently. By not actually being a 'real' nurse and therefore responsible for patients, I was struck by an overwhelming sense of freedom, which at the bedside had been quite alien to me (refer 'my story', chapter one). I was

able to concentrate on all aspects of the activities going on and not just on the patients, (as the CNS was obliged to do). This gave greater depth and width to my 'vision' and I began to realise I was looking at nursing through researcher eyes, as distinct from those of a nurse.

Nevertheless, despite this sense of freedom, it was not 'complete' freedom. For unlike research undertaken in the discipline in North America, interpretive studies in this country that see nurses actually go into the clinical environs, are relatively new. As a result, I was a 'foreign object' on the wards, not only for the clinicians, but for everyone else with whom I came into contact. As a researcher in the clinical field in a large well established, traditional, teaching hospital, I do believe I was at the frontier in nursing research in this State. For the sake of up and coming nurse researchers I was well aware of the need to tread cautiously. Had I made too many 'waves', or appeared too radical, I had the impression I would not have been tolerated.

Although my 'bird's eye-view' was an exciting discovery, it did not make the period of fieldwork any easier. For, while there was no doubt being nurse-researcher was an advantaged position, there were drawbacks, which would become evident. Crick (1989:32) writes of the need for social scientists to create 'a role for themselves in the field'. Yet the problem I encountered even on the first day, was that I was going to have to come to terms with more than just 'a role'. I was going to have to learn two or three. Perry (1989:6) points out, 'fieldwork confronts the researcher with a host of particular and personal dilemmas'. This particular dilemma confronted me during the first patient interaction I witnessed leading to the quandary of exactly *who* and *what* I was to be in the field.

It began when the first patient that Jay (the CNS) was attending, took an unexpected turn for the worst. He was performing a post-operative dressing on a skin graft for excision of a melanoma. The patient was sitting up and as he was having difficulty removing the Op-site dressing from her wound, she said she'd close her eyes. I was conscious of not interfering in any way with the interaction going on between Jay and his patient, wanting to capture the 'essence' of it, as it might have been had I not been there. Keeping in the background I was self-consciously jotting things down in my field notebook. I heard Jay saying to the patient she could look at the wound now, and he was advising her that although it may not look too good at this stage it would be much better in a few weeks time. We all focused on her wound, and just at that point she said she felt a little unwell and reached into her bedside locker and inhaled a couple of puffs of an aerosol

spray which we assumed was ventolin, but later discovered was nitroglycerine. Jay remained stooped over the wound concentrating on cleaning it - while I, with my new found bird's-eye, was seeing things with a wider lens. In point of fact I was seeing the patient lying back looking pale and becoming clammier and sicker by the second.

I was faced with a serious dilemma. The researcher in me was saying leave it, I have to see what Jay does about this. On the other hand, the nurse in me was saying we had better help this woman before she gets worse. I felt some fleeting but very real turmoil before the nurse in me stepped in and I reached to take the patient's pulse. At about the same time, Jay too must have noticed something was not quite right and together we began the resuscitative process she was to require. And yet, my quandary did not end there, for having become nurse I found it very difficult to resist the urge to take control of the situation over and above Jay, whose knowledge of cardiac emergencies was less than mine. Afterwards I thought about the potential of an incident such as this for upsetting the researcher/respondent relationship, especially in a case like mine, where the researcher has not yet had the chance to establish a rapport with the participant.

Chenitz and Swanson (1986) refer to this quandary of the nurse participant observer, and cite Byerly (1969) who observes, 'occasions may arise when [she] feels forced to make a nursing judgment even though her primary goal in the study does not involve patient care' (p55). As it happened, throughout the fieldwork I tried first and foremost to be researcher. Yet at times I felt obliged to become nurse, and at others I felt disenchanted with researcher and, longing to be nurse, would consciously swap over. Sometimes I would even combine the roles. And while in the beginning I felt happier being nurse, in the latter stages of the fieldwork I found being 'nurse entirely' and tied to the bedside, restricted my bird's-eye view. Because this meant I missed out on some aspects of ward life, after a while I found myself avoiding the role of nurse only.

Not only did I have to come to grips with the complexities of multiple roles in the field, but each day during out-of-the-field periods I had to return to academia. The difficulty in bridging differing 'worlds' was brought home one day when a patient the CNS and I were observing, suffered a cardiac arrest, and I reverted into the nurse 'mode'. A code was called and after a dramatic attempt at resuscitation the patient was pronounced dead. Shortly after, I returned to Faculty to attend a departmental meeting, and recall sitting in the formal boardroom reflecting on life and death issues such as the one I had just witnessed while my colleagues discussed

administrative policies as if they were the most important thing in the world.

Such navigation of differing realities is documented in the literature - Johnson for example (1975,cited Muetzelfeldt 1989:58) refers to the typically 'schizophrenic' existence of the fieldworker who moves 'back and forth between the realities of the social settings being studied and those of [his] sociological colleagues'. Wiley (1987, cited Jorgensen,1989:80) experienced similar disorientation or confusion in moving between the mental health settings in which she participated as an observer and the world of her ordinary daily life.

Like Muetzelfeldt (1989), my role became a 'process of self-exploration'. He describes his fieldwork enterprise as being among people who were so like himself that many of his 'experiences and reactions were typical of theirs'. As a result, he became personally 'overinvolved' in the field. Describing a 'dual view', he perceives that he ended up both participant and observer, source of data and analyst, subject and object (p.56). Jorgensen (1989) attests to the multiple roles the participant observer performs during the course of fieldwork, and yet believes these roles are desirable.

Other issues arose during the fieldwork which I had not anticipated in any conscious way before 'going in'. For example, I discovered early on that the participants began to have an effect on me. That is, from being strangers, with only nursing in common, I came to know and like them. And yet it struck me I was getting to know a lot more about them than they were about me, and in some way I was troubled by this. The distinction came about through my listening to the tapes of our conversations over and again, and by reading their diaries in which they revealed themselves quite openly. All of them were showing themselves as individuals with their own set of abilities, aspirations and fears, and I began to feel a strong sense of loyalty to them - but knowing more about them meant the relationship was a bit 'lopsided'.

All in all, as the field work progressed I began to feel as if I was taking without giving, and this revealed itself in many ways. One time, I was observing a very busy CNS who had started what turned out to be a quite a complex dressing. Halfway through the procedure she ran out of a dressing material and she asked me to open up additional supplies for her. This happened on two further occasions during the dressing and at the end of it all she thanked me and said with a big smile, *'lucky you were here'*. I wrote in my field notes, *'I feel useful!'* What is more, when the

CNSs were busy and things were a bit chaotic on the ward for example, as researcher I could ostensibly go in, observe and exit at my leisure leaving the CNSs to stay to the bitter end. Sometimes however, I would abandon the 'researcher who is sometimes a nurse' role and take up 'nurse in her entirety'. By helping the nurses out I felt useful and more valued on the ward, and my sensitivity about giving nothing back was to some extent assuaged.

On Rose Ward there were a core of CNSs whom I came to know particularly well, and during the year as it turned out, there was some internal conflict going on amongst them. This placed me in a difficult position because I was 'thrown into the middle' of it. Being researcher I saw and heard a great deal, and in our conversations they had all individually disclosed their points of view, so I knew the story of their discontent from all sides. Yet, because of my tenuous position on the ward, and the need to maintain strict confidentiality, I believed it unethical to attempt to mediate and subsequently found the situation unsettling. I wished for them to be happy and to work harmoniously because I had grown to like and respect them all as advanced nurses. And although I knew the medical staff, had in a way, perpetuated the split, it was doubly difficult because I believed the research process itself may have brought matters to a head. There was no doubt that during the study they had all reflected on their lives and roles in a manner never required of them before. This may have precipitated their appraisal of each others practice, causing them to see that allegiance to certain medical staff on the part of one was a problem for them all.

Perhaps I should have foreseen such problems. For example, Carol (who was at the centre of the dissent) referring to a conversation we had at the very beginning of the research process, in her diary wrote:

> *. . . the unsettling aspect was that it brought me directly in contact with other aspects of nursing. I've long known I do not want to continue for the next* [x] *years of my remaining working life doing hands-on shift work. Since I don't seem able to achieve my modest ambitions in this ward I am coming to the conclusion I need a more radical change. I think talking to you was a catalyst. My inertia has been given a prod!*

I remember reading the entry and feeling uneasy, but it was not in any anticipation of trouble amongst the CNSs, rather as researcher, I faced a dilemma. Realising I had raised her awareness about herself and nursing, which on the one hand, could be seen as a positive thing, on the other I was anxious she might become so discontent she would leave before the study was completed.

My thoughts centred on the fact that although our conversations had possibly empowered her and no doubt had been therapeutic, what would I do if I lost her? This raised the issue of whether I should continue to encourage her to reflect critically on her lived experience and take the chance she might become so dissatisfied and leave, or should I downplay her concerns in an effort to keep her in the field? While I was conscious of my ethical commitment and a concern to do 'good' by the participants I did have my research interests at heart.

In his reflections concerning anthropologists conducting fieldwork, moral issues such as these are raised by Crick (1989:39). He points out, that very often the central concern of the research enterprise is in the shaping of a career, in the 'coming up with the goods', and this must have ramifications for the study. In my case I had identified Carol as a source of valuable information regarding the working life of the CNS and did not like the thought of losing her. As it turned out, I just continued with her as I had begun, and although she did eventually leave, fortunately it was not until after the fieldwork phase was over.

While individually the CNSs on that ward assured me that the research process played no part in this dispute, I am not entirely convinced. I had not gone into the field with any critical intent, (I was not there to change things) merely to see 'what is', their lived experience. By encouraging them to look at their world in a different light and in seeking to reveal hidden aspects of their experiences it was inevitable they would be changed as a result. The process was critical therefore in the sense that it transformed their perception of their world, but I certainly had no intention of causing dissent amongst them, nor had the thought arisen that my involvement would cause dissent directly or indirectly.

However, apart from these concerns, another 'anomaly' that came to light which I believe, needs to be addressed to assist research in the clinical environs. This was the lack of a suitable venue on the wards where we could go for 'professional' conversations (I suspect this is the case in most other hospitals as well). While the nursing literature is replete with strategies for effective interviewing, no mention is made of such deficits. Of the many interviews that took place, not one was noise free or uninterrupted. I was constantly finding I was interviewing in the staff tearoom, with differing personnel drifting in and out peering inquisitively at the tape recorder before replenishing their teacups or filling up patient's water jugs from a noisy urn or tap. Once, when interviewing in an outpatients treatment room which was not booked at the time, we had

to contend with the whirr of a centrifuge in the background and laboratory personnel shuffling in and out. On another occasion I was offered the NUMs office and breathed a sigh of relief only to find the 'domestic' in there firmly attached to the telephone. When she finally departed I discovered the office to be adjacent to the patient's call-bell board and had to contend with my informant disappearing on me on at least two occasions because 'the bell sounded urgent'.

While the patients I interviewed did not perform disappearing acts, we were interrupted at times and an even greater drawback concerned the lack of privacy afforded them in the wards. Despite the drawn curtains, the patient and I quickly became aware we were not 'alone' by any means, and that during our conversation our voices would carry beyond the immediate confines of the bed. I believe this definitely had a detrimental effect on a patient's willingness to disclose innermost thoughts during interviewing. A further drawback was in the form of the paperwork with which I was required to approach the patients as stipulated by the Ethics Review Board. Comprising a consenting contract and a participant information sheet that included such statements as: 'participation in this study is entirely voluntary. . . you can withdraw at any time. . . .your decision will not affect the nursing care that you receive'; all seemed too much for a brief informal chat. In addition to which, at the outset I was equipped with a tape recorder. Even with the best of intentions I found for many of the patients it proved overwhelming. (Quite apart from the few patients who viewed me with suspicion believing me to be on a mission to assess the nursing care).

Interestingly, in the Australian Health Ethics Committee Guidelines for the Assessment of Qualitative Research, mention is made of the fact that the building of rapport is essential in qualitative research and that 'written consent is shown to interfere with this process'. This was certainly the case in this instance. Not long into the second phase of the fieldwork I dispensed with the tape recorder. This meant I had to jot things down as they were said and after the interview augment the transcript with snippets from memory. Fortunately however, this strategy worked better than the obtrusive tape recorder. Unfortunately I could not dispense with the paperwork.

As it happened, despite my initial enthusiasm I found interviewing the patients not an easy task. I firmly believe this also had to do with my concern, that as a nurse, I should not be burdening sick and hence already encumbered people with my questions. The vulnerability of the patients

was indeed an issue, and quite a number of them actually began to weep as I conversed with them (both men and women). Yet, like Kellehear (1989) who writes of similar experiences, even though I knew the patients wanted me to hear them, I still felt responsible for their anguish. One of my journal entries provides an insight into the emotional side of researching in the clinical environs:

> *. . . there are many concerns going on in my head. Carol began to weep during lunch when she was describing how upset she is in regard to the 'trouble' on the ward. She feels she's not to blame. Twice today someone has cried 'on me'. During the interview with the patient. . .a woman who's been here about six weeks and has suffered many set-backs, she started to cry. She started to cry when I was asking her about what it is the nurses do that makes nursing special for her. She said it was the comforting aspect of the nurses' work. 'When they comfort me when I'm upset' and the tears started to fall and I automatically reached for her hand, and I thought, 'gee this is the nurse in me too'.*

Kellehear (1989:64) believes however, that people must be given the chance to speak about their lives. Writing of his experiences in interviewing dying patients and the fact that they often wept, he highlights the difficulty in not feeling responsible in some way for those tears, and yet, he perceives it unmerciful to disallow persons the right to speak about their anguish.

When all is said and done, being a participant researcher had a number of ups and downs and this reality is substantiated by the literature (see Perry (ed.), 1989;Reinharz, 1979;Davis, 1986). And yet, as Reinharz (1979:238) asserts, 'fieldwork as a method of self discovery is cumulative'. Echoing her sentiments, I would suggest there are undoubtedly hidden costs, certainly there were more than those to which I have alluded in this chapter, but by the same token there are some varied and positive elements to fieldwork, not least of which is the potential for self-transformation through discovery.

Conclusion

This chapter has described the processes involved in the planning and implementation of this piece of research. It has also examined issues relating to the gathering and preliminary analysis of the CNSs' lived experience material. The concerns of a nurse academic in the role of researcher doubling as nurse, were also shared as part of a circle of understanding that has seen the original 'whole', that is, the perception of experienced bedside nursing stemming from

personal experience, reconceptualised through the addition of theoretical 'parts' introduced in the chapters to date. Following on from the periods in the field, was a time for sorting the material gathered and then began an interpretive process culminating in the development of the phenomenological text. This second phase of the research process is recounted in the ensuing chapter, and explains how the phenomenological text was created. The phenomenological text itself is presented in chapters seven, eight and nine.

CHAPTER SIX

INTERPRETING THE TEXTS OF LIVED EXPERIENCE MATERIAL

> *Interpretation involves the interpreter and the interpreted in a dialogical relationship* (Plager, 1994:71 drawing from Heidegger, trans.1962).

Introduction

The purpose of this phenomenological study was to understand, and reveal the life of the CNS at the bedside. To achieve some of these goals the study, as has been discussed, turned to hermeneutic phenomenology. And while both van Manen (1990) and Benner (1994) point to interpretive phenomenology as being unresponsive to reduction in the manner of a definitive set of procedural steps and techniques, they offer a number of steps from which one can choose in order to give the 'best possible account of the text presented' (Benner, 1994:xvii). Leonard (1994:59) explicates that the term 'text' as used in this context, comprises 'transcribed interviews, observational notes, diaries and samples of human action' which are treated as 'analogues for interpretive analysis'.

In this study, in order to analyse the text garnered from the lifeworld of the CNSs, a framework espoused for the human sciences by van Manen (1990) was used. The analysis was carried out in interrelated stages and culminated in the development of a phenomenological text (narrative) in an attempt to render visible 'the essential nature of the phenomenon' (p171).

The Interpretive Analysis

-Experience and Phenomenon as Concepts-

In phenomenological work it is necessary to distinguish between *phenomenon* and the notion of *experience*. As Crotty (1996:17) points out, in terms of meaning, phenomenon and experience are not interchangeable. As an approach to research, phenomenology focuses on questions regarding the structure and essence of the experience of a phenomenon for certain individuals. The phenomenon being experienced may be for example, an emotion, or a relationship as in this

study, a job (Patton, 1990). Phenomena[1] are investigated from the subjects' unstructured descriptions of immediate experience/s (Bartjes, 1991). But as noted, one's thoughts, feelings and perceptions of the phenomenon are not the phenomenon (Crotty, 1996). For as van Manen (1990:22) states, human science phenomenology goes beyond an interest in 'mere' particularity. In fact, the 'basic and straightforward concept of *phenomenon* understands it as *the object of experience'* (Crotty, 1996:18).

Phenomenologists are not primarily interested in the subjective experiences of their informants for the sake of reporting their particular views, perspectives or vantage point. On the contrary, the deeper goal is to remain oriented to asking the question of what is the nature of this phenomenon as an 'essentially human experience' (van Manen, 1990:62). van Manen (1990:20) states:

> Objectivity means that the researcher remains *true to the object*. . . He or she seeks to 'show it, describe it, interpret it while remaining faithful to it. . . "Subjectivity" means that one needs to be as perceptive, insightful, and discerning as one can be in order to show or disclose the object in its full richness and its greatest depth.

Crotty (1996:142) describes van Manen as a mainstream methodologist who seeks a description of phenomena through an emphasis on 'world' as intentional *object.* Crotty takes this passage from van Manen's text to illustrate the 'paramount aim' of mainstream phenomenology that is to account for, and reveal the 'world'; not the 'person':

> From a phenomenological point of view, to do research is always to question the way we experience the world, to want to know the world in which we live as human beings. And since *to know* the world is profoundly to *be* in the world in a certain way, the act of researching - questioning - theorizing is the intentional act of attaching ourselves to the world, to *become* more fully part of it, or better, to become the world. Phenomenology calls this inseparable connection to the world the principle of 'intentionality'. In doing research we question the world's very secrets and intimacies which are constitutive of the world, and which bring the world as world into being for us and in us (van Manen, 1990:5;Crotty, 1996:142).

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[1]According to Husserl, true phenomena are objects seen after the proper use of the phenomenological method and comprise objective ways of being that are necessary ways of being, if a thing is to exist (Catalano, 1980:8). Heidegger (trans.1962:53) purports, 'phenomena are never appearances' but the showing-itself-in-itself signifying a distinctive way in which something can be encountered. 'Phenomenon' in the phenomenological sense is that which shows itself as Being and as a structure of Being' (Heidegger, trans. 1962:63). Heidegger (trans. 1962:51) asserts that the expression *phenomena* denotes *'that which shows itself in itself,* the manifest'.

The phenomenological text appearing in the succeeding three chapters, seeks to identify the essential structure of the phenomenon, that is, the job of the CNS as presented to her through her experiencing of it. In other words, what has been elucidated, is nursing as a CNS, not just CNSs[2]. Because involvement with the participants was for the sake of illustrating the phenomena, the need to engage with the phenomenon and not the particular human subjects as a group was essential (Crotty, 1996). The text is therefore, a search for the objective reality of the CNSs (Crotty, 1996). It set out to delineate the structure of the job, what it means for her; how it presents itself in her consciousness, and what the structure of it is within her experience of it (Crotty, 1996).

To create such a text necessitated commitment to 'due' processes:

-Immersion in the Lived Experience Material-

In the first instance, the tapes of the conversations were listened to and each one transcribed into prose by way of a word processor. The transcripts were read several times so that the lived experience of each CNS came to be known and grasped as a whole. This process saw the researcher literally immersed in the data, living with the CNSs' stories, placing excerpts on the walls around her study, both at home and at work. Listening to the tapes over and over, she read and re-read the transcripts of the interviews so that the stories became known by heart. Similarities in the experiences of the CNSs were looked to and global essences discovered. In addition to these commonalities, four existential themes, which as previously noted (see chapter four), van Manen (1990:101) identifies as integral to the lifeworld of every human being, and therefore considered as 'belonging to the fundamental structure of the lifeworld' (p102), were used. These proved helpful as guides for reflection in the research process and consist of:- lived

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Crotty (1996:173) speaks of intentionality, which as we have seen, is a notion central to the phenomenological stance. A person is not just a being with an inner world to explore. Rather, they are a being-in-the world wherein they are inseparable. As a free, self-conscious being-in-the-world, a person is destined to address that world, make sense of it and act upon it - to shape it even as they are being shaped by it. In which case, Crotty (1994) asserts, in asking the participants to describe the phenomenon they should be asked not to describe themselves loving or hating nursing for example, but the nursing that they love or hate. Not that they themselves are fulfilled or frustrated by nursing but the nursing in which they find fulfilment or frustration. Not themselves approving or disapproving of nursing but the nursing of which they approve or disapprove. Not the ways in which they understand nursing but that which they attach these understandings to. In his treatise he stresses that the viewpoint of existential phenomenology is to see the world as it presents itself to a person not merely as a person has been taught to see it (Crotty, 1996:174). These are fundamental concepts and as such, are worth repeating.

space (spatiality), lived body (corporeality), lived time (temporality) and lived human relation (relationality or communality).

-Hermeneutic Phenomenological Reflection - Identifying Themes-

> *Human science research is concerned with interpreting meaning* (van Manen, 1990:79).

Van Manen (1990:77) writes of hermeneutic phenomenological reflection and describes it as a process in which an attempt is made to grasp the essential meaning of something. He points to the difference between our pre-reflective lived understanding of the meaning of a phenomenon and the reflective grasp of the phenomenological structure of the lived meaning of the same phenomena. To get to the latter he asserts is a 'difficult and often laborious task' - and 'involves a process of reflectively appropriating, of clarifying, and of making explicit the structure of meaning of the lived experience' (p77). Because the meaning or essence of a phenomenon is always multi-dimensional, its meaning can only be communicated textually, that is 'by way of organised narrative or prose'. As such, 'to do human science research is to be involved in the crafting of a text' (p78). In order to structure the meaning of the text he advises, it is necessary to conceive of the phenomenon described in the text as 'approachable in terms of meaning units, structures of meaning, or themes' (p78). Analysing real life material van Manen (1990:86) asserts is a process in which 'we try to unearth something "telling", something "meaningful", something "thematic"'.

He describes themes as 'the stars that make up the universes of meaning we live through' and that 'by the light of these themes we can navigate and explore such universes'(p90). Themes facilitate the process of phenomenological description, and represent the 'fasteners, foci, or threads around which the phenomenological description is facilitated' (p91). Themes are the instruments for getting at the meaning of the experience i.e. 'being a CNS'. Phenomenological themes are avenues for getting to the 'meaning'. Themes, van Manen (1990:79) says, are not conceptual abstractions, not objects or generalizations but 'structures of experience'. As the stories and anecdotes of the CNSs were read and re-read, questions were addressed of the text, such as 'what is going on here?' What is the *eidos* or essence of the notion of advanced practice nursing that is coming through in these stories and how can the essence be captured by way of thematic

reflection on it?

Themes, can either be incidental or essential, and according to van Manen (1990:106) differentiating between the two can be difficult and also a controversial element in phenomenological human science. He explains; 'in determining the universal or essential quality of a theme our concern is to discover aspects or qualities that make a phenomenon what it is and without which the phenomenon could not be what it is' (p107). And so, using this model the question became 'is this phenomenon still the same if one imaginatively changes or deletes this theme from the phenomenon?' If for example, the notion of being 'experienced' was regarded as an essential theme of being a CNS, one would ask could a CNS still be a CNS without being experienced in the area of her work? Certainly, one can be experienced in an area without necessarily being a CNS.

It is the 'essential' themes that matter in phenomenological research. 'Incidental' themes may be a part, but are not 'special' to that phenomenon or experience. For instance, to be a CNS it is not sufficient just to wear a set of 'pink tags'. She has to know the ward 'inside and out', she has to be able to relate to others, and to be approachable because it became obvious that she has a central mentoring, mediating and monitoring role, and so on. The themes became the foci around which the phenomenological description was expedited, and so identifying the themes enabled the phenomenological process to be effected.

Van Manen (1990:93) advocates three approaches to uncovering thematic elements of a phenomenon in the text. In general, his selective reading approach was taken wherein the text was read several times while asking the question: What statement(s) or phrase(s) seem particularly essential or revealing about the experience or phenomenon being described? At other times the other two approaches: the wholistic or sententious approach and the detailed or line-by-line approach were used in combination with the first. These approaches advocate the exploration of each sentence or sentence cluster (called meaning units), or the text as a whole, and were adopted to uncover meaning which was explicated true to the universal quality of the experience (p97).

Once the themes had been identified they were reflected on to provide even deeper understanding. Theme analysis involved recovering the themes that were 'embodied and

dramatized in the evolving meanings and imagery of the work' (p.78). As a process, this was not undertaken in any mechanical way such as a methodical frequency count for example (it was not performed with the aid of a computer software package). Rather, via a process of discovery, envisaged by van Manen, (1990:79), as a 'free act of "seeing" meaning'.

Bergum (1991:63) writes of her experience in identifying what she calls 'thematic moments' wherein as she read her participant's stories she began to notice each story somehow characterized a particular theme. Following this, she discovered these moments appeared in other informant's stories as well. In a similar vein, certain themes were noted to recur as commonality in the experiences of the CNSs, and as van Manen (1990:93) suggests, they were 'held onto' and captured 'in a singular statement'.

Nevertheless, because it is difficult to capture the full mystery of lived experience, a theme cannot usually be a singular statement but needs to be a fuller description of the structure of lived experience (van Manen, 1990:92). In fact, a thematic phrase 'only serves to point at, to allude to, or to hint at, an aspect of the phenomenon' (p.92).

Bergum (1991:64) cites van Manen (1984) to caution against making too much of themes or moments, because as he points out 'they are not magically appearing essences but are useful focal points or commonalities of experience around which phenomenological interpretation occurs'. Van Manen (1984, cited Bergum 1991:65) distinguishes between the story and the interpretation of thematic moments inasmuch as 'the interpretation of thematic moments represents further involvement with the texts of the transcripts and entails tracing etymological sources, searching idiomatic phrases, studying [the literature] and artistic sources, and attending to personal experience'.

Crotty (1996) advocates opening oneself to the phenomenon. To ask what is this phenomenon saying to us? What does this phenomenon strike us as being? That is to say, a reflective recapturing of what it means to be an advanced practice nurse was the focus, and not the everyday meanings or the subjective experience of individual participants. (Although, as will become clear, the subjective experience of the participants has been incorporated into the text predominantly by way of anecdotes).

Each of the transcripts was read several times and the lived experience material separated out. This text was then sorted into the various themes. Initially, the existential themes of temporality (lived time), spatiality (lived space), corporeality (lived body), and communality (lived relationship to others) were used as a framework to guide this process. From the initial stages of sorting, three broad themes emerged a)Being-in-the-world as a CNS, b)Relationship with Others, including doctors; nursing administration and nurses in general, and c)the Patients. From these themes emerged sub-themes into which the original existentials were interworked.

Text that was not an anecdote or story was not discarded. Rather, it was looked at analytically to decide whether or not it was describing immediate experience. If not it was separated out, yet much of what could be called the 'other' data was 'rich' and holistic, and had potential for revealing complexity. While there was no doubt the stories, the anecdotes, provided 'thick descriptions' that were vivid and enshrined in a real context, other lived experience material still had a 'ring of truth' about it, which had an impact on the study (Miles & Huberman, 1994:10). Questions posed of the narrative material were similarly asked of this 'other' material. How is this advanced practice nursing? Is this what it is like to be an advanced practice nurse? Is this what it means to be a CNS? What is this situation like for this CNS? What is good about advanced practice nursing? What is not good about it? What is going on here? What does this piece of dialogue tell me about being a CNS? Is this getting to the reality of advanced nursing? What is this lived experience like? What is the meaning and significance of this experience? and so on (adapted from van Manen, 1990:63/145/166).

-The Use of Anecdotes-

Phenomenological writing makes use of anecdotes which van Manen (1990:115) calls special kinds of stories. An anecdote is used to 'make comprehensible some notion that easily eludes us' (van Manen, 1990:116). Van Manen (1990) speaks of the importance of story when describing the preparation of phenomenological text because it allows the text to acquire a narrative quality combining the power of philosophic or systematic discourse with the power of literacy or poetic language. The significance of anecdotal narrative is situated in its ability to; compel our attention, lead us to reflect; involve us personally; transform, and finally, measure one's interpretive sense (Rosen, 1986 cited van Manen, 1990:121).

Van Manen (1990:116) cites Samuel Johnson (in Fadiman, 1985) who described an anecdote as 'a minute passage of private life'. While he concedes that phenomenological research does not aim for empirical generalizations, it could be true to say an anecdote is like a poetic narrative which describes a universal truth (p.119). Because they are concrete and taken from life, anecdotes can therefore be offered as an example or a recommendation for acting or seeing things in a certain way, and in that way can teach. Moreover, in some way anecdotes contain 'messages' that may be unclear when put into any other form of language. Anecdotal narrative as story form is an effective way of dealing with certain kinds of knowledge. Anecdotes, in every day life usually begin their course as part of an oral tradition. Nurses (and women) are renowned for the oral tradition underlying their culture (Street,1992a), and certainly the CNSs' ability to narrate anecdotal material relating to their experiences, served only to confirm this belief.

Van Manen (1990:120) tells us anecdotal narrative reveals something *particular* while essentially addressing the *general* or *universal.* Anecdote is similar to human science because they both operate between particularity and universality in an epistemological/methodological sense. By the same token, the fundamental insights or truths tendered by anecdotes can be tested for their value in the contingent world of everyday experience (van Manen, 1990). He explicates that some anecdotes spring out of real life experience while others just relate to everyday experience. It is necessary therefore, to look for anecdotes that really concretise immediate direct experience, and not anecdotes couched in everyday understandings of the phenomenon (1995).

Following van Manen's (1990) blueprint, the anecdotes of lived experience were extracted from the transcripts of the conversations with the CNSs. The process involved opening oneself to the text and asking questions such as: What does this text reveal about the actual lived experience of the CNS? What is being seen here? An attempt was made to (re)describe it, to take a fresh look at the practice of the advanced nurse. By virtue of the potency of the 'messages' contained within it and the potential for others to learn from it, anecdotal material has been included in the phenomenological text.

Proceeding to Phenomenological Writing - Creating the Phenomenological Text

> *Creating a phenomenological text is the object of the research process* (van Manen, 1990:111)

Van Manen (1990:132) makes clear 'responsive-reflective writing is the very activity of doing phenomenology'. To all intents and purposes, 'the object of human science research is essentially a linguistic project: to make some aspect of our lived experience, reflectively understandable and intelligible', as such it requires a commitment to write (p125/6). So much so, that van Manen (1990:126) attests, because writing is closely interwoven with the research activity and reflection itself, 'writing is the method'. Through the interpretive practice of writing, the experience is described. For van Manen, writing is a process that allows us to measure our thoughtfulness in a number of ways: it separates us, yet unites us more closely with what we know; it distances us from, yet draws us more closely to the lifeworld; it decontextualises thought from practice yet it returns thought to praxis; it abstracts our experience of, yet it also 'concretizes' our understanding of the world, and finally it objectifies thought into print while at the same time it subjectifies our understanding of something that truly engages us (p.127-129).

The key to writing is language, a central concern because phenomenological recollection needs to be brought to speech (van Manen, 1990). Therefore, phenomenology is a languaging activity used as a way of addressing human activity. The phenomenologist writes the text as s/he is engaging with it, and because s/he is involved in the world, and has an interest in the phenomenon, s/he does not give neutral descriptions (van Manen, 1995).

Van Manen, claims phenomenological writing requires sensitive reading, and attention to the silence around the words by means of which we attempt to disclose the deep meaning of the world. Yet writing, he says, requires of us that we rewrite; the methodology of phenomenology requires a dialectical going back and forth among various levels of questioning, between the parts and the whole. This involves a complex process of rewriting, re-thinking, re-flecting, re-cognizing. Finally, phenomenological texts need to be oriented, strong, rich and deep. What is more, intuition is an essential component in writing, in so far as one opens oneself up to the data rather than imposing one's own thoughts on it (van Manen, 1995).

Bergum (1991:66), addresses these issues when she writes of her own experience:

> The writing and rewriting, the constant search for deeper meaning changed not only the understanding of the particular part of the study but also the totality of the study, which again required rewriting. This constant search for new understanding has been called the hermeneutic circle, which contains the possibility of deeper understanding. The recognition that it is not yet finished is very real.

Clearly, writing this text required a commitment to writing and rewriting. Having separated out the non lived experience material, and identified emergent themes from among the rest of the text, the phenomenological description was written. This was not a task completed in a hurry, it was an artistic endeavour requiring a 'dialectical going back and forth among. . . various levels of questioning. . . going back and forth between the parts and whole in order to arrive at a finely crafted piece' that in some way reflects the personal "signature" of the researcher (van Manen, 1990:131/2). And although there is 'no compelling reason to structure a phenomenological study in any one particular way' (van Manen, 1990:168), the study proceeded into phenomenological writing by using approaches suggested by van Manen (1990:168-172). The phenomenological writing was organised *thematically*, around global themes such as 'being', 'knowing' and 'doing' in-the-world as a CNS; *analytically*, by reworking lived experience material into a 'reconstructed story' of the life of the CNS (p170); *exemplificatively* by making visible the essential nature of the workworld of the CNS and by 'systematically varying the examples' in order to reveal 'invariant' aspect(s) (p171), and *existentially* by weaving the phenomenological description of the lifeworld of the CNSs against the existentials of temporality, spatiality, corporeality and sociality. The text was structured around the questions of how CNSs experience, for example, time from day-to-day and what is different about their experience of it compared to non CNSs, how they experience space, how they embody the experience of nursing as a CNS and how they experience their relationships to others in their workworld and so on (van Manen, 1990:172).

From the beginning, it was clear the CNSs did not consider themselves different from other experienced registered nurses and so many of the differences portrayed in the text spring from those between the CNS and more junior registered nurses. By the same token, much of the phenomenological description might equally apply to an experienced registered nurse at the bedside. Finally, the combination of approaches as outlined above has resulted in a textual structure which could be said to have been *invented* (van Manen, 1990:173). But, as van Manen

(1990:173) points out, 'human science research as writing is an original activity'. The phenomenological text constructed in this study attempts to uncover the essential nature of the phenomenon CNS. It is, in a sense, a narrative which borrows the CNSs' words and combines their voices not only with each other, but also with the researcher's interpretations, in an effort to provide an coherent understanding of their lived experience.

Bergum (in Morse, 1991:62) writes, 'knowledge revealed through stories is contextualised, personal, never replicable, and full of life experience that is not explained'. Like Bergum, with her stories of women's experience of childbirth, the stories of the nurses were written out of reflections on the hermeneutic conversations. The CNSs were fed-back the stories for comment. This was a collaborative activity for discussing and testing a research text. Each agreed they were able to see aspects of their experience in the text (van Manen, 1990:101).

Why Write a Phenomenological Text?

> *The object of human science research is essentially a linguistic project: to make some aspect of our lived world, of our lived experience, reflectively understandable and intelligible* (van Manen, 1990:125/6).

Human science phenomenology asks what is this or that kind of experience like? 'It offers the possibility of plausible insights that bring us into more direct contact with the world' (van Manen, 1990:9). It examines a lived-experience as a 'whole', for the purpose of understanding social reality from the context of the person/people who lived the experience (Bartjes, 1991:249). Because the 'origins of human reason are to be discovered in the structure of appearance, in the basic ordering of human experience', phenomenologists focus on how we piece together the phenomena we experience in such a way as to make sense of the world, and by so doing, develop a worldview (Mitchell, 1979:141). Van Manen (1990:62) expands on this concept when he writes:

> The point of phenomenological research is to "borrow" other people's experiences and their reflections on their experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience, in the context of the whole of human experience.

For van Manen (1990:121), phenomenological research 'aims at elucidating those phenomenologically structural features of a phenomenon that help make visible, as it were, that

which constitutes the nature or essence of the phenomenon'. A phenomenological description describes the original of which description is only an example. As such, the description is iconic, inasmuch as it points at the 'thing' being described. He points out (1995) that human science text must confirm experience. Benner (1994:xviii) cites Dreyfus (1991) who makes the point in his lectures (as does van Manen, (1995)) that the validity of a phenomenological interpretation is demonstrated when the informant turns to the researcher and says: 'you have put into words what I have always known, but did not have the words to express'. Hence phenomenological descriptions come out of experience and are validated by experience. What is more, as van Manen (1995) suggests, undertaking phenomenological research is a process of changing ourselves, inasmuch as we become moved by our words, and produce a knowing body rather than a body of knowledge.

In interpreting the lived experience text and generating the phenomenological text, the voices and concerns of the CNSs were carefully listened to, so that a description giving 'the fullest possible account' of their lifeworld could be produced (Benner,1994:xviii). It is experience drawn from an oral account and used in an effort to understand the phenomenon of their advanced practice. The intention of creating a phenomenological text, was to offer the reader a plausible, understandable and illumining account of the phenomenon as a possible human experience. Meanings were not imposed on the data, the interpretations all link back to it, and unknown aspects of the phenomenon are revealed. By a 'sharing' of the CNSs' workworld, a reader, should be able to say 'this speaks to me and enriches my lived sense of the world'.

And, while phenomenology does not purport to get at the 'ultimate' truth, it does seek to illuminate and transform lives through such illumination. The text unfolding in the chapters that follow, presents the 'life' of the CNS based on phenomenological ideals, and should provide insights for the informants themselves and other CNSs to grasp in a reawakening of their experience. The text should enlighten and assist nurses, nurse academics, students of nursing and others to more fully understand the practice of the advanced practice nurse, and should make the reader critically aware of some of the concrete concerns these nurses have. Writing the text evokes a 'vicarious experience' of aspects of her lived life (Sandelowski, 1994:480). Heron (1981:166), describing experiential research says of it, 'research of this sort closes the gap between research and "real-life"'. Because the reader develops an understanding of the role in a new way, this should inform practice and the general perception of the CNS, so that non bedside

nurses 'get back in touch' with real-life nursing.

Readers may include nurse administrators, and other policy makers having a direct influence on the working conditions of the CNS, and so it is quite conceivable that phenomenological work has a political agenda (van Manen, 1990;1995). As Bartjes (1991:261) attests, 'phenomenology endeavours to provide insights into the continuing debate on the role of the nurse as one of the indispensable members of the health team'.

This work could never be conclusive, and so this thesis is not the last word on the subject CNS. It serves only to make the reader wonder more fundamentally in a more animated way about the phenomenon. Further to that, revealing the essence of the phenomena of experienced nursing should open up 'new possibilities for engaging the problem' (Leonard, 1994:60) and precipitate further research in the area.

Methodological Rigour

> *A phenomenological description is always one interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially richer or deeper description* (van Manen, 1990:31).

Van Manen (1990:17) says, human science 'operates with its own criteria for precision, exactness, and rigour', and that precision and exactness are sought in the endeavour to produce interpretive descriptions 'that exact fullness and completeness of detail, and that explore to a degree of perfection the fundamental nature of the notion being addressed in the text'. Sandelowski (1986), who has based much of her analysis on the work of Guba and Lincoln (1981) speaks of a 'faithfulness' to the original intent of those involved in the research process, so that 'credibility' becomes a criterion for truth value. She also points out that credibility is enhanced when researchers describe and interpret their own behaviour and experiences as investigators 'in relation to the behaviour and experiences of the participants' (p.30). The criterion of 'fittingness' relates to when the findings 'fit' into contexts outside the study situation by others recognising their own experience within them. 'Auditability' becomes apparent when it is deemed another researcher could arrive at similar conclusions (at least not contradictory ones) in comparable circumstances. Sandelowski (1986:34) refers to the issue of 'confirmability', which

fits the criterion of neutrality. Neutrality, that is, in regard to the findings themselves and 'not to the subjective or objective stance of the investigator'. Van Manen (1990:20) attests to objectivity meaning 'the researcher remains true to the object'.

Leonard (1994:60) believes that unlike the traditional positivist paradigm there is no technical procedure for 'validating' a phenomenological account. Nevertheless, she posits that an interpretive study can be judged by the following criteria:

a) how carefully the question is framed and the initial interpretive stance laid out;
b) how carefully the data collection is accomplished and documented, and
c) how rigorously the interpretive effort goes beyond publicly available understandings of a problem to reveal new and deeper possibilities for understanding (Extracted from Leonard, 1994:61).

Plager (1994:77) describes three factors that contribute to the rigour of hermeneutic phenomenology:

a) the inevitable retrospective and historical nature of interpretive work,
b) the involved and time-consuming need for studying participants in their everyday situatedness, and
c) the arduous commitment involved in interpreting the text.

Finally, it should be stressed as van Manen (1990:18) does:

> To *do* hermeneutic phenomenology is to attempt to accomplish the impossible: to construct a full interpretive description of some aspect of the lifeworld, and yet remain aware that lived life is always more complex than any explication of meaning can reveal. The phenomenological reduction teaches us that complete reduction is impossible, that full or final descriptions are unattainable. But rather than therefore giving up on human science altogether, we need to pursue its project with extra vigour.

Conclusion

In this study, a phenomenological text has been written to determine the 'boundaries' of the lifeworld of the CNS in contemporary nursing practice. This chapter has explained how the CNSs' lived experience material was framed, sorted, drafted, and redrafted until it could be presented as the phenomenological text in the chapters that follow. The issue of methodological rigour in this study has also been addressed. It is believed that the resultant phenomenological text is a coherent, faithful, credible, plausible interpretation of the experience/s of the CNSs.

With Regard to the Phenomenological Text: Its Nature

The phenomenological text displayed in the next three chapters, is a narrative written with the intent of revealing the immediate experience of a group of advanced practice nurses in their day-to-day workworld. As previously noted, the creation of this text has to a certain extent been *invented* and it is therefore essential that aspects of its literary style are brought to attention. In the first instance, it is important to note that in the narrative the thoughts of the CNSs are interwoven with the researcher's own interpretations, and that their words appear in *italics*.

Secondly, it should be said that their words are direct quotes, but unless indicated from which CNS they originated, the italicised text is not enclosed in inverted commas, as is usually the case. This is because punctuating the text in this way produced a narrative that appeared too 'cluttered', and consequently detracted from its reading. The unattributed quotes reflect thoughts that were deemed consistent across the group, and it was thought to be integral to the 'artistry' of the text that they appear as they do.

Thirdly, the attributed anecdotes (excerpts of lived experience) that appear in the text, are included because of their richness and their power to render the voices of the CNSs heard. As will become clearer in the reading of the text, this is a group whose voices generally go unheard.

Finally, as previously noted, by reason of their respective professional representation, in the text the CNS is referred to as 'she', and the medical officer as 'he'. In chapter eight the medical staff are also commonly referred to as 'medicine'.

See also Appendix I - Glossary of Technical Terms

CHAPTER SEVEN

THE PHENOMENOLOGICAL TEXT: ON THE MEANING OF BEING A CNS

Being-in-the-world as a CNS

-Being the Same-

While for the medical staff, and certainly the patient the different uniform insignia of the CNS (in this case a set of 'tea-rose pink tags'), represents very little, to the nursing staff they indicate a person who is seen to *know what they are doing.* The CNS herself will insist her CNS emblem means she holds *the knowledge and basic nursing skills of any good nurse.* This presupposes, *being able to take observations and interpret what's happening and ascertain whether there are any problems,* and be able to *apply these skills anywhere* she *works.* She will see her job as *more than just emptying bedpans,* but is under no illusion that her contribution is in any way regarded as anything special by the hospital system. And, she will tell you that on an *ordinary day,* there is nothing significantly different about being a CNS compared to being an RN. '*When you look at the criteria* [for CNS] *I was doing all those things anyway: so as far as my day-to-day work goes, there's no difference',* says Jay. To all intents and purposes a CNS is performing the same tasks as when she first began nursing; and so to be a CNS is *above all being a registered nurse.* A CNS just: *knows that little bit more* because she is more experienced and often has undertaken an extra course of study. Thus, it is being *more experienced in one specialised field of nursing that makes the difference, not necessarily because* she *is a CNS.* Annabelle delineates the concept:

> *You can put on two thousand pairs of TED stockings and you get to the two thousand and first pair and they seem to go on more easily and more comfortably for the patient - not so awkward as if you were putting on the first pair. It's the same for every nursing procedure.*

Moreover, although confident of her expertise, a CNS will resist the label 'expert', for, in nursing, she believes, *you're always learning.* Besides, as Sarah points out: *'it's fairly routine - the surgical field, so it's not hard to develop an expertise - it's not much out of the ordinary, so expert is too big a word'.* Initially, she may be pleased with her promotion inasmuch as it

symbolises a *little bit of hospital recognition* - it's good for morale - but deep down, she accepts there is no real value in it. The role has been demeaned in her eyes because there are *'too many of us running around'* and *'you don't have to do anything to get it - it's just given away'*. All in all there is nothing *elite* about the role. Anne sums up the general feeling: *'You can work on a ward for 3 years with your hands over your ears; and your eyes closed, and still become a CNS'.*

Furthermore once the position has been assigned, the criteria for its retention are nebulous - role expectations appear to differ from ward to ward. Once the novelty of wearing CNS tags has worn off, and she approaches her 8th year of service ('thereafter') the CNS reaches a point where the salary differential between CNS and RN becomes minimal. As a result, the CNS perceives she is afforded no extra privileges. In a sense she believes the implementation of the career structure has seen only the names and terminology change - *it's just the same job in a slightly different uniform.* She recognises she *has no more control over policy and patient care than she had as a RN.* A CNS may even go so far as to say:

> *There are so many positives and so many negatives* [in nursing], *and yet CNS just doesn't seem to have changed the perspective. CNS seemed to have such possibilities of good things, but it just doesn't seem to have worked out.*

Anne also disillusioned, sometimes wonders if the coloured tags aren't akin to *'Brownie good behaviour points'.* Similarly, Debra is convinced CNS was developed as a *'lollipop' - if you stick at something long enough you deserve a token reward'. Good in theory,* the concept has become *clouded in practice.* By and large, in the eyes of the CNS, she feels she is *'nothing different, or special, just better'.* Someone who can do the job just a bit 'better'.

While there are some CNSs for whom being a *better* but not *different* bedside nurse is enough: there are others whose experience has led them to construct a different view of their workworld. From this point on, where necessary, these differing understandings about the world are referred to as emanating from either CNSs as phenomenon-A (phnA), or CNSs as phenomenon-B (phnB). (But, that is not to say the two categories are mutually exclusive - on the contrary both types have many traits in-common).

-The Phenomenon-A CNS-

The phnA-CNS is generally single, and usually free of family commitments. She is looking for more from nursing because she sees her future is more intricately bound up in it. She has been a CNS for a number of years and although she has an affinity for nursing at the bedside - and would not necessarily want to lose that aspect of it - she is frustrated by what she sees as a lack of opportunity to expand her role in the clinical field. Anne for example, points out:

> *If we are ever to gain any credibility as a group, we must be seen to be people who have more knowledge and expertise - not merely RNs with different coloured tags on our uniforms.*

This type of CNS wants greater challenge and autonomy because there are times when she *just doesn't want to have people telling her what to do* and would prefer *a position where she can be in-charge of* herself. Moreover, because she is essentially *bored with everyday basic nursing,* she just *'sits'*, biding her time - waiting for something better to turn up. This type of experienced nurse will refer to herself, not as clinical nurse specialist, but as ***clinical nurse survivor.*** Anne is the phnA-CNS: she is single, in her early thirties, has undertaken tertiary education, likes bedside nursing, but is in a position where there are no more avenues to explore. Work is no longer stimulating and the 'system' denies her the opportunity to make full use of her considerable knowledge and skills. Everyday she scans the 'situations vacant'.

-The Phenomenon-B CNS-

The phnB-CNS is an experienced nurse who, generally, works part-time, perhaps has been in a higher position in nursing at some stage, but has left usually to have a family, happily returning to a less senior position. Life-style changes have seen her priorities change, and she no longer wants a career from nursing. Because she is on-duty at home as soon as she is off-duty at work, she is content not to become overtaxed. Alternatively a phnB-CNS may be a CNS who has only recently been awarded the position, and is still in a kind of 'honeymoon' phase: or a CNS who is generally less career-oriented. It may even be the case, a phnB-CNS was once a phnA-CNS, and considers herself as having *moved on from that.*

Annabelle is a good example of a phnB-CNS; hospital trained, without tertiary qualifications and working part-time. Before the career structure, she saw herself at a *dead-end* in nursing: for her, CNS status increases her standing in the eyes of university-trained nurses. She sees the position in a favourable light because *'it gives the young ones something to aspire to'*. Essentially, she feels different only when she ventures to another area of the hospital where she is recognised by her 'pink tags' as a more experienced person - the irony of which is not lost on the CNS, because out of her familiar world her specialist expertise diminishes. Annabelle has no intention of undertaking further study as she has a growing family and a husband whose career takes precedence. This sort of advanced practice nurse will be most concerned with the basic care of the patient, aspects such as *washing them and making sure they are comfortable and warm and dry and so on,* and is much less interested in extending her role or appropriating quasi-medical tasks. She is content to be an *ordinary nurse* who is recognised as a specialist in her area. Bo, a former NUM - realised from that position *what goes on and what the politics are,* and is happy with her lot as a CNS. She is not interested in extending her role or revisiting the position NUM. She says, *if I wasn't CNS I wouldn't be phased, I'd be doing the same job anyway. . ..*

-Being Older (Lived Body)-

While a CNS still does a considerable amount of *running around*, nowadays, she paces herself. And where the junior nurse is willing to forgo rest breaks during a shift - a CNS rarely is. This is because she is older, and although thoroughly enculturated into a nursing life-style, she will usually admit to finding shift work more wearing in a physical sense. *Going for a picnic at midnight used to be fun, but not so much anymore.* There comes a point where she seeks *more order* in her life, and most would prefer to be working regular hours. Anne points out that it is not nursing *per se* that affects her private life; *'it's the shiftwork'*. On the other hand, another might see benefit in shiftwork for a variety of reasons including its penalty rates and the fact that it obviates the need *to do the weekly shopping on a Thursday night* (when people who live a more *'normal'* existence are doing theirs). A phnA-CNS will more than likely prefer to work afternoon and weekend shifts because the NUM and many of the MOs are 'out of the way', hence she *is more her own boss.* Nevertheless, regardless of the pro's and con's of shiftwork, it is probably true all CNSs dislike getting up before dawn on a winter's day, and all will find late/early shifts gruelling even though they *make the day/week go quicker.* This is because in contrast to an office job for example, the job of the CNS requires she be on her feet for eight hours; *'hauling' people*

in and out of bed. On top of this she will probably walk no less than 4-6 kilometres each shift. There can be no doubt, the job is physically demanding, and in order to perform it effectively it is essential that she is fit.

A CNS may either be a university graduate or hospital-trained nurse. For some higher education graduates it appears the ward on which they gain their CNS status may well be the only ward on which they have worked. Any CNS will naturally feel more comfortable nursing patients to whom her specialty knowledge is applicable, yet because out-of-the-ordinary incidents arise, or the ward fills up with 'outliers' who have differing problems, any deficit in a generalist knowledge base will quickly surface. Specialising without a generalist foundation upon which to build, is perceived as a shortcoming - *a cop-out*, by many CNSs who have extensive generalist backgrounds.

Wolley, a hospital trained nurse with many years experience and an intensivist background, is an 'old school' nurse who is scathing of the CNS without general nursing knowledge, and who argues that no nurse should become a CNS unless he/she has had at least 3 years general experience. To illustrate her claim, Wolley describes a night she arrives for duty and discovers a patient undergoing a blood transfusion via an expensive 'immunogard' giving-set that has been incorrectly assembled. Due to her extensive background in acute care she is able to salvage not only the giving-set, but also the remaining blood. Experience in other areas means that the CNS *picks up a number of skills that come in handy now and again.* Wolley refers to this as simply: *'letting little bits of stored knowledge out to air'.* Anne says:

> *Just because you know a lot about oncology for example, doesn't mean that you can recognise when someone is having a pneumothorax or is coning, any of those little things that a wider experience gives you.*

To make matters worse, there is a perception that because of their narrow experience, CNSs without a generalist background often become too *afraid* or *entrenched* to broaden their skills base by moving on. More often than not, the CNS who is not a generalist will admit to having *no idea of what to do* when presented with non-routine cases. This is especially disconcerting because, as we shall see, above all else the CNS likes to feel *in-control.* Jay, a CNS with a limited general background, acknowledges this as a *weakness* which does affect his work. Nevertheless, as far as Jay is concerned, the 'real' strengths of a CNS are embedded in their

'knowledge of the specialty itself'.

-Being Tied-

While there will be degrees of quality in each category of nurse, it will become evident in the retelling of their stories, the CNS - whether she be phn-A or B, hospital or college trained, is undeniably beneficial to nursing. In point of fact, each category tends to offset the other to provide a comfortable balance to patient care. The problem for nursing is that the *'system'* is liable to lose phnA-CNSs. Irrespective of typology however, being a CNS is grounds for the experienced nurse to defer transferring to another ward: a move she may well have considered otherwise. This is because she would need to give up her 'advanced' status; a situation which necessarily implies descending the ranks. Knowing *'what I'm doing'*, asserts Jay, is one of *'the greatest reasons for staying on the ward rather than working anywhere else'.* Carol who eventually did make the move describes it as *'starting all over again'.* She observes: *'apparently your skills aren't transferable - you have to lose all your skills by making that hundred yard shift; I'm going back to being a beginner'.* For someone who has been perceived by their peers as highly competent; to suddenly become incompetent is not an attractive proposition. As a result, unlike other bedside nurses, the CNS becomes anchored to the ward. This is an especially beneficial position for hospital administrators and patients alike, because as Annabelle points out: *'it's quite a moving staff situation we get a lot of new people in, so it's good to have some permanent staff in specialty wards to help the ward run efficiently'.*

-The Sameness of Being-

There is no doubt that being designated a CNS, gives a nurse an increased sense of professionalism, yet in general, this is only the case if she is working alongside staff whom she perceives have need of her expertise. Because she knows the junior staff rely on her to be a resource person and for support in times of difficulty; working amongst the converse - a group of CNSs - she no longer feels as valued. Therefore, feeling good about her role depends very much on *what happens on the day.*

> *If you're having an ordinary day and you're working with three other CNSs then you feel just the same; but if you have a day where a lot of people come up and ask you things, and you can supply the answers then you feel good.*

While it may give her pleasure to be able to say she is a specialist in a given area, *rather than just a nurse on the ward* - after a certain interval of *seeing the same patients day-in, day-out* she will, more than likely, (particularly if a phnA-CNS), confess to becoming dissatisfied with the role. This is because, at the bedside - *there's nothing really to tax the brain anymore.* For the most part, it's as if she were on *autopilot*, mechanically carrying out more commonplace tasks. *'I could go to work blindfolded and still do the same job'*, laments Anne. She feels she is just *'plodding along'*, not *'stretched or stimulated'*, and on occasions perceives she is no different to an enrolled nurse. Carol voices her discontent - *'if I was called upon yes, there are certain things I could do that others can't - but I'm not really called on to do them'.* Jayne writes in her diary: *'isn't it terrible to wish for someone to be sick so my life can be more interesting'.* The upshot of this is her impression of being *stuck in a rut,* of *becoming stale,* and seeing her role as very *ordinary and anybody could do it.* Consequently, she begins to live in hope of some new challenge/s, yet at the same time, as we have seen she is reluctant to move on.

Adding to this problem, is the fact that in most cases she does not want to be a NUM, and because CNC positions are few and far between, the CNS finds she has no-where to go. *'One of my big problems in nursing is about what to do next'* says, Jay - *'nursing doesn't allow for any further movement at the bedside'.* Carol says: *'there is just no where to go to; I am quite bored with the sort of work I am doing, and the thought of doing it for years to come is just daunting'.* In so far as the career structure created an extra step-up at the bedside, the concept was enthusiastically embraced, yet today ten years later, it would appear a senior CNS - in terms of bedside nursing - is no better off than a 'thereafter' RN.

While for many phnA-CNSs this situation lends itself to burnout, for the phnB-CNS as distinct from feeling frustrated by the lack of new challenge, being *so used to the ward* makes life generally more comfortable - she can come on duty and because the work is unwaveringly routine she just *puts in the 'right disk' for the day* and performs tasks about which she basically *doesn't have to think a lot.* At the conclusion of the shift she can then *go home and not think about it any more.*

A CNS may view knowing the job *inside-out* in a negative or positive light, but she does acknowledge that being stuck-in-a-rut affords a certain familiarity, and *ipso facto* she will have established a *secure* spot for herself on the ward. For the present it must suit her, but the minute something better comes up the phnA-CNS will be off; because basically as with any job, *when there are no more challenges left, it's time to move on.* Hence for both types of CNS a certain amount of inertia sets in.

While it can be said a CNS may often be on *'auto-pilot'* because of the routine nature of her day-to-day work; at the end of the shift when she walks off the ward, the job does not cease to exist for her. There is little doubt, she will aim for it to be that way, for she has been in nursing too long to succumb to *taking work home*. Yet, on occasions a patient in particularly *tragic circumstances* may break through her resolve, and she will find herself thinking about them in her off-duty hours. Moreover, because she is often *in-charge*, the added responsibility means she does in fact muse over events at the end of the day. She may worry for example, that less experienced staff on the ensuing shift will fail to *pick-up on* aspects of a patient's condition, (on the other hand, if she is aware a CNS is in-charge on the next shift, she will be relieved). At times, she may even feel the need to contact the ward to check aspects of particular concern. After a late shift, and faced with an early start, reflections about work come to a head, and more often than not she has difficulty getting off to sleep (only to discover when she does; she dreams about work): hence she arrives on-duty the next morning, tired, even before the shift begins. When she finally gets so weary she needs a day off, she reports in sick. When she returns, in contrast to other professional jobs her work has not accumulated, and yet her absence does require the other nurses to pick-up extra duties because she is unlikely to be replaced.

-Lived Time-

Although the tempo of life on the ward can vary, that is, between shifts and even within shifts, in general, a CNS does not have time to spare. Those times when the ward is *lento,* she will quickly become fed-up *kicking her heels for half the day.* In addition, on quiet shifts she faces the possibility of being moved to another ward - which is *bad for morale.* And yet, while she will tell you she dislikes *being sent to another ward;* she does admit it affords a break from the usual routine. More often than not she removes her 'pink tags' on a foreign ward because she finds numerous staff, unaware she is relieving, ask her questions specific to that ward. As a rule, a

CNS can *cope with new situations* and an unfamiliar environment is not unsettling. A more junior nurse finding herself in unknown quarters however, may find the experience highly stressful.

A *quiet day* is often uninteresting. On a *quiet day* she will be going to the patients and saying: *'Is there anything I can do for you?'* And they will look at her and reply: *'well you asked me that half an hour ago'.* For Annabelle *'not being busy'* means she has *'spent more time with some things than she actually needed to'*, and was able to *'speak'* to the patients about such things as *'their surgery, their recovery, their fears and anxiety and their discharge plans'.* However, a CNS likes the pace to be fairly *allegro,* for, on a *reasonably busy day* she is alert and acts more efficiently, and feels *organised* and *in-control.* In addition, there are *enough little things to do and when things happen,* [they happen] *in sequence, so that one thing is finished before another presents itself,* and if anything out-of-the-ordinary *crops up,* there is time to deal with it too.

On the other hand, *busy* shifts see her *frantic;* working *non-stop* and in *horrible haste*, and *everybody seems to rush the patients a lot,* and she has *a lot of patients whose care takes a lot of time,* and there are *too many things to do,* so she *gets behind* and *people say things to* her *and* she *forgets* and *can't get everything finished* - which all results in less effective caring of the patient. Being too busy *throws her routine* out and makes for a *messy* day. On a *busy day* she will often be hounded by a sensation of *something left undone* and may never discover what it was.

In general, being *busy* is produced by a ward which is full of patients yet short on nurses. What is more, the nurses who are on-duty will comprise a number of new staff requiring *just that little bit more support,* which the CNS is unable to provide because she has her own patients. On [Violet Ward], because the patients are *heavy*, so is the workload - and due to the nature of their surgery if a patient *has any changes; any deterioration; it usually happens pretty quickly.* For Annabelle then, even more stressful is a full ward staffed with relief nurses. This is because she is aware that changes *'can happen, and* [she] *is not quite sure if the relief staff will be able to pick up on them, and if they do, if they will know what to do next'.* As dressing sister, for Jay *busy days* are usually the result of doctors imposing on his time. And yet, even though a CNS really **does** like to *structure* her day, sometimes she gets a *sense of achievement out of having survived an extraordinarily busy and unstructured one.*

Although a CNS can have differing shifts according to the momentum of events, more often than not, she labels the shift in more quintessential terms. A *reasonably good day* (otherwise known as an *ordinary day*) consists of coming on-duty and being allocated so many patients and the day's work goes according to plan, but it will be quiet and the work routine. Preferable to this, is a *good day* - here the CNS comes on-duty and her work is allotted her and it all goes according to plan, but *something interesting crops during the day* which she *handles* well. *Good days* (which might average about fifty-fifty) consist of being able *to relate to people,* both patients and staff, and of being able to effect the job properly - which means *above adequately.* In oncology a *good day* is when *all the patients have had good news, or if they've had bad news* a CNS *really feels* she's *been able to do something for them and support them in some way.* Jay's *good shift* includes:

> *. . . a number of different sorts of dressings taking a few clips out; doing some new grafts; a couple of biopsies in the middle - a trip off the ward - not bad for a break. Nothing going horribly wrong or even disappointing . . .*

For Sarah a *good shift* is working with two new graduates who react positively to her tuition. A *good day* can be reasonably busy, that is, just enough work to keep going, yet remaining *totally in-control.*

> A *good day* is the *sort of day where you get called upon a few times "oh what do you think we should do with Mr so and so because he's having trouble with such and such?" And you'll know what to say - and you'll know that no-one else would know that.*

Furthermore, on a *good day* a CNS will be working with a group of nurses she likes, and leaves the shift feeling she has *accomplished something.*

On a *bad shift,* often referred to as a *nightmare shift* - something *untoward* happens, or the ward is so busy she *cannot get everything done,* or she *has to deal with a particularly trying patient, or is feeling off-colour or tired.* Not infrequently, a CNS will end up *feeling a bit cranky* on a *bad shift.* Jay's shift turns *bad* because he treats an outpatient in the clinic whom he believes should be admitted, yet he perceives he has not the position, nor the authority to challenge the *'system'* to act in her best interests.

He expounds on the problem:

> *She's one of the patients who came through Cas. one night and while she's nominally the responsibility of our doctors here, they don't really want to know about her. . . . But this woman needs something done; she's got the biggest breasts I've ever seen, and one of them is full of pus. . . and these are the sort of days where you think 'I don't know what to do with her'. I think this woman should probably come in and be opened up again to clean up this wound - because sticking in a probe and pulling a bit of gauze through isn't doing anything. Yet being a nurse you can't do a whole lot; so that's the sort of thing that makes it a bad day.*

Because of the unpredictable nature of the nurse's work, at any given moment a *good* day can turn into a *bad* day, (rarely the other way around). On a *horrible day* something horrible happens.

-Lived Space-

The ward is a familiar world for the CNS, she feels at one with it and can take possession of it (van den Berg, 1972). Whereas healthy people dwelling in the outside would see it as an abnormal world, for her it is ordinary and everyday. And, like most other realities, it is a shared world.

The structure of the ward also has a big influence on the CNS - *'being an 18 bed ward makes an enormous difference'*, Jay says. This is because he only has to work a couple of shifts and he *'knows all the patients'*. [Rose ward] has big windows opening on to wide verandahs surrounded by Jacaranda trees. Jay states, *'in the main hospital they've got great big windows, and yet you can go all day and not know what the weather is like'*. Carol, who sees the ward *'as a bit of a dump'*, would like a nicer environment to work in and believes the patients need one too,*'but the money is spent on other areas'*.

Not infrequently, a CNS will have to cope with an environment and equipment that *takes up such a lot of time and energy when she's busy.* This creates discontent - Annabelle, for example cites the *'horrible beds and furniture'* as following closely on the heels of her main dissatisfaction - *'staff shortages'*. On [Rose ward] there is *'one decent sphygmo'*, and the number of *short sheets* they *have to put up with is 'highly annoying'*. Carol writes about the lack of space in the patient's

rooms once all the technical equipment has been assembled *'To get to the patient I have to re-arrange the furniture in the room'*, she declares, *'which is frustrating and tiring'*. What is more, because there are so few electricity outlets on the wall, when a patient has too many items of equipment which necessitate power:

> *. . . there is a tangle of cords over which one must shift furniture - difficult with these flimsy unstable tables which have a habit of collapsing and shooting cups of tea into freshly made beds.*

Carol sees these problems as easily fixed - she suggests the TVs be mounted on the wall and new oxygen and electricity sockets be installed. Yet, she perceives the monies for this are being spent by the *'system'* on other superfluous equipment deemed essential by non-nurses for non-nurses. For example, there is a campaign to get equipment off the floor in the store room and panroom which means that cartons etc. can no longer be stored there, apparently there is some difficulty with the cleaners regarding those areas. Carol is *mystified* by the sense in this and questions the whereabouts of nurses' voices in arguing against it:

> *Why are we so patient? Why isn't someone pounding tables and shouting? Why do we have to put up with people with clip boards and fancy names telling us the important thing is not to store equipment on the floor - when nurses are injuring their backs simply getting to the patient's side? . . .*

Yet, *'if* ***they*** *had to put up with these conditions'*, she asserts, *'they would soon be fixed'*.

The tearoom and nurses station are spaces which have assumed personal meaning for the CNS. The tearoom, which in general, is out-of-bounds to patients and their relatives, is an especially useful area for periods of time-out. Here she finds camaraderie amongst fellow nurses, or as in the case of Carol experiencing some conflict, the coolness of indifference. In places of sanctuary, a CNS will often exhibit a side of her character not seen by the patients and certain other hospital personnel - in a sense she reveals her 'flip side'. As a matter of fact, a CNS will sit in the tearoom and not infrequently *talk and bitch about patients*, or if she gets cross about someone or something, she may go into the tearoom and actually *thump the table, and feel a whole lot better afterwards.* She will tell you that *'in the tearoom you can go and shout at other staff members or try and talk it out - say terrible things about the patient that you would never show them'*. In the privacy of the tearoom, a CNS can, not only *vent her spleen,* but she can also get in touch with life on the outside, and talk about everyday happenings in the world outside of the hospital

environment. Very occasionally a patient will venture into the closed world of the tearoom and invade her space, she dislikes this but will be gracious about it. In the tearoom she can never truly escape. Nor even in the hospital grounds. Unless she physically removes herself from the hospital environment, she can be sought out, and is thus in a sense, forever on call.

[Violet ward] has just been refurbished and has a new tearoom situated in such a position that the patients' call bells can easily be heard from within. This has made the staff happy because they can all go tea more or less at once, and it has become a social event with rituals such as fresh rolls and jam every Friday. On [Rose ward] the tearoom is cramped, most of the staff who are smokers will go up to the 'roof' for their break. This is divisive and has tended to split the staff into factions of those who smoke and those who do not. 'Going up to the roof' is a ritual too, the CNSs will go up there not only to smoke cigarettes, but also to fill out the crossword and complete the word games in the daily newspaper. It takes their minds off the sickness that lies beneath them. Reposing in a haze of carbon monoxide, for the CNS, being on the 'roof' is literally *'a breathe of fresh air'.*

-Encountering the 'System'-

As she becomes increasingly senior, the CNS begins to perceive she has a wealth of knowledge and experience within, and behind her which the *'system'* does not encourage or allow her to make the best use of. This may, or may not, trouble her. For those it does trouble; the *'system'* becomes the single most overarching frustration to confront her workworld, and there is no doubt she would, and often does leave nursing because of it. Carol voices her concern: *'I could do a lot more as a CNS but I just don't get the opportunity. I know there are so many more interesting and creative things I could do - that I don't do'.* Eventually those who are discouraged by it, may come to regard bedside nursing as *restricting* and *crippling.* Like Anne, who writes in her diary:

> *So many aspects of the 'system' are designed to keep you in your place rather than encourage you to develop as a professional. I know I have abilities and knowledge that could be put to service more effectively than they are. In a sense, my expertise is wasted.*

The *'system'* itself comprises the huge hierarchical infrastructure of the organisation, of which, (more precisely 'under' which), the CNS is a part, and within which are situated an endless mass of bureaucrats comprising administrators, support staff and differing health personnel, all co-habiting the hospital and all of whom are likely to share directly and indirectly to varying degrees, in the CNS's everyday worklife. Far and beyond any of the other workers, the two groups that represent the *'system'* most completely for the CNS, and which have the most impact on her ability to perform effectively and gain satisfaction from her work, are nursing administration and medicine. Ironically, the two run counter to each other, yet together constitute a formidable opponent. An opponent that is seen to control and repress the CNS. Particularly the phnA-CNS, who, through her experience, has gained the knowledge and confidence to want to make greater use of her skills on the job.

Above all else, a phnA-type CNS wants to be able to use her initiative at work, and yet because of the *'system'* and its dictates, she discovers *sometimes she can, and sometimes she can't.* The *'system'* envelopes a CNS within a pall of bureaucracy so that in the end she cannot move without some, or other, protocol affecting her practice. And although a CNS will know her policy manual

backwards, a phnA-type CNS will be exasperated by the constraints imposed on her by these guidelines - *all of those things that are in place for* her *benefit*, but prove so *frustrating*. Where she believes she is supposed to have some *responsibility and authority* in her role; she perceives *in lots of ways* hospital rules *prevent that from happening*. And while she is the first to acknowledge rules are needed in order to run large institutions - there is no doubt in her mind, *some of the bureaucracy is silly, and some of the rules ridiculous*. She will readily admit - *it's nice to know when you can bend them*, and *if you can get away with certain things*. In actual fact, she says, *'sometimes, you have to bend the rules anyway; to make things run smoothly'*.

For the phnA-CNS, initiative is bound up with autonomy, which she sees as *the ability to function as a practitioner by making decisions based on her knowledge* (decisions which presumably would fall within hospital guidelines, but on occasions not necessarily so). If not within hospital protocol however, she would want to know that her expert opinion would be backed by the *'system'*. As it presently stands that is not the case, and using her initiative may actually involve overstepping protocol for which she is often punished. And so, as Anne points out, she gets to know *'the people who appreciate* [her] *using* [her] *initiative and the people who don't; so* [she] *just modifies* [her] *behaviour accordingly'*.

For the most part however, acting autonomously requires a furtive element. Carol for example, gets a call from an ex-patient who has a 'collection' in her wound and although it has already been drained by her GP, has recurred, and because it is a long weekend and he is away, she turns to Carol. Strictly speaking Carol should have sent the patient to Casualty - but knowing she would have been waiting in reception for hours, and not being too busy herself, Carol agrees to drain the site. *'It took me a whole five minutes'*, she says. *'And I sent her on her way quite happily - but I had to swear her to secrecy - if it was found out I'd be in trouble'*. Having performed this procedure *'lots of times before'* Carol did not *'consider there was any risk at all'*. She was in fact, prepared to *'bend the rules to keep the patient at the centre of* her *work experience'*.

A phnB-CNS, on the other hand, is more likely to view autonomy as not necessarily desirable, because for her - *'in the long run, it's more stressful'*.

-Disencountering the 'System'-

Coupled with, and somehow tied in with the *'system'*, there are *a lot of little things in nursing* that act upon the CNS (particularly phnA-CNS). *Things* which make her disheartened, and eventually *all add up, until* she *is no longer enjoying work;* and which lead to regular vocational crises. These are the times when *it all gets on top of* her, and leaves her thinking; *'I don't want to do this anymore, I've had enough'*. So much so in fact, she may actually *dread* going to work. But:

> *. . . it's not the dread* [she] *might experience when the ward is frantic or* [she] *is tired after a late shift and* [she] *just can't face it, it's deeper more insidious; it's not the next day that's the problem; it's the next issue that leaves* [her] *feeling powerless; it's next year when* [she] *can't see things being any better but probably worse, and it's the years to come when there seems no way out.*

Jay believes these feelings stem from the hierarchical nature of the *'system'*, and the *'whole culture of complaint, defensiveness and inferiority which is endemic to the profession'*. And because the job cannot be severed from the *'system'*; the CNS, subjugated for years under its influence, discovers the toll is taken in the guise of these stretches of acute despondency.

Debra observes that:

> *I come to work in the morning and often before a hello or time to put my bag down, I'm confronted with problems and complications. One of the doctors I work with is making my life misery. Everyone is just so demanding of my time. That's before I even get to my patients . . .*

Jayne goes through an *'identity crisis'* desperately *wanting to get away from the politics on the ward,* while at the same time believing she is not adequately fulfilling the criteria CNS as laid down by the *'system'*. At such times a jaded CNS will say she is *'fed-up with the system'*, and might *cut-off* altogether. Yet for all that, the CNS has been around long enough to recognise signs of discord and will generally seek time-out in the form of holidays or a stretch of days-off to assist in alleviating her distress. Jayne eventually resolves her disharmony by giving up CNS status altogether. Jayne explains she is looking forward to being an *ordinary RN* - so that she can:

> *. . . just come to work; do my work and go home. . .without feeling guilty that I should be teaching more or knowing more. . . . it will get me away from the politics on the ward and get me out of having to act NUM when she goes away.*

The CNS who cannot work out a resolution to worktension might even *go home one day and never come back.* Perhaps this is why, as Jay points out:

> *. . . there are so few expert, experienced nurses left. Just a full-time working on the ward normal member of staff - you'll seldom find anyone in this hospital who is 8th year and beyond. It means that on every ward there are very few expert nurses and not that many proficient ones either.*

Jay says at times he feels almost a moral responsibility to keep working on the ward, and yet at other times he thinks *no wonder there's no-one.* And despite the advent of tertiary education, it would appear for nurses, the *'system'* is little changed. Anne supports this:

> *In spite of the fact that nurses are educated to a very high standard and capable of performing the most complicated of tasks when it comes down to it, who disposes of the dressing that the doctor removes during a round, who makes the beds and who throws out the dirty linen? None other than the university educated RN and highly skilled CNS.*

That nurses who have been nursing for a long time, leave, and go off to something else has ramifications for the CNS, because it means; as Jay attests, *'if you've been in the job 5 or 6 years you're the senior nurse. And'*, he asks: *'what other profession has, as its senior people, those who've only been doing it 5 or 6 years?'*

For the CNS who does resolve her temporary bouts of alienation from nursing, there will be, intermingled amongst the 'bad' times, periods of calm or normality during which the more positive affirming aspects of the job provide a balance against the stressors. At such times, the CNS may perceive *the positive aspects of the work outweigh the negative and make the whole thing worthwhile again.* She may even reluctantly concede, that because she has been immersed in the *'system'* for so long, she *understands it.* She *knows it* - she knows the hospital and how the place works - *'it's a dinosaur'.*

And because the *'system'* affects patients as well, often she is wedged in between, acting as a buffer to cushion the impact between her patients and the cogs in the wheels of health department bureaucracy. Indeed, trying to make others accept the peculiarities of the *'system'* is not easy, and a CNS will frequently find herself making excuses to patients regarding some of

its facets. *Why things don't happen; why doctors fail to turn up; why doctors seem short with the patient and offer such inadequate explanations regarding surgery.*

Carol has a patient who is angry because he has been kept waiting to undergo a procedure that would allow him to start chemotherapy. She attempts to placate him and tells him she will contact the clinic to ascertain the cause of the delay - deep down she knows this is a waste of time - *'they are obviously so busy'*. She is informed they will be ready for the patient *'sometime in the afternoon'* and relays the information to the patient who proceeds to retell the anguish of his diagnosis (liver cancer) and how difficult it is for him to have to wait. She listens to his story - *'it'll get done'* she assures him - and yet she is fully aware that in all likelihood his appointment will be postponed again, and it will be she who has to tell him when it is. Carol, who can see his point of view and *understands his anger completely* and *doesn't blame him* in any way, has nevertheless, to uphold the *'system'* in front of his eyes. Carol shrugs it off, she is well versed in this *mediation role - 'having been a Mum and a wife for all those years - it comes naturally doesn't it?'*

Before a patient is discharged, Jay endorses the value of a 10 to 15-minute educational session. This is because experience has taught him wound healing is enhanced if the patient is well informed about its care. Because he believes it the most appropriate time for the patient to receive the information; he prefers to conduct this session the day before the actual discharge. Notwithstanding, he finds the *'system'* constantly disrupts his plans because patients are rarely afforded adequate time to prepare for their departure. Consequently, he is continually apologising for the shortfall, and in an attempt to redress the missed or rushed session, has to furnish each patient with the ward telephone number in case of any questions or problems regarding the wound. In a way he feels compelled to compensate the patient for the *'system'* by furnishing a link to his expertise.

-Thinking like a Nurse-

Despite the *ups and downs,* for Jay, nursing is *'a worthwhile job'.* In the following extract, he recalls a conversation with a dinner guest - *'a lawyer in some hot-shot legal firm',* who voices his strong belief in every individual engaging in some kind of community service other than their paid employment.

Jay takes up the story:

> *And, it was like I thought - Nope! I don't! . . . maybe if you were in some job, which however much you enjoy, you don't see yourself as actively contributing to social good . . . maybe you do feel a need to go out after work and buy groceries for sick people. But, I don't - and that's one of the reasons I like nursing; it does make me feel involved. . . I used to work in a bookshop all day long doing something that the world would be no worse off if it didn't exist at all - but with nursing, that satisfies that.*

There will always be some CNSs in nursing for 'higher' minded reasons than others (not surprisingly, the highest rate of exhaustion seems to be amongst those who are in it for philanthropic convictions). On the other hand, there will be those CNSs for whom nursing does nothing to salve a social conscious, because for them, nursing is *no more and no less -* ***just a job.*** And yet, for all that, it is without a doubt - *no ordinary job.* As she matter-of-factly captures a moment of it in this story, Anne illustrates quite clearly the singularity of the world in which she spends a large part of her life:

> *We had a woman here . . . she had a fungating leg and it had gone into her groin and she had lymphodoema from the waist down in both limbs and she was just leaking out of her skin. And we were changing the sheets every couple of hours and we could just squeeze them out they were so wet with lymph. Oh golly, we didn't even bother dressing that; there was no point. We've got some really revolting pictures of that.*

Anne is no longer overtly distressed by the magnitude of this woman's suffering, having borne witness to numerous similar cases in the 'never-ending production line of human repair and despair' to which she is privy. Anne believes the longer she is in nursing the more *immune* she becomes to pain and suffering. Jayne shares her sentiment and makes the comment: *'you get more confident as you get older - you get it out of your system - you get less caring, and in the*

end you're just a hard old nurse'. In spite of this belief however, unlike jobs outside the realm of disease, discomfort and death; in a hospital - *immune* or not - because body and world are interconnected (van den Berg, 1972), staff can become *really emotional at times* and often do become sick themselves. Sick, that is - in the sense of being *tired and emotionally drained.*

And so it can be seen, that to be a nurse for many years is clearly to experience a very 'different existence' (van den Berg, 1972) - essentially incomprehensible to none but a nurse. *'It's been 10 years I've been thinking nursing',* says Jay, intimating it requires even modes of thought considered unique.

-The Giving Agent-

On the whole, a CNS becomes more involved in extra aspects of ward-life than does the RN - for example updating policy and orientation manuals, and overseeing aspects of quality assurance. She either resents this expectation, or rises to the extra responsibility. Moreover, because she has command of all the *ins and outs* of ward-life, a CNS spends a great deal of time *teaching, helping and supporting* those who do not; augmenting the information she imparts from a stockpile accrued over the years. That is to say, a CNS has a leading part as the *information-giver* on the ward, and takes her role seriously. To a large extent she is *information-giver* to patients - *'in the long run'*, she posits, *'it means a better patient; easier to manage because there is less fear'*. Carol, for example spends ten minutes explaining to a very tense young man, all about what is going to happen to him when he goes to theatre for a neck dissection. She *explains the procedure, and warns him about drips, drains and staples.* She tells him he will be *alarmed when he first sees himself in the mirror, but that in six weeks time the wound will hardly be noticeable.* At the same time, Annabelle painstakingly explains to the wife and son of a non-English speaking patient, all about his operation, the progress of his recovery, and all the procedures involved along the way - so they can translate it all back to him. And yet, there are times when a CNS gets a *bit tired of saying the same thing over and over,* and will be pleased when rewarded for her efforts. Like Carol, who recalls the patient above telling her after his surgery, he was *'very grateful* [she] *had warned him what to expect'*. Bo, endeavouring to have patients and their families *'pretty well informed'*, has compiled information leaflets to hand out - an activity which frees her from some of the endless verbal discourse filling up her life.

Jay has a patient who is about to be discharged, and is preparing him with instructions on the care of his wound, as well as advice on how to avoid complications and regain optimal use of his arm. Jay quickly discerns the patient - *'is not interested in all the details, and just wants to know the basic information he will need to recover from his hospital experience'*. This presents a challenge in so far as Jay will need to furnish explanations in terms simple enough to avoid overwhelming the patient. In addition, knowing her input will be essential for carrying out the instructions imparted, Jay includes the patient's wife in the session.

The information a CNS gives in these circumstances will always be truthful: Bo says *'I'm always honest with them on what to expect whether it be pain or drains or tubes, I have to tell them'.* And yet, like most registered nurses, the CNS is singularly honest in certain situations, and singularly diplomatic in others. Because she is the one who has *to deal up front with the patient*, and because mostly it is to her the patients' questions are directed, and above all, because she is concerned for the subjective human experience, there are times when she may simply *'bend'* the truth, that is *alter the colour slightly.* Jay explains:

> *If it looked awful I'd probably say 'it's not perfect'. . .'we'll have to keep a close eye on things'. I don't want to give them the impression that everything is fine, nor do I want to totally freak them out. It depends on the person too, some people I play it down more than others.*

The CNS may even *'evade'* the truth. She will not, for example, give a patient bad news; preferring to leave that to medicine. In the event of bad news a patient would pose some difficult questions and she believes she would not be the best person to furnish the answers. Moreover, in order to engender confidence, and thus hope in the patient regarding the treatment they are to receive, a CNS is not averse to *'magnifying'* the truth in relation to the merits of the surgical team, the treatment and so on. All of this is to ensure - *'the patient is not sitting there panicking about what is going to happen'* explains Carol. Now and again, a CNS will be compelled to participate in a *game* of *'out-and-out deceit'.* Carol describes an incident in which the MO decides a patient is not to know the extent of his disease, hence the nurses have to - *'follow a cloak and dagger routine of getting information to the relatives without* [the patient] *suspecting'.*

By reason of the capricious nature of some of the types of cancer seen on [Rose ward], sometimes the CNS feels in a difficult position when faced with questions from patients regarding the outcome of their treatment. Rather than *'bending'* or *'evading'* the truth, more often than not, she will fall back on a *'big line'* rehearsed over the years, and which seems to have stood her in good stead in the past.

Jay never tells a patient *'things will be alright'*, instead, he articulates his *'big line':*

> *Mr* [XYZ] *said to me this afternoon 'now is that the end of it?' He'd had a horrible groin dissection somewhere else . . . and he came here a week later because it was so messed up. And I said, 'you just don't know - the only thing you can do is not to be neurotic about it, but keep an eye on yourself, if anything happens go to the doctor. Don't get neurotic; don't be obsessed by it; but keep an eye on yourself, and if you notice anything out of the ordinary do something about it instead of just wondering if it's alright.*

-The Sharing Agent -

For Bo, an ex-manager, being CNS is first and foremost: *'giving something - passing on my knowledge and my experience of many years and enjoying it without getting involved in the politics of the hospital'.* As a result of her solicitude, a CNS will often be approached by junior staff seeking her advice or instruction on various aspects of patient care. *'It sort of happens all day and every day'*, explains Sarah, *'it can be small things like "can you come and just have a look at this wound?" Or something bigger where I have to go and actually assess a procedure'.*

Thus, she fulfils the role of *resource person* for the ward - different to *information-giver* in so far as it involves mostly staff and frequently includes a practical 'hands-on' component. The *good* CNS sees this as an essential component of the job and will make sure she manifests herself as willing to be approached. In fact, a CNS will frequently perceive she has a moral obligation *to hand down her skills.* Yet, not all CNSs exhibit this quality; as Sarah points out: *'there are some CNSs who don't have the knowledge and therefore they get quite defensive when people ask them questions and they are unapproachable, and basically just a waste of time'.*

Often, she is so much in demand that if she leaves the bedside for any reason she will more than likely be waylaid in the corridor (sometimes forgetting the reason she left the patient in the first place) - in the meantime, the patient waits for her return. The CNS (and eventually the patient), accepts that this being *sidetracked* is a normal part of her day, and her *'I'll be back in a minute'*, gradually becomes discredited. Not only is the CNS *sidetracked* while she is gone from the bedside, in point of fact each time she enters the patient's room there is a degree of indeterminacy regarding the outcome, in so far as she starts to undertake one aspect of patient care only to learn something else - something quite unexpected - requires attention. As Jay points out: *'you might*

go in to do one thing, but you sort of get deflected off into a few different directions'.

For any personnel not attached to the bedside, that kind of responsibility toward the patient is not a consideration - a doctor or a physiotherapist for example, may perceive: *'it's not my responsibility to take care of those extra things. . . I can hand that over to the nurse who is looking after them'.* In effect, when the bedside nurse is looking after her allocated patients, in terms of responsibility *there isn't anyone else to pass it on to (except perhaps the doctor occasionally).* And so it can be seen, that contrary to other professional jobs, which often allow for staff to leave the work area for short periods to pursue either work-related or personal ventures, there is no *sneaking off* in nursing. Being a bedside nurse means being *on-call* for eight hours a day. She cannot pass off to someone else, whichever patients, and whatever work she has been allocated for the day. If she wishes to attend an in-service tutorial or an in-house lecture for example, and the ward is shortstaffed (as is often the case), the CNS has no option but to forego the session.

While a CNS can cope with unscheduled incidents at the bedside and will amend her plans, a newly graduated nurse for example, finds it more difficult. Consequently, a CNS will assist junior nurses in their work and feel concern and pleasure for them when they perform well. For Bo teaching clinical skills to the juniors *'makes it all worthwhile'*. Hence a CNS takes on more responsibility than an RN, and yet unlike the NUM, who is *set apart* - she remains *a member of the team.* And although the NUM is the ultimate manager, because the CNS is experienced, she will often take on a *co-ordinating role* and organise aspects of wardlife. *'You have all these forces acting on you'*, says Carol, *'and you end up co-ordinating them all'. 'Like an airhostess'*, interjects Anne humorously. Sarah organises the newly graduated staff:

> *Sometimes you just have to tell them "well you can put Mr X's stockings on", or ask "have you done this yet?" And if they haven't I say, "do you need a hand?" . . .but it takes a while for juniors to get into the routine. . . if you don't say to people it's time to go to tea now they are still pottering around at 11.30am . . . they need to have a break.*

When rostered on with staff more junior than herself, even though she is not looking after them directly, a CNS will still presume *a small amount of responsibility* for all of the patients on the ward, and will *always try and keep an eye on what everyone else is doing.* On the contrary an RN feels no similar obligation and usually attends solely to her allotted patients. In effect a CNS has

an overseeing role - almost *mothering* in some aspects - Sarah illuminates her concern: *'people like* [Bonnie] *she hasn't worked here very long and if she does something detrimental to the patient; well I try and intervene before she does'.*

-Being Human: Mistakes-Risks-Shortcuts-

In this environment she needs to be and is, quick to spot the mistakes of others; but occasionally she will miss one of her own. And like most people she does not choose to make mistakes; and yet unlike people in other jobs, if she does, the potential is there for it to be irreparable, even life-threatening. Bo fills out an incident sheet for an IV which *ran through too quickly.* She is angry with herself and relieved when the error proves non-injurious. Jay recounts a time he overlooked taking a swab on one of the *'worst wounds'* he has ever seen, that is, until someone mentioned it in passing which led him to reproach himself severely because *'of course, I should have known to do that'.* Rarely, a CNS will do something for which she *really gets wrapped over the knuckles.* Carol unwittingly organises for the wife of a patient rather than the patient, to pick up a dose of a schedule drug. The patient, due out on a gate pass, has not had his script organised through pharmacy (as is normally the case), and because *'the poor bloke could hardly walk'* Carol takes pity on him and instructs his wife, whom she has come to know quite well, to collect it instead. As it was to be picked up at a time when she herself is off-duty, Carol's mistake escalates because it becomes necessary for junior staff to dispense the drug. Although acting in good faith, technically, what she has set up is illegal. Admonished by the NUM, Carol is forced to submit a report on the incident.

On the whole, a CNS will be *appalled* at making a mistake along the lines of those outlined above. And yet generally speaking, when she commits an error it will be fairly minor in nature. Minor mistakes are usually brought about by a *lack of sufficient attention* - like Jay for example, who sends a patient off to theatre with an incomplete consent form, and inconveniences a number of people. *'Embarrassing - just stupid things like that happen quite often - it's not deeply upsetting, just annoying',* he bemoans. When asked how long she would dwell on a simple mistake; a CNS will tell you with good humour, *'a night maybe, there'll be something else to take it's place by the next day'.* In a similar vein, it certainly is the case, a CNS will not get through her working life without occasionally *overlooking* or *failing to identify* some facet of care requiring attention. As distinct from mistakes however, *overlooked aspects of care,* tend to be

little things forgotten in the furore of a busy shift. Jayne for example, forgets to check an hourly urine and subsequently finds it has dropped off, which she is able to remedy. Invariably, *overlooked aspects of care* present themselves to her consciousness when she is off-duty.

Where the novice nurse goes 'by-the-book' afraid of making mistakes (Benner, 1984) a CNS will happily cut corners in terms of her practice and may refer to this as *safe risk-taking.* Carol describes the concept in terms of sterile technique:

> *If you really stick to hospital protocol, if you think anything is contaminated you wouldn't use it. But, then you're doing a dressing; you set it all up, and you put your gloves on and everything, and you pull the old dressing off and get the doctor to come and have a look at the wound, and he sticks his finger in it and has a poke at it, and you think 'my God here I am trying to keep it sterile'. So you realise very quickly that you know what should be done; how to do something so that it remains as sterile as possible, but you also get to know what you can get away with. You know what's a safe margin.*

Similarly, another CNS might refer to *legitimate short cuts.* Anne believes experience has taught her she no longer needs to go 'by-the-book'; she has enough background to practise *'legitimate short cuts perfectly appropriately'.* To illustrate her point she relates how she has learnt that once a donor site gets *'that lovely jelly all over it - it's best left alone'. 'Yet'*, she says, a junior nurse would be *'disturbing it, going through the whole bit of cleaning it with saline and redressing it etc etc.'*

Nevertheless, having seen some *'very dodgy practice'* in her time, Anne will not take short cuts involving risk, either to the patient, or to herself. For example, she describes how carefully she handles chemotherapy *'we are giving chemo to patients to kill things - I don't want it to kill me'.* As a matter of fact, a CNS has *a strong sense of self-preservation,* and knowing she has *everything to lose and nothing to gain* will rarely take risks or step outside the legal boundaries of her job. If she breaks protocol at all she will break it *very carefully.* On the odd occasion, she may hand out *more than the ridiculously small amount of panadol* for which she is covered, or coloxyl or digesic, and although she will often *cover herself first* by gaining a telephone order, most times she will just ensure the intern writes it up as soon as possible. *'I know the routine'*, attests Carol, *'sometimes the doctors forget to write things up so you just give those without an order'.* When the ward is very busy, she will go to the bedside with a schedule drug minus the

statutory second RN. In times of emergency, she may instigate life saving medical treatment because medicine is not immediately on hand.

A CNS has the expertise to know those situations where corners cannot be cut. Her advise to juniors will always include a caution for them to be *'very aware of your limits. Decide very carefully if you are going to make that patient's position better, or worse, by your action'.* Wolley points out that she tells the juniors:

> *If you're not sure you should take no risks. If you're playing a hunch you shouldn't take risks - it's somebody else's life that's involved. And if not their life, certainly your reputation.*

All things considered, as the expert and senior bedside nurse, a CNS is intensely protective of her reputation and will want to preserve it at all costs - in which case she would never jeopardise it with groundless risky practice. Wolley recalls a situation where another staff member asks her to check a schedule drug in front of a senior nurse administrator, without following protocol. Wolley:

> *My whole reputation as a nurse and especially now as a CNS was on the line, and if this woman* [the ADN] *didn't know me she would think I normally check drugs out this way - and I couldn't bear that. . .*

The job of CNS is not without some risks to the CNS herself. Mostly they are minor ones; a bad lifting technique for example. But some are not so minor - such as *plunging a bare fist into the wound of someone who is bleeding to death and getting their blood all over you:* or *things gushing unexpectedly out of wounds*; or *getting splashed in the eye.* Not unexpectedly, the thing a CNS worries about most - is AIDS. And yet, Carol, Anne and Jay have all experienced needle stick injuries within recent times. Carol says *'it can happen even if you are careful'.*

Jay expands on the idea of risk:

> *I guess it's one of those things, and its only when I'm really down about work it does affect me. And you think there are just too many possible things about this job that could stuff up your life. Whether it's you getting an infection; whether it's like that nurse down at Kid's hospital who sent that child home* [the child subsequently died]. . . . *You know there are just so many things that can come out of the blue, and like policemen, firemen, doctors, even teachers I guess - if you are responsible for thirty, six year olds and one of them runs out of the front gate and gets run over by a truck. It can happen to everyone, but in nursing there are a lot of things that could happen. If I'm on top of things it's not a worry, but if I'm not, I often think it's all too much.*

Anne on the other hand is less intense about the risks - *'if you sit around worrying about that sort of thing you'd never do your job'.*

-Ordinary Doing-

There are times when the experienced nurse will encounter unknown elements in the course of her work, and may actually need to seek assistance from more junior nurses. Carol describes how *inadequate* she felt returning to ward work after months of being in a differing role and finding herself unaware of aspects concerning new intravenous equipment and chemotherapy treatment. Nevertheless, these instances are rare, and it is usually the case that *after all these years* a CNS finds herself still enacting the same old *basic tasks* - and what is more, enacting them on a regular basis day-in day-out. Bedmaking, washing, bedpans and observations of vital signs, are in her eyes, all *doing without thinking jobs* - simple tasks *anyone could do.* She either loves; hates or more often than not, simply tolerates these jobs, and yet she is quick to point out the crucial part they play in offering opportunities for observing and chatting to the patient. *'Washing people is a good chance to talk to them',* admits Carol. Indeed *'a time for establishing normal human contact. . . and establishing a degree of intimacy so that they 'open-up' to you',* asserts Jay. Annabelle believes a nurse *'never outgrows basic nursing procedures: you just don't think too much about it; you just do them'.* And while most CNSs would agree to never having to make a bed again - they do accede that relegating to nurse assistants washes and bed pans in their entirety, would be a *bad* thing. Carol points out: *'sometimes you need someone who knows what they are doing when they take a patient off the pan'.*

To any CNS the task of *doing the 'obs'.* is probably the most soporific and certainly she is more than likely to *switch off at 'obs'. time.* For Sarah, listening to the apex beat, for example, *'it's the same thing over and over. I'm just a bit of a robot and just sort of wander around'.* Thus it is impossible to ignore the fact that for the CNS some jobs are boring and routine, and others quite satisfying. On account of this reality there is undoubtedly a hierarchy amongst the tasks which embody her work; and every CNS will have those she prizes above the rest. Carol describes such a task:

> *. . . fiddling with drains; unblocking them and cleaning them out and getting them working again. Sometimes you have to cut bits off and try and draw clots out, that's quite good fun - getting it to go - and trying to work out why it's leaking, and plugging up the holes. . .*

Clearly, a CNS enjoys interesting tasks like complicated dressings - *things that if normal people saw they would faint.* Trimming a skingraft is pleasing to Jay because he perceives he is actually *'doing something'.* Anne too, *'loves draining lymphoceles - it's so satisfying - it's like cleaning up a really mucky wound and scraping it all out - the end product is so beautiful'.* Thus, assignments which afford the opportunity to actually apply her *special expertise* and/or to be *creative,* lead the CNS to feel she is *achieving something,* as distinct from those chores she regards as basic to nursing.

Aside from all this, there can be no doubt - surgical nursing is routine work - patients are admitted, undergo surgery, and on *day one they all do this, and on day two they all do that and so on.*

-Extraordinary Doing-

That is, unless the patient gets *some kind of complication and then it gets a bit more interesting.* Paradoxically it usually is just the case; when the CNS gets to the stage where she thinks *'I can't stand this* [the routine] *anymore', the next day something interesting happens.* And by the very fact that not much out of the ordinary comes up during the day, extraordinary events take on particular significance. *Exciting things do happen in nursing and these are high points*; they are the unpredictable incidents - *the bits of adrenaline rush* - that keep the CNS (particularly phnA-CNS) at the bedside. Because for much of the time, she is faced with limited variety in her job, significant incidents set in motion all the finely honed skills she has accumulated, but is rarely allowed to display. While a CNS will tell you she *'doesn't like arrests'* and that living the experience of dealing with a critical situation in which a patient's life usually hangs in the balance, is unnerving; to the phnA-CNS unashamedly, they *do make life a lot more interesting.*

The phnB-CNS however, may have a differing view about being a CNS which repudiates its everydayness. On the contrary, *' you don't know what's going to happen and you're not doing the same thing day in day out - you're doing different things all the time'.* To her, working in a shop or an office would be dull. When all is said and done, both viewpoints would acknowledge a degree of uncertainty amidst the sameness of the routine. To be sure a large part of the CNS role, and one where her expertise is called upon, is: *dealing with situations as they arise.* While the

nature of the CNS is such that she likes to feel *in-control* at all times: it is the nature of a hospital ward that *it's difficult to have control over anything - things go haywire so quickly.* It is a fact in a nurse's life that if it is quiet there is no guarantee it will be quiet for long. When it does get busy, it may be because of normal routine events such as numerous admissions, or little upsets: a patient vomiting; three patients requiring pain relief simultaneously, and so on. Alternatively, the ward may suddenly erupt into chaos because of a major incident - as Jayne's diary entry would affirm:

> *Finally get my teabreak at elevenish. Was just walking past room one and decided to go in. Good timing really, because he decided to arrest on me.*

There is no denying patients do have their *ups and downs, and are sick, but generally it is the sick expected of their condition.* If a patient undergoes a procedure the CNS expects them *to be sick in a certain way, and certainly there will be complications, but they are expected complications.* They are expected because *they have happened before* - so they run a course, and she knows what to do. On the other hand, extraordinary complications such as the one mentioned above, *are unexpected and tend to be dramatic* and even today *still catch* her *by surprise.*

In point of fact, unexpected - extraordinary events may greet a CNS even as she first steps on the ward at the start of a shift, and although she may not be the first to discover the problem she is certain to be called upon to assist. During unexpected events which usually entail a rapid change in a patient's condition, rather than caring for individual patients: the 'at risk' patient becomes *everybody's patient,* especially the experienced personnel on the ward. The diary of a CNS is likely to be littered with entries depicting incidents of a similar nature to those outlined below: (Annabelle)

> *. . . His pressure dropped and he went into respiratory distress. . . . and he just sort of started to deteriorate and we put a mask on him and we nearly needed to intubate him . . .*

(Anne)

> *. . . One of the registrars injected xylocaine with adrenaline into the chest wall and the patient started feeling quite awful. He was only a young man and went very pale, and MO said 'I think he's going to arrest'. . .*

(Jay)

> *. . . Following a routine first day dressing of a skin graft on a patient's leg - the patient reacted anything but routinely, and although she didn't quite arrest a medical emergency was called. . .*

(Anne)

> *. . . he had ascites and he had a pleural effusion. . . he sat up but then suddenly he had a lot of trouble breathing. So the boys came up and they tapped the ascites and put in catheters and things. . . So it was a little bit exciting for a while.*

Jayne's diary entry cited on the previous page, pertains to a newly admitted patient - actually an 'outlier' who unexpectedly deteriorates and dies despite efforts at resuscitation.. Jayne describes how the team *'stopped about forty minutes later, which was quite sad because he was only sixty plus and had never been sick in his life'.*

In the event of an arrest, a CNS will probably be *a little bit shocked and mildly panicky at first*, but she quickly composes herself and *just gets on with it - mechanically doing the things she is supposed to be doing.* Wolley describes how it is for her:

> *I've been in enough arrests to know what to do, . . . but no matter how many arrests you've been to and how good you feel you are at it; there is still that initial shock reaction and sometimes you just shake . . . it doesn't mean you don't do your job well, it just means you're thinking 'wah this isn't happening'.*

When it comes to extraordinary events a CNS will generally be resigned, because *mostly they are sort of inevitable or they are simply tragic,* and besides, she has come to know *awful things happen in nursing.* In regard to the arrest previously described, Jayne says she *'felt quite mean'* when she had to *'kick the family out'*, but she says; the man's wife was yelling *'get help, get the doctor!'.* It was, she says *'lucky we had a doctor there* [before the team arrived] *because we could actually do something apart from just CPR'. 'When they first got him back it was a nice feeling; but his eventual dying didn't surprise me; they don't get them back very often'.* Jayne attests to the fact she *replays* dramatic events in her mind, and yet she never feels in any way to blame - *'you'd be a wreck if you thought that; you'd be on valium all the time if you go round thinking every little thing is your fault. It's not your fault; it's their condition'.*

She recounts an incident from the past to illustrate her point - believing it *'just one of those things'*

> *Once, we had a patient who had been in here for months and months, and he just never wanted to get out of bed. And I remember walking him back from the bathroom one day and saying quite firmly; 'now come on, you'll never get better if you don't start walking'. And I had just got him back to his room and sat him in the chair when he suddenly arrested and died . . .*

Annabelle is involved in a tragic case in which a young woman has had a massive pulmonary embolis following a caesarean section and has been brought to the ward in a vegetative state, basically to pass away.
Annabelle describes the morning the patient finally dies:

> *The family seemed to accept her condition because they just wanted to have some time with her. When I went in again her sister had already taken the oxygen mask off and took the nasopharyngeal airway out, and she was just sponging her face. And at that time the baby was at the door, but the husband didn't want the baby in there, so we took the baby back . . .*

Annabelle has cared for this young woman, and when asked her feelings about it all, she says:

> *Oh it was very sad, but you know you're quite helpless really. There was nothing you could do. Put it this way, some patients live and some patients don't.*

With the passage of time a 'dullness' may creep in and a CNS may come to perceive the extraordinary, as ordinary. Jayne says: *'nothing stands out - just the usual post-op bleeders or the usual not enough fluids - no disasters.* And so basically non-disastrous incidents, where the novice for example would be completely nonplussed, for the expert nurse become *all in a day's work.*

Once in a while however, a day's work does actually include a disaster. Jay recently had a *horrible* shift during which a patient died in disturbing circumstances. Jay recalls he was on night duty, and *'an old patient who had been in lots of times'* who had an operation on Monday, by Tuesday night had become *'really paranoid'*. In the morning, Jay requested a psychiatric consult for the patient who was duly seen by a psychiatrist and deemed *'deluded'* but *'not at risk'*. When Jay returned that Wednesday night the patient appeared just as paranoid and believed the doctors were *'coming in the middle of the night to put a pillow over his head'*. Furthermore, the man's fears had been exacerbated by a visit from the priest leading him to believe he had received the last rites. Jay gathers up the story:

He started telling me these fantastic stories . . . and I said 'it's not true. . . this is not going to happen - you know me, these are delusions and they are not going to happen'. (Wolley was off sick that night and I was with a 'pool' girl who works here occasionally but certainly didn't know the patients). So I went back at 1am and he wasn't in his bed. I didn't immediately think the worst.

[He searches for him.]

. . .I went back into his room and the window was open and there was a chair pulled up at the edge of the balcony because he needed to climb up there because of the operation. . . As soon as I saw that, I thought 'Oh God, I know where he is' - and he was, flat out, down the bottom there.

Because of the location and the darkness it takes 10 minutes for the arrest team to find the body.

They tried to resuscitate him, and I thought 'what are they doing?' It was all sort of surreal because normally if you are watching people resuscitate someone you never see the person you just see this huddle of bodies and machines: but this looked like something out of the movies because I was looking straight down on him, and they were doing it with torches and so he was spot-lit in the middle of this thing, and I just saw these shadows around him as they were working on him.

Looked upon as the *worst* business ever to happen to him in nursing, the incident left him *'very flat for a week or so'.* In addition, for Jay, there was disillusionment in respect of the opinion of the psychiatrist - akin to *'well why listen to the experts?'* On top of which surfaced doubts about his own performance. Yet, in the final analysis, he asserts:

I can dismiss this episode to a degree - it happened. . . . but things like this come from nowhere and sometimes you have this feeling; like it's always hanging over you; that something really awful is going to happen that could ruin your personal and professional life.

In the act of nursing, the 'inhumanity' of life and death presents itself in many ways.

-Therapeutic Agency-

All things considered, it is little wonder the CNS finds it restorative to be able to 'play games' and have fun on the ward. *For everyone's mental health, staff included - you've got to have fun,*

asserts Jay. In addition to finding it a useful way of *breaking the tension* and getting to know the patients, a CNS believes it *therapeutic.* She knows many patients enjoy *a bit of a laugh, particularly when they are worried and they've not got a lot to laugh about.* In order to make use of humour though, it is important for a CNS to be natural, to act normally and not be constrained by too much formality on the ward.

Jay describes a situation recently in which there were a *'bunch of rough guys down in the end bay'*, and how it was *'quite fun to go in, swear and curse and make rude jokes with them, about them'*, but, he exhorts, he would never have repeated the behaviour in front of the four women in the bay opposite. He says, *'I think it's all part of forming some degree of empathy with the patients. You can't do it with everyone'.* In which case, a CNS will not impose humour. *Testing the waters first,* the CNS *carefully picks* the patients with whom to be light-hearted.

As it turns out, there's *'always the odd staff member who plays up inappropriately'* admits Jay and so *'limits need to be set'. 'For example'*, he says:

> *. . . if you're making a bed with someone, and I would say everyone I know has done this at one time or another - you put that top sheet on and you cover their* [the patient's] *face; you know it's a joke; and some people love it. But I've been with some people who've done it to someone and I've thought no, not now; it's not very funny - this is too close to home.*

What is more, an awareness of the lived reality of the differing patient's on the ward is essential - so that when *there's something really heavy going down on the other side of the door,* 'high spirits' are muted. As a general rule, the sicker the patient the more tempered the interaction. Anne unfurls the notion of humour:

> *I know these patients quite well; a few have been patients before, so you get to know them. You start off really formally, 'hello, I'm Sr so and so, and I'm looking after you this shift, blah, blah, call me Anne'. But after a while you get to know them and you know which patients want a bit of a laugh, and want you to be a good fun person; and which patients want you to be serious and for you to take on that very professional role and basically just furnish the facts.*

The CNSs will use humour amongst themselves. Jayne and the NUM are laying out the body of a patient who has died quite suddenly and dramatically - Jayne writes in her diary *'there was a lighthearted moment when we found he was nearly too long for the body bag'.* She believes that

telling jokes in a situation like that, is *'just your way of coping - of stopping you bursting into tears'*. Debra too, says humour is probably one of her biggest coping mechanisms, *'even sarcasm to a certain point'*. Carol describes much of the conversation in the tearoom as *'stuff you wouldn't want the patient to hear'*.

She says:

> *A lot of it is quite funny. . . the outside public wouldn't cope with it. They wouldn't understand our laughing at certain things. They would think we were very hard. We probably are, but I really see it as a survival sort of thing. You just get in there, sound off about certain things and humour is a good way of dealing with it.*

'Its pretty sad to say', adds Jayne, *'laughing at patients who are driving you nuts.'*

Unlike the novice nurse so intent on the physical labour, the CNS fully confident in her role with the patients, makes optimum use of light hearted humour.

-Making a Difference-

While she may not perceive a difference in the patient care provided by a CNS in comparison to an experienced RN; she will accept there is a vast difference between that of CNS and junior RN. Sarah recalls the occasions she has come on duty and immediately apprehended the previous shift has been staffed by juniors:

> *The patients haven't got their stockings on and its 4 o'clock in the afternoon, and they haven't had this, and they've got wet pacing wires and leaking leg wounds that haven't been changed all day.*

In this situation, she makes certain the junior staff are made aware of their incomplete work, but not, as Sarah points out, with any punitive intent, mainly for the benefit of the patient. As a rule there is a wide range of proficiency in the skills of the nurses on the ward. Unhappily for the CNS there are occasions in which she identifies unsatisfactory aspects of care pertaining to the patients of lesser skilled nurses, and yet has insufficient time to remedy them. Carol, vocalises her concern *'there were a couple of wounds I thought were quite unsatisfactory and I wish I'd had more time to spend on them to clean them up'.*

There can be no doubt the experienced nurse is quicker on the job and is able to prioritise tasks more effectively. *'Things that are automatic for us aren't necessarily for them - it's take them a lot of thought whereas we just go and do it'*, declares Anne. Being experienced allows the CNS to be able to *do three things at once* and to be *one step ahead at all times.* Jayne says she can be *'doing one thing for one patient while at the same time thinking about another thing for another'.* Anne hints at her approach to prioritising her nursing which has been perfected over the years:

> *You make all the beds and do the temperatures and pulses and nursing care plans and it's being able to get those out of the way quickly - things that are not the biggest priority so that you allow yourself time to just go in and have a chat. Not getting caught up in making sure everything is done on time. If I know a patient has been febrile then I'll make sure their obs. are done on time but otherwise not. . . .to me it would be more important to talk to a patient who had just got bad news than to make sure their obs. are done on time. More junior staff tend to want to get everything done, or they just want to talk to the patients and not get anything done!*

Debra:

> *It's not that our work ethic is any different, or that they don't work as hard - they do, but our experience and knowledge make up for a lot, as far as time management goes. . . our prioritising is different. I think that frustrates them, as well as frustrating us with them.*

A CNS can *pick up a lot of signs which somebody else might not appreciate.* Hence a further distinction between a CNS and a junior RN is uncovered in the ability of the senior nurse to detect changes in a patient's overall state of health/illhealth. These changes may be in mood/affect or physiological, and are often almost imperceptible. By reason of her ability to notice untoward signs faster; the CNS can often 'rescue' her patients 'in the nick of time'. What is more, a CNS is able to make well informed guesses regarding the aetiology of these changes and foresee repercussions in terms of the patient's welfare. So in effect she has the ability to act coherently on her perceptions and prepare for the treatment she believes will be implemented. *Ergo*, she has, more than any other bedside nurse, an *'interventionist role'* to play which may be crucial to the well-being of each and every patient. Sarah elucidates this notion:

> *I can be looking after a patient who is not well and I can often see they are going to be very unwell in a short period of time and you can sort of intervene and get the doctors up quickly, and you know to give them oxygen and make sure you are ready for when they do go right off.*

Bo gives support - illustrating her expertise as she recounts an incident in which she was approached by an RN who informed her that one of her [the RNs] post-operative patients had dropped his blood pressure, and she was unsure if he was haemorrhaging or not. Bo is critical of this nurse because - as she points out, the RN had been on the ward two years at least, and still had to be reminded of simple strategies to counteract a diminishing blood pressure. Bo directed her course of action and told her to repeat the blood pressure reading in a few minutes. Bo then went to look at the patient:

> *Well as soon as I went in I saw she'd put the bed up too high. So I put it back down because he really was stood on his head. I was looking at his general condition - a very quick assessment just by looking at him - his colour and everything. I was watching the urine as well because a little bit of blood in water does look a lot more than what it really is. Basically I was assessing how much he was bleeding, but he wasn't bleeding excessively by any means: it's quite normal for him after a TURP at this stage.*

And you know, things went through my mind - why is his blood pressure still low? He wasn't a spinal but a general - what drugs had he been given? The fact that he's had an AMI recently; all those sorts of things. I couldn't put my finger on why he had a low BP.

. . . so I just told the intern. . . . I don't think they'll do anything except speed up his IV fluid - which we've already done.

Because she has an in-depth knowledge of the pre- and post-operative care in relation to the types of surgery she repeatedly sees; the CNS is vigilant in regard to possible complications.

When text-book complications do occur the CNS will respond decisively because *they happen all the time,* and so she has anticipated them. She has encountered the scenario before - (usually not the case for junior nursing and medical staff). Carol describes such an incident:

She'd had a groin dissection and she came back to the ward about midday. I was on an evening shift and the nurse that was looking after her said that her drain was quite full. So I went and had a look at it, and yes, it was quite full. We measured it and I watched it for the next hour or so, and then I realised that although it was still draining in the haemovac; her leg was also swelling up. [At this stage she calls for medical assistance] . . . *and she was just swelling up really rapidly and her blood pressure was dropping and her pulse was racing - all the classic signs.*

On the odd occasion however, a CNS may be caring for a patient who has undergone an operation of which she is unfamiliar, and will be thinking *'what am I supposed to look out for here?*

At other times, beliefs about the patient's morbidity will be intuitive - an instinctive *gut-feeling'* something is wrong. Just by observing the patient she can sense if they are *really sick* and will be watching out for signs of deterioration. Where a junior has not had the experience of seeing situations before; an experienced CNS knows because she *has seen it all before and has developed a 6th sense.* In a sense, the CNS has developed first-rate powers of observation. She has nursed *all these cases so many times before,* consequently she *picks-up on complications much quicker.* Juniors *'don't know that this is wrong or that things aren't going right'* and *'that is why'*, argues Bo: *'I always keep a close eye on them'.*

Anne , Jayne and Bo all refer to a *'sixth sense'* - Anne explains:

> *You know something is going to go wrong and you are virtually dialling [999] before anything happens because you just know and maybe it's just subtle changes in the patient. Maybe they are just a little confused or there is something about their obs. You don't know what it is but you are picking up something.*

Anne expands on this notion describing a scenario in which a patient exhibits a subtle sign which a more junior nurse would, more than likely have deemed insignificant - yet Anne picks it up as *'something you wouldn't really expect'* from that patient. On closer examination Anne discovers the aetiology of the out-of-character behaviour. Anne:

> *We had a lady here recently and she had a bleed - but there wasn't anything obvious at first, but she was incontinent; which was unusual. Not an old woman - not a spring chook either, but we thought something was wrong with her being incontinent. So I just sort of did a quick recki: What's happening here? A blocked catheter? Are there any drains or whatever? I picked up this drain and thought, "Mmm a bit heavy", and she had about 800 mls in it. So of course we immediately sped up the fluids; put the foot of the bed up; checked her BP; got the doctors up, and we fixed it.*
>
> *Things like that, you just know when something is not right. You just look at someone and think 'Mmmm'. Many times I've called an intern and said: I don't know what's wrong with that patient they just don't look right. And then inevitably something goes wrong with them. And the intern is saying - "Well you know I can't diagnose symptoms that aren't actually there yet". But I know there's something, and it usually happens very quickly.*

Debra shares the times she has felt *'something was happening to the patient'*:

> *Years ago if someone's obs dropped you'd think what the hell am I going to do now? Nowadays, you go through all the motions of doing everything you can to counteract what's happening. You make decisions then and there as a senior nurse - a CNS. If you have a patient whose blood pressure is dropping post surgery and you look at the drains and see blood pouring out; you automatically speed up their fluids and tip their bed and call someone and start setting up the things you know they* [medicine] *are going to want; or you go to the phone and say "look I'm putting this up now". . . .The simple procedures that will tide them over until someone gets there to help. . . . most experienced nurses will automatically do those things. . . it's almost an unwritten thing for CNS as part of their role to make those sorts of interim decisions because doctors aren't always here. They are in theatres or wherever and it takes time for them to get here, and what do you do with this patient in the meantime?*

Annabelle describes another situation in which:

> *. . .the patient just seemed not so well. So we kept monitoring her blood pressure and everything and there was no change at all except that her oxygen sats. kept going down. But we were worried, and we got the RMO to see her and then they did an echo and she did have a pericardial effusion and they took her back to theatre to drain the pericardium.*

Now and again, a CNS will be confronted with a situation in which there is no need for her 'sixth sense' because from the patient's physical manifestations it is obvious something intensely untoward is happening. At such times, she will have to act swiftly and competently. In the early morning or at night for example, she may well be the only senior person on-duty and during an emergency her *decision-making* skills come to the fore. She will need to decide when to get medical backup and what information needs to be relayed in their direction, and often what initial treatment is required - in which case, she will either contact the MO to get permission to carry out emergency measures, or instigate them herself and arrange for her actions to be sanctioned later. During such times a *good* CNS is confident enough to give orders and delegate responsibility to junior staff.

Wolley describes how she manages a night during which she is confronted by not one, but a number of incidents all of which are potentially damaging to the patients.

> *Well it started quite early, it started at 10.30pm . . . one of the patients was a bit wheezy and breathless so we put the oxygen on and the doctor was coming to see her. Her observations were quite stable during this time, but she was a little bit dyspnoeic and so he came up but couldn't see her because he was rushed with another emergency, so he said to give the night person a ring. So we gave the night person a ring, and in the meantime the patient's temperature had to risen to 39 per axilla; her pulse had gone up to 140, and she was very restless and so we were querying maybe a PE or something like this. So we put more oxygen on her, got the oxymeter and her saturations weren't bad 97, but her pulse was very high, and her blood pressure had gone up as well. So the doctor came and felt the same about the whole situation. . . . its very hard to tell by tapping or listening to her chest it all sounds very dull* [because of her disease] . . . *so they intended to do a septic work up on her.*
>
> *. . . Then a man who earlier in the shift had had a panic attack - he had a neck dissection yesterday and had felt claustrophobic. His neck hadn't been swollen, his observations had been stable and he could breathe quite easily, and he could swallow.*

But the two drains - he just felt that one of them was digging into his throat, and he felt he couldn't breathe. So he had got up, and had wanted to go and sit in the TV room - and just at this time I'd had a little thought in my head and had given him a bell; and he had gone and sat in the TV room and I'd said 'if you want anything don't get up just give a little tinkle on the bell'. So he gave a little tinkle on the bell - just before he fainted.

And so we went down there, and in half an hour from 3 to 3.30am his neck had blown right up. He was still able to swallow but his pupils were dilated and he was a bit dyspnoeic. His pulse was only 60. . . his blood pressure was 60/30. So we lay him on the floor, his drains were full, we made a mess on the floor because we emptied the drains - not on to the floor but they splashed everywhere. And it was just starting to ooze out of his neck. The doctor came, he already had a line in so we put up some haemacel. Ran in two units of haemacel which brought his blood pressure up to 110/50 - then they took him to theatre. We had to put him on the trolley, he's a big man he's probably over six feet tall, and so there's hernias for all of us lifting him up on the trolley.

. . . Then at 6 o'clock another man who hadn't like to ring us earlier in the night - said he had chest pain and he'd had it most of the night; but we were so busy he hadn't like to ring. So, we put the oxygen on . . .

Wolley was rostered on this shift with an enrolled nurse, an intern whom she saw as 'timid', and a frantically busy registrar. To all intents and purposes before the arrival of the more senior doctor, Wolley was directing proceedings because she says of the intern *'she actually didn't do very much'*. For Wolley the night was *'continuous'* - compounded by the fact there was no other RN available which meant she was required to *'closely monitor all situations'* instead of delegating *'as is the norm'*. Wolley expands on this:

No matter how competent the EN, s/he does not have the knowledge or experience and therefore is not an equal partner - and while on an ordinary night this is of no consequence, on another night it is a load for any one sister to carry (let alone a junior one). . . . I have the expertise to cope. . . I just don't have enough hands to be in more than one place at a time.

The following extracts reveal some of her thoughts during this eventful night, which illustrate the significance of her knowing the patients and her expertise. Here, she is discussing the first incident:

With her it was a little bit hard because she looks terrible - she has been sick for a long time - but initially she complained of being breathless; she was wheezy and she's never really been wheezy before and that was probably the only thing that was different at the beginning and we thought 'well this isn't like her'. . . . and then when we took her temperature it was 39. She wasn't hot on the outside, it was just that her pulse was up and I thought:-

Mmm take her temperature - because she wasn't, she didn't feel hot to touch.

. . . if you want a doctor to see someone you have to be able to give him some statistics. . . because invariably they are going to ask for them. So we took her respirations, her temperature, her pulse and her blood pressure and we put on oxygen and we got the pulse oxymeter from downstairs and had that as well. So when the doctor actually arrived we could offer a whole range of things to say this is what's going on . . .

In regard to the second patient collapsing in the TV room, Wolley says:

. . . I don't usually like someone to be somewhere where they can't be in contact and we were going to be busy and so when he went down there I just thought 'I'll give him a drink, a bottle and a bell - just in case'. And it was remarkable that he rang that bell just before he fainted because we were still busy - I was going down there to empty his drains at some stage but you know a little bit longer and he might not have been here, or we would have had a full on arrest - one or the other - so it was just one of those things.

. . . when we came in and I saw his pupils were dilated and everything, I was talking to him and I lay him on the floor and I'm saying 'now take deep breaths, deep breaths', and all the rest of those sorts of encouraging things, and when he came round he was talking to me, but he was petrified. . . . and I'm thinking 'this isn't happening - it can't happen now, I've got this sick lady up that end, you can't be sick now'.

Even though she describes this as: *'not your average night'*, conceivably she could face a night like it every night. Yet despite its *stressful* nature, Wolley feels *good* about the outcomes, because as she says, *'we did the right thing by everyone last night'* - and she *'feels satisfied'* with herself. This is in contrast to nights in which extraordinary events occur but she goes home feeling disgruntled because - *'I think I've done the right thing, but it's not the right thing because it hasn't been completed or I feel angry with a doctor or whatever'.*

Wolley describes an incident in which both she and the patient were at risk, and yet because she did not receive the medical backup she felt she should have, she goes home feeling dissatisfied. A patient goes into the D.T.s *'quite dramatically, and was running around trying to break windows and jump out of them'.* Rostered on with another RN who was *'only a small person and not very strong'*, Wolley finds she has to contact security to come and assist her because the drug and alcohol team refuse to come and see the patient until he is securely restrained in bed.

She takes up the story:

> *So in the end, we had three security men, a doctor and myself and we had him tied to the bed and he could still move around. He was very bad. The drug and alcohol people finally consented to come and see him at 6am, and he had gone into the DTs at 1 am. So we'd had all night with this man being aggressive. . . .*

Wolley, frustrated by the attitude of the drug and alcohol team, believes *'they didn't do the best by us'.*

Once in a while, the decision of whether or not a patient warrants emergency medical attention, will not be so clear cut. Anne is called by the RN to see a patient who turns out to be unrousable with shallow breathing and a fading pulse. Because of changes to the usual paging system Anne knows she will either have to call a full-on code or wait for the intern on the ward. At this stage the patient starts to come round; only to pass out again moments later. Knowing this is not an actual arrest situation (as yet), she has to come to a decision. Anne explicates her dilemma:

> *. . . and I thought she's probably having a vasovagal, but what if she's not? And I thought someone really should see her. So I was going,* '[Sue] *call the arrest team; no don't call the arrest team; call the arrest team'. . . . anyway she called them, and of course she* [the patient] *was looking really brilliant by the time they got here. . . she didn't quite know what all the fuss was about because she'd come round just as the arrest team bolted through the door - like about 15 anaesthetists and registered nurses all sort of staring at her.*

A CNS takes no chances with a patient's life; and bases her practice on the belief - *every patient be treated with a healthy bit of respect and fear; so they are never overlooked or taken for granted.* What is more, a CNS is fully aware of the legal ramifications of her actions and is governed by a further maxim: *if there's a change* [in the patient's condition] *you tell the RMO.* By informing the MO she perceives the situation becomes *ultimately not* [her] *responsibility* - and so a CNS will readily defer liability to medicine. In view of this outlook she will tell you:

> *A lot of the time you get worried and you notify them* [the doctor] *and there's nothing wrong with the patient; but if you ask the doctor to see the patient they've got to see them. It's better to be safe than sorry.*

Anne echoes this position: *'if I'm worried I just phone the doctor anyway whether it's a stupid thing or not'.* Wolley would defend Anne's action. She too believes it better *to ring doctors a million times, and have them hate you than risk the patient's safety.* When all things are considered however, an experienced nurse has generally been in enough similar situations over the years to be able to correctly gauge whether or not to hold off calling for medical attention. Not so the junior - as Wolley attests:

> *That's what junior staff can't do - they can't afford to - unfortunately some of them do take risks by holding off medical attention, but they're taking risks they know nothing about, and that's not good enough. That's why we have to have senior staff - a ward that's run on junior staff is a dangerous place.*

Bo describes an unexpected event in which her seasoned tactics result in extra benefit for the patient's overall outcome. Bo recounts the story:

> *We had a young girl not so long since who was only in her early thirties. The first time I met her was when I came on in the morning - she'd been in a motor traffic accident and she'd had a whiplash injury and she'd got real trauma . . .*
>
> *When I first went into her she wasn't really crash hot - she was vomiting - having a lot of problems with nausea and vomiting. So I sorted that out, and I said to her I would come back - do my pills, and come straight back.*
>
> *Well, I didn't even get the chance to do that because by the time I got into the next room she had collapsed . . . it just happened so quickly. We actually put a crash call out for her - she hadn't arrested but we put a crash call out because her breathing and resps and everything were going. . . . her oxygen sats. were just dropping down down down - so we just put out a crash call. There's some nurses who believe the crash call is only for cardiac arrests but we felt she needed help there and then and quickly. . . . a junior nurse would probably have gone and called the intern and waited for the intern to come and it would have got to an arrest situation. Whereas we bypassed a lot of people to get urgent treatment for that girl.*

Bo's actions demonstrate she is not afraid to transcend a number of links in the hierarchical chain of medicine in order to *'get'* to the people she perceives have greater competence, especially in an emergency situation. (And yet, by the same token she takes the very real risk of displeasing both her colleagues and the hierarchy by such action).

This scenario is in sharp contrast to junior nurses who often behold nothing amiss. Sarah describes an incident during which two RNs are about to remove a chest tube without realising the usual suture for securing the tube is missing. As a result they remove the special suture intended for tying off the wound site once the tube is withdrawn. Sarah recalls:

> *They were about to pull the tube out and that could have been a bit unnecessary for the patient because air would have got in. . . and there was a chance the patient would have got a pneumothorax. If I hadn't said to them 'oh there's no suture there', they probably would have taken it out.*

Bo too, describes how she will *never stand back* if she sees a junior nurse *having a problem.* It must be dealt with immediately, because she believes - *' you can't let it slip especially where junior ones are putting peoples' lives at risk'.* As the 'expert', Bo is of the opinion - nurses who perform at a less than desirable standard should be confronted and made aware of the implications of their inattention. For example, she discovers one nurse who neglects to give an IV medication for two nights in a row. Bo is concerned and suggests to the RN she devise a timetable by which to work to avoid future oversights.

Not only will a CNS identify and intervene in major concerns threatening the patient, she will also take heed of minor issues as well. Annabelle, for example, relates how she liaises with the dietitian in regard to a patient in whom she has noticed ankle oedema which she suspects is due to protein deficiency. Following consultation with the MO a serum protein check is arranged. In point of fact, resolving countless minor problems is an essential component of the behavioural repertoire of any CNS. Junior staff will refer to this problem-solving ability as *troubleshooting,* especially in relation to equipment. Annabelle recounts an incident in which she demonstrates her troubleshooting expertise on a patient, abrogating the necessity for further treatment.

> *One time, it was a mechanical thing, a chest drain came up and there was a persistent leak. . . everybody had checked the tube already and said no no no it's not leaking; but we were just clamping the tube to check it, . . . and we found the leak, just as the doctors were starting to think about doing a talc pleural adhesis . . . so he* [the patient] *didn't need to have that done.*

Every CNS has a story about an unexpected downturn in a patient's condition, as opposed to those downturns not unexpected and for which she is prepared. When a patient takes an expected downturn and is going to die; it is often difficult to gauge just how long it will take, but over the

years Anne has developed an unusual means to sense impending death. She describes it:

> *. . . there is just this smell. I always smell it when someone is just about to die. It's not something you normally smell, and I don't know how to describe it, but when I smell it I know what it is.*

Throwing light on the phenomenon CNS illuminates a number of special skills. Debra shows she is able to correctly identify the cause of a patient's untoward signs based on the opportunity afforded her to observe the patient at length, and from her vast experience of patients with similar physical problems:

> *Mr X was admitted with hypotension and generally unwell. His WCC was 14 and he was query septicaemia. My impression was the WCC was not overly high given the area of his wound and it's appearance and that the most likely cause of his condition was more to do with his misuse of analgesia. This may have been due to a communication error on behalf of all involved in his care, yet he certainly appeared to be over-medicated. Once this was changed his confusion ceased and his overall condition improved.*

Annabelle removes a line of complicated sutures: a less expert nurse may not have attempted the procedure because the sutures look awkwardly placed and are partly embedded. Annabelle can do it; because as she points out:

> *I've encountered them before - I know it can be niggly because most of the groin sutures get a little bit like that. . . . so I knew it was going to be a problem. . . . they can be removed - you just have to get that stitch cutter right in there . . .*

Where a novice will be constrained by the thought of *'hurting'* the patient, a CNS aware of flinches and winces will acknowledge them and yet persist with the task.

This is not to say a CNS is never confronted by a situation in which she feels unsure of herself: Carol says: *'When I'm sticking needles into people's groins, I sometimes think, 'God what would I do if I hit an artery?'*

Jay captures his experience:

> *That lady this morning, well she was very worried, but I would have been too when all this fluid gushed out. With her I sort of said "look I'm sure it's all right" - but, I'm not sure absolutely sure it's all right. I think it might be all right but I'm not sure - I don't know what it implies exactly; because I've never seen so much - I didn't know an airstrip could contain that much fluid or keep that much fluid contained.*

Notwithstanding, it is almost certainly the case a CNS who has been on a specialty ward for many years will have a greater knowledge about the disease and its treatment than a less specialised doctor. In this extract, Anne demonstrates how her in-depth knowledge of the area affords her the confidence to act autonomously for the benefit of a patient. She describes the incident:

> *Mary had a groin dissection about six weeks ago and she was down in the out-patient's waiting room and told me about this abscess her general practitioner had diagnosed, and I just thought it probably wouldn't be - because they rarely are. I've not heard of too many people getting an abscess unless they get a lymphocele which becomes purulent; that's a bit like an abscess but still . .*
>
> *She was booked into the clinic as an emergency; well, she would probably have had about an hour's wait, and after that the MO would probably have grabbed me and said "Anne could you have a look at this?" So I thought 'oh well let's cut out the middle man', and I just took her straight into the dressing room. I drained it and sent a specimen off . . . whacked her on some antibiotics and that was it. She was a bit sceptical about it at first I must admit - well her GP had told her it was an abscess and there's me about to shove a cannula in her groin . . . There was this sigh of relief when all this fluid came out; about 400 mls too, I thought it was never going to stop. So that was the abscess - I wrote a letter to her GP saying: "I drained the lymphocele".*

Anne is so confident in her role she tells the patient that if the condition recurs to contact her [Anne], rather than the clinic. She firmly believes the patient requires expert nursing care as opposed to medicine. *'Those clinics are so busy - you can well do without people coming in with problems that aren't really related to doctors anyway.* Jay too, makes informed decisions in the role of dressing sister - in this extract he sees a patient in the outpatients clinic and his observations lead him to believe all is not well:

> *. . . he's pale he's broken out in spots; he actually looks like he's lost weight. He just looks drawn - more so than when I saw him a week ago when he was discharged.*

He goes on to demonstrate his knowledge of the normal course of recovery by observing: *'by this stage I would expect that someone would be looking better, and yet I think he looks worse'.* Furthermore he makes clear his knowledge and consideration of the patient as an individual in the statement: *'I didn't think there was much point in commenting to him that he wasn't looking well - he's a very anxious person anyway'.* Jay is unable to put his finger on what exactly is wrong with the patient, but because he intuits something is amiss he searches for a cause:

> *I don't know what's wrong with him. Whether - well he's just started chemotherapy and sometimes that knocks people around a bit. He's a really anxious person who's holed up at home not walking for weeks because of this wound. . . . he just doesn't look right.*

Aware the medical staff are all in theatre, and knowing the patient is to return at the end of the week, Jay decides to let him go. Thus he demonstrates the skill a CNS has developed in differentiating between conditions requiring immediate medical attention and those that can be held off.

In addition to judging whether or not a patient is in need of medical advice; a CNS is often capable of anticipating the medical treatment for a particular patient's condition before an MO has even seen it. Jayne illumines this skill by setting up an IMED in advance of the MO's orders; because she knowingly predicts *'the patient was going to have a pretty good output, and would therefore be needing fluids'.* Anne recalls how she removes the dressing on a patient's skingraft immediately prior to discharge and discovers areas of harmful swelling. Yet, it is a condition she has seen several times before, and even when the MO reviews it and believes it a haematoma, she is convinced otherwise - as she recalls:

> *Well as soon as I saw it I was thinking IV antibiotics - and he definitely wasn't going home. And then MO saw it and thought it was a haematoma, but I had a feeling it probably wasn't - it just didn't feel like it.*

She proves the MO incorrect and skilfully draws off several mls of pus. The confidence such a CNS displays in her skills is garnered by the patient who quickly discerns the work of an expert. In point of fact, confidence is a quality which radiates through a CNS and distinguishes her in the very first instance from lesser skilled nurses. It certainly is the case a confident CNS makes a difference in terms of the practical care of the patient, and what is more, by virtue of the talents inherent in that confidence she has acquired the versatility to wear different hats.

-Living Different Worlds: Wearing Different Hats-

Being a senior bedside nurse necessitates periodic role interchange, and apart from numerous in-charge shifts, the CNS takes on the role of NUM in her absence. For some this can be a *nice little break*, but only she stipulates *'if the position is short-term'*; yet for others even short-term *acting-up* is a burden. Clearly being-in-charge has differing connotations for differing CNSs - the majority of whom would agree *management isn't really* their *scene*. Jayne views acting NUM days as *'paper shifting, not nursing days'*, and yet she will acknowledge people listen to her and take more notice of her as NUM, which in turn, makes her more assertive. The CNS also discovers that as NUM, she *has to deal with everybody's problems* - as distinct from her own role where she *doesn't have ultimate responsibility; because there are certain limits*. In a sense, where being CNS means being able to *palm off* certain problems - the NUM's job entails having to *pander to everyone all the time*. In point of fact, the NUM's position finds her al*ways seeming to get the blame for everything, even if* she *is not there*. Furthermore, there is a quandary in acting-NUM in terms of fellow nurses, because as Anne points out, *'it's pretty difficult when you are a peer to suddenly come down on someone. You have to keep in the back of your mind you will be working with them again'*.

For the phnA-CNS, in-charge offers the opportunity to make decisions which means the job becomes more challenging and hence more satisfying. By and large interchanging roles keeps the CNS on her toes, and she will tell you *'when you're doing shiftwork year upon year, it's nice to suddenly work different hours'*. The CNS's adaptability does not stop at recognised role changes, she frequently dons the hat of differing subsidiary personnel within the hospital as well. For example in one shift a CNS can fulfil the functions of a porter, a ward clerk and/or a ward assistant: and like much of her work in which she *is filling in spaces* - undertaking these auxiliary roles will go unacknowledged. Carol illuminates the problem:

> *. . . yesterday the ward clerk was away; the ward assistant was away; and it was a normal admitting day - so guess who does their roles when they are not there? It always falls to the nurses to do other people's jobs because they are not replaced. The nurse has to expand her role to bridge the gaps.*

Anne who has been acting NUM; dressing sister and acting CNC all in one year, can come to work and think *'now who am I today?* Anne will tell you in comparison to a CNS, the CNC is left

much more to her own devices, and the role involves responsibility that is unimaginable to the CNS; even to the point of *'telling the honoraries what to do'* when unfamiliar with protocol. The CNC is usually a CNS who has been fulfilling the task before promotion (like Debra), and yet, once a CNC she would *never go back to ordinary bedside nursing. The repetition of the work - doing the same thing each day in the same order* no longer appeals to her because she has entered a different reality. Anne writes of her acting position in Debra's absence, *'I went to a few meetings and suddenly realised here is a position in nursing where you are seen as an important person in that team.'* Not without its drawbacks; the job of the CNC permits a nurse to make decisions *'of slightly more consequence than handing out panadol or something like that'.* At long last, the CNC discovers the *'system'* values and *respects* her in her nursing role.

For patients, who generally do not recognise the position CNS - differences between bedside nurses become apparent only in the care they render. And, it may not necessarily be the actual care they receive that is different, *but the manner in which it is given, and how efficiently it is being carried out and to what depth their questions are answered.* It can be said however, that those nurses who *don't do what the rest of the nurses do,* in other words, those nurses whose roles set them apart, **are** perceived by patients as *different.* One example of a *different* role in nursing is the 'dressing sister' job on [Rose Ward], which is shared on a rotating basis by the CNSs. As well as carrying out all of the daily wound dressings on the ward, the position involves working in the outpatient's clinic. It is a job with regular hours and essentially involves none of the traditional bedside care of the patient. The perception among the CNSs is that patients believe, because she is not on the ward carrying out routine nursing tasks, the dressing sister is 'more important' than the bedside nurses. As a result, the patients see her as possessing greater expertise and *must therefore know what she's talking about.* In which case, they tend to save all their questions for her, and pay more attention to the outcome. By reason of the dressing sister being regarded by all concerned as a *little bit different:* and because being seen as *different* means somehow being *special*; the job appeals to the CNSs.

In a way the role of dressing sister transforms the CNS because it periodically removes her from the day-to-day humdrum of bedside nursing. By the same token it reposits her in the day-to-day humdrum of the role of dressing-sister. Yet for her, although equally as repetitious as traditional bedside nursing, the job has more satisfying facets.

These elements have been described as:

> *You don't have to make beds and empty bedpans; it's more challenging because it allows you to problem solve to some extent; like getting in there and looking at things and deciding the best way to treat them; there is more autonomy and the job is more creative; you can structure your day yourself and not have to follow guidelines like 'well it's 7 o'clock everyone must be sat up for breakfast'. You have more control over your day, and can plan your day. You can choose when you do certain things, whereas working at the bedside it's the patient who largely dictates when things get done.*

The dressing-sister's work frees the CNS from the shackles of the bedside and permits her to express her expertise more uniquely. *There are things* she *can do that are not formalised into a hospital protocol which makes the job more interesting.* In effect, *being in the dressing sister position lets* her *act the CNS a bit more.*

The dressing sister role sets the CNS apart from a less experienced nurse because, for example, in regard to surgical procedures the CNS is capable of knowing the difference - often a *'subtle difference - between something that is very bad and something that is going to be fixed'.* Anne describes how she can tell by looking at a skingraft whether it is *'going to take or not'*, and furthermore *'what to do with the graft to make sure it does take'.* Where a less experienced nurse might believe a graft which appears purply blue, is inviable, and treat it as such; the CNS will know grafts are practically always that colour at first sight, and are most definitely viable.

By reason of the job involving fairly extensive and at times repetitious tutoring of patients in aspects of wound care; the dressing sister is presented an opportunity to deal with numerous individuals each day - some of whom she recognises will grasp the concepts more quickly than others. And even though this takes up a large part of her day the CNS enjoys the relationships she develops with her patients along the way. *'Besides'*, says Anne, *'explanation doesn't take long and it's what you get in between that's important - when you are just sort of chatting - how're things going - how's your dog and things like that?'* While the CNC from her elevated position might view the dressing sister's job as *monotonous* - the CNS believes it a role that has the potential to be developed. (As it stands however; the *'system'* will not support that idea).

Nevertheless, the role is not without its drawbacks. One minor drawback Anne describes as *'having to be pulled back into ordinary wardwork at lunch time'*. Major drawbacks Jay describes as the days that are *'horribly busy'*; and yet others as involving *'grotesque dressings'* - such as, the *'man with no face'* or the *'woman with the tumour that grows visibly in the time it takes to dress it'*. Anne has just dressed the latter and refers to it as she is about to go off to lunch:

> *I'm sick of looking at pus this morning, and fuzzy smelly fungating dead things. I might skip lunch or at least anything that's yellow or red or black. The first time I did that dressing I felt really nauseated but I think you get used to it - I know what it's going to smell like now.*

Debra has to take the *'man with no face'* into the clinic to assess the extent of his wound. This unfortunate man has an extensive BCC which has eroded one half of his face from his chin up and halfway down the back of scalp. It has also eroded away one eye and half of an ear. The mutilation is considerable. Debra says, *'when I uncovered it, the smell just hit me'* - as a professional she redresses it without a hint of repulsion.

Moreover, because the CNS works in the outpatient's clinic the job involves *pandering* to medical staff - acceptable to some; to others not. There is also the fact she often has to stand and wait; since like all nurses she must rely on the medical staff to fulfil certain obligations. She will in fact, spend a large part of her day unable to act because medicine does not *pander* to nursing. As it happens, doctors are the single biggest cause of delay in the administration of her nursing care (a phenomenon discussed in the following chapter).

CHAPTER EIGHT

THE PHENOMENOLOGICAL TEXT: LIVED OTHER

Being-in-the-world with Doctors

Whereas a CNS knows full well the hierarchical structure amongst the medical staff, the medical staff have a limited concept of the career pathway of the bedside nurse. As a result, an intern with a query will usually approach the first nurse he sees; while a more seasoned MO will approach the nurse he perceives as having been the longest on the ward (usually the NUM). Despite this lack of clarity regarding her position, the medical staff *play a fairly large role* in the work life of a CNS, and can *make a huge difference* to her work environment. Anne conceptualises this environment as a vast circle comprising the doctors on the *outside* and the nurses and the patients *'mucking-in' together* on the *inside.* During the course of her career, a CNS will have encountered an assortment of doctors; some of whom she will have perceived as working *with* her, and others of whom she will have perceived it has been more the case of working *for* them. And yet, because she lacks autonomy in many aspects of patient care, a CNS recognises the benefits in working *with* medical staff, if for no other reason than *to have good patient care.* As a result, she will look upon the medical staff as members of the ward team, although on occasions *not very functional members.* (The concept of a team is important to the CNS).

Carol gives voice to this concern:

> *The decisions come from both areas but nurses notice things as well as doctors and they need to be able to go to the doctor and say 'well this lady's leg is swollen or she has pain in her leg' - it's no use sitting around waiting for them because we can't initiate any treatment. We need to be able to communicate.*

In point of fact, because she is conscious of the *natural animosity* that exists between nurses and doctors, a CNS will consider herself *lucky* if she works with medical staff with whom she can communicate. By and large, the perception amongst the CNSs of *luck* in working alongside a congenial group of medical staff is widespread, and what is more, the less medical staff around - the *luckier* she feels. No doubt this is because a number of doctors are notorious for *poor behaviour*, while others in contrast are deemed *just terrific.* Some CNSs will be charitable about the range of behaviour stemming from medicine - *'there will always be some rotten apples in a barrel'*, and, *'they are no worse than any other group of people'*, they will say. Others will perceive to a large extent, doctors consider doctors *better than everyone else, and that doctor is spelt G.O.D.*

Because she has been *around for so long,* Debra, considers herself *lucky* the honoraries and registrars *know her.* As it happens, she is reliant on their *full support* if she is to achieve the outcomes she desires for her patients - and so counts herself *'more than anything else, lucky that the doctors I work with have been fairly open to what I'm doing'.* (While the CNSs on the ward will tell you the interns and residents learn a great deal from Debra - it would be of interest to discover if, in that respect, they too consider themselves *lucky*). Similarly, Sarah comments: *'we're lucky here because we've got a very good team - the honoraries are all very friendly and nice'.* Especially it seems, if she has been on the ward a while, *'they tend to trust you and think you know what you're talking about'.* Anne believes the ward *'lucky'* at the moment to have such approachable doctors, and that she is *'lucky'* one of the honoraries will usually *'listen'* to her opinion on certain aspects of patient care (this is after six years on the ward). In fact if the medical staff listen to the CNS at all she considers herself *lucky,* yet she will tell you it makes her job so much *easier.* Both Jay and Sarah consider themselves *'lucky'* to be rostered on a ward with limited medical staff as opposed to some wards which have up to twenty different teams of doctors where in, one could surmise, *there wouldn't be much teamwork going on.*

-Being-in-the-world with Junior Medicine-

While a CNS is permanently assigned a ward, the interns, residents and registrars *turn over* at regular intervals. Interns may be rostered for as little as a three month term. As a rule, the intern has less background knowledge than a CNS - most probably never having seen the types of patients in that specialty before. The residents have been in the *'system'* longer and because they move around, they have to learn the varying routines or protocols of differing surgeons, so generally they seek any assistance on offer. The best source of such assistance is the CNS, who clearly knows *what's going on* in the ward; and although she concedes the MO will usually have greater theoretical underpinnings to his knowledge, she is fully aware of her superior practical know-how. That being the case she takes it upon herself to teach new MOs the *ways of the ward.* Anne points out:

> *A big part of our role is teaching doctors, because the registrars have hardly got time. . . the registrars are teaching the surgical side of things. We are the ones who are telling them the things like 'you need these bloods, they need this test, here fill out these forms, just sign here we'll go and do it'.*

The CNS *fills in a whole lot of gaps* in the education of junior medicine, some of which ironically, will be about aspects of care she herself *is not allowed to undertake.*

Under the circumstances a CNS can be a *bit of support* for a junior doctor because if nothing else, she can *confirm* whether or not the treatment he advocates is conventional. Furthermore, most often the CNS has *done some background work* to substantiate his decisions, so in a sense she becomes the MO's *back-up. Back-up* strategies might include checking on the patient's electrolytes or other results in advance so that abnormalities can be dealt with earlier. Annabelle is asked by the RMO for her advice regarding the suitability of a specific IV fluid for her patient. She says:

> *It happens quite often because a lot of times they know the patient, but they might not know what's been going on immediately; and they are really asking you to double-check themselves.*

When circumstances arise she has seen before, the CNS will offer suggestions *(cues)* to the MO in terms of the patient's treatment. Annabelle frequently suggests the addition or removal of certain treatments based on the knowledge she has gleaned from being a nurse for all these years.

A patient of hers complaining of light headedness has a haemoglobin (Hb) of 9.3, Annabelle is prompted to look up the admission Hb result, and discovers it to be 10.6. Immediately she seeks out the MO to suggest *'they put the patient back on some iron'*.

By the same token the CNS has discovered she needs to *keep an eye on* the new MO because of his unfamiliarity regarding protocol. Although she knows *he has got the protocols printed for him;* she is aware *he won't read them enough.* Appreciating the human element with its potential for mistakes, the CNS watches the junior doctor carefully, especially in the early days.

A junior doctor is likely to take note of her input, and yet most of the time in the eyes of more senior medicine (especially registrars it seems), she finds it necessary *to prove herself first.* And while she recognises an MO has expertise in his specific domain, she is hard pressed to find a senior MO who recognises her as an expert in hers. Those MOs who do pay heed to nurses generally tend to think *only the sisters in intensive care know things.* Yet, unlike a fledgling nurse who tends to place medicine on a *pedestal* and is *seen but not heard*, the CNS is no longer afraid to ask the reason/s for certain medical decision/s and when her input is ignored by junior medicine she will often ask why.

-The Intern-

In the eyes of the CNS there are *good* interns and *bad* interns. Once again, she considers herself *lucky* should the ward host a *good* intern. A *good* intern is usually a *nice* intern, that is, one who happily *listens* to the CNS and then *does what he's told.* In point of fact *nice* interns when they first start out, are usually very anxious for the CNS to give them advice, the wisdom of which is not lost on her. In effect, with a good intern, a CNS does not always have to *hint at* or *suggest* a course of action but can *direct* one. Anne highlights her position with *nice* interns:

> *They come up here and you say; 'right I want you to do this, this, and this', and they are like 'yes sir', and off they go and do it and, they are happy for you to do that, to take that control away from them . . .*

A CNS recognises *it must be pretty damn terrifying* for him to come on to the wards, and it is *unfair to expect him to know the ins-and-outs of every area*, and so she is fully prepared to *guide him along,* and it makes her feel *useful* answering his questions. However, she perceives a *nice*

but not *terribly good* intern; *takes all his cues from the senior registered nurses* - (junior nurses have not acquired cues to give). A *nice* intern is *malleable* - Anne who is too busy to attend herself, sends the intern to assist with the outpatient biopsies. *'Teach him how to be a nurse'*, she says with a touch of humour, for she is fully aware that while it is probably true that some nurses want to be interns - it is certainly true most interns do not want to be nurses.

In contrast, a *bad* intern can range from one who appears to be *just not listening*, to the intern who is basically *incompetent.* The upper level of the *bad* scale embrace the *difficult* intern - a *cocky* individual who *doesn't like being told what to do and starts criticising the way things are done on the ward.* Essentially, he is the one who *thinks he knows everything; does everything his own way,* and although he may listen to the NUM; he ignores all the other bedside nurses and tries to exclude them from the team. Jayne attests to the frustrating aspect of a *difficult* intern:

> *If some conceited little intern comes along and is giving all this mouth about this, this, and this, then I say 'look I'm trying to explain something to you would you just listen! This is right, I've been here 6 years - I know this!'*

But, as she says, often the CNS will have the *last laugh.*

Sarah:

> *A classic example is last night; Mr XYZ had a high INR: 7 - now we know from experience that we never try and reverse that. You can reverse it with vit. K or by giving them FFP but we never do that. But last night they* [the new MOs] *went ahead and did it even though we said to them 'don't do it, because you will get into trouble tomorrow'. . . . and they went ahead and did it anyway; they just didn't take any notice of us, and they absolutely got blasted this morning by the Honorary. . .*

'We are all trying to do the right thing by the patient' protests Anne, *'but it's when they don't treat you as part of the team that's so disconcerting';* even more so when *'they are doing things wrong'.* Carol describes her reaction when an intern chooses to ignore her thoroughgoing knowledge of ward practices:

> *On Sunday I wrote it up on the board that it needed to be done on Monday* [a pre-surgical photograph of affected limb] . . . *and apparently he refused to do it because the surgeon hadn't told him to. So he won't take our word for it . . but that annoys me because we've been here, he should take our word for it - we know the routine . . .*

Because a CNS has been on the ward long-term, it is discouraging and embittering to find medical staff - rostered to the ward in the short-term - ignoring her expertise, and who, by virtue of their disinterest, jeopardise the *good reputation* of the ward. A reputation which in the eyes of the CNS exists only because of the selfsame skilled nursing the MO refuses to acknowledge. Wolley expresses her wrath:

> *In this ward patients don't recover by good luck: it is our good management. The standards we create are what gets our patients through; not the HMOs and certainly not the junior MOs (who mostly have little experience or motivation).*

Unlike more junior nurses, a CNS quickly recognises an 'incompetent' intern, the one *who doesn't fill her with confidence* and *whose judgment* she *wouldn't trust.* Such an intern may or may not choose to listen to the CNS. Carol recalls a shift where her suggestions were accepted, (possibly for the wrong reasons). The scenario begins when an RN asks Carol to look at the dressing of one of the patients which is damp. . . . *'I went and had a look and pulled the dressing off and it was saturated - and there was a little trickle of blood which constantly ran from the upper end of his wound.'* Having assessed the situation Carol rings the intern to come and review the patient, her problem is compounded because she has little confidence in him. She relates the scene:

> *The intern on is a bit useless; . . . but anyhow he came up and had a look and he was just flapping round and didn't know quite what to suggest . . . I knew what he would have done is ring the first-on and if the first-on was a bit doubtful he would have rung the surgeon at home. . . So I said to him "do you think if we put a pressure pad on, it would help?" "Oh yes", he said "that's it, put a pressure bandage on it".*

Clearly, it is often the case an expert nurse works at a level over and above that of an intern. In many instances throughout her career the expert nurse will *'save the day'* for an intern (*ipso facto* the patient/s). As Carol points out: 'a CNS *will often assess a situation and know exactly what the treatment should be, and yet is still required to check with an MO who often won't know themselves'.*

Anne recalls an incident in which several patients went into septic shock within minutes of each other:

> . . . *we* [another RN and myself] *loaded up a trolley of all the stuff we needed - because when they spike temps like that and if their blood pressure is down you do a full septic work-up . . . and if you let the intern do that you know they'd be there all night and they stuff things up so you don't let interns anywhere near. . . . so we loaded the trolley up and we' re sort of alternating - one's doing the swabs while the other's taking the blood cultures off, and we're throwing these forms at the intern and whacking haemacel up and saying 'now just sign this; sign this, sign this'. You could tell he was just so relieved someone had taken the responsibility. We were randomising people on antibiotic trials and just throwing envelopes - opening them up 'oh yeah what do they want?' 'Okay' - and we'd be drawing them up saying 'just sign the order' and we'd be off giving the first doses* [laughing], *and he just sat there being the secretary all night signing his name to all these documents.*

Through trial and error the CNS learns some interns are just a bit harder to teach and less receptive than others, and it may mean she has to make her suggestions sound either more, or less cogent, depending on how she perceives him; and what is more she may even have to get a *bit irritated with him* before he takes note of her, (if indeed he does). *'In the end they usually come round',* asserts Anne. Whether an intern is liked or not, a CNS recognises the reality of their existence; *long hours, so much responsibility.* Notwithstanding, she will be *glad to see 'the back of' a bad or incompetent intern.*

-The Resident Medical Officer (RMO) -

A CNS recognises 'shoddy' medical practice, and in the case of junior MOs, will not baulk at reporting it. Wolley firmly believes that: *'the dereliction of duty of care by one MO can often "snowball" if the nursing staff feel in any way intimidated'.* In which case a senior nurse will never leave a patient subject to inferior medical practice, but will seek to redress the situation. Wolley recalls an incident in which an RMO was *'needlessly rough in the pursuit of his duties'* and basically *'botched the job'* anyway. He was called upon to replace an abdominal cannula required for peritoneal tapping:

The RMO arrived, immediately claiming that he doubted the cannula fell out, implying a nursing error. . . . he did not wish to put another one in because he had never done this before. Instead of admitting this; he proceeded to go through the garbage to see what cannula was used. On realising this I advised him to ring someone more experienced. . . he ignored this, went to the patient and placed a small cannula in his side, without analgesia and without warning. On examination, the cannula was barely in the tissues and had not reached the peritoneal space. . . . of course it did not drain and the night Registrar was informed. . . . [The next morning] *I made an official complaint to the HMO about the evening RMO and so did the Registrar. . . . thankfully the patient did not become anxious.*

This is not to say she will not recognise a job well done by an MO. Annabelle remarks on a *good* procedure performed by a doctor. Wolley writes in her diary about the successful insertion of an intercostal drain:

The insertion of the drain itself went very well, the RMO was more than competent and caring and the patient was placed under no undue stress during the procedure.

To be sure, following insertion of this drain, the RMO cleared away his own debris - for when it comes to junior doctors, above all else, a CNS will resist being a *handmaiden.* A CNS believes many doctors perceive even today, *he is there to be waited on hand and foot*, and she is there to *clean up his rubbish.* Often a MO will sit at the desk and say *'where's patient so and so's chart?'* expecting her to *chase-about* looking for it. On occasions, she has been known to page the MO should he leave a mess on the ward, especially if it entails careless management of sharps material. By the same token, because she believes in the reciprocal nature of teamwork, if he is *pleasant about it* she will help him out.

Like the *'system'*, of which they are a basic ingredient, doctors make work for a CNS. For example, on an evening shift, especially at the beginning of a new term because the doctor on the ward (usually the intern), does not know the patients, a CNS has to spend a great deal of time *going through everything about the patients.* She's got to say, *'well this is what we do, and this is what you should do'.* As another example, Anne points out:

On the big Friday round where you reef all the dressings off, they go round and poke their noses in and go "yeah very nice", and then you are left with 15 dressings to do and the patients are rattling their cups on the rails.

Jayne describes how she likes to be in-control by having *everything done before the night staff come on*; therefore she makes sure *'all the pre-ops are organised and have all had everything done before coming back on the next day, and finding, for example, an x-ray hasn't been done and theatre has had to be cancelled or postponed'*. This involves a large amount of paperwork which she sets out in an orderly fashion in the nurses' station, yet more than likely during the course of the shift, *'the doctors and anaesthetists will all come along and throw the notes everywhere and not put them back again, and then they'll take them away'*. So at the last minute, she finds herself - out of control - *chasing-around; searching for items other people have displaced.*

-Doing For Medicine-

Arguably, a CNS must have talent as a 'dogsbody' because she will tell you in her job she does a great deal of *chasing-around,* both for and after other people. Sarah says:

> *You chase-around for everything; you chase-around for their bedcharts; you chase-around for their medications; you chase-around for their TED stockings. . . you chase-around for the doctors . . .*

In a similar vein to *chasing-around,* a CNS will also do a lot of *chasing-up.* One of Annabelle's patients is spiking a fever post-operatively, and *'just seems not too well'*. Although she knows the doctors are aware of the situation and have carried out a 'septic work-up', she still feels the need to *chase-up* what they (the doctors) intent to do for him that day, - *'in case he is overlooked'*, she explains.

Rather than having to *chase-up* doctors to ascertain what is to be done for a patient, a CNS will welcome any opportunity to make her own decisions in that regard. Jay, as dressing sister, derives pleasure from using his own initiative in the treatment of wounds, so that ultimately the responsibility for promoting satisfactory wound healing is his.

Jay describes how he treated the wound of a patient re-admitted to hospital for grafting to a groin dissection undergone in past weeks:

> *I took down his graft wound for the first time. From the green colour and smell of the extremities, I decided it was probably infected with pseudomonas. . . I trimmed off those parts of the graft that appeared infected, redressed the wound by cleaning it with saline, applied adaptic and acriflavine, and securely padded the wound.*

When he receives confirmation of the merits of his treatment from the MO, Jay derives a moment of satisfaction from his job.

-Waiting for Medicine-

To be sure, feelings of satisfaction where medicine is concerned will only be momentary. One of the biggest sources of frustration for a CNS is *knowing things have to be done,* and yet she *can't do them because the doctor has to do them.* Especially, when she is unable to obtain him to carry out essential aspects of patient care within an acceptable timeframe: a particular problem on weekdays because the interns are *so hard to drag out of theatre.* Carol says: *'it's frustrating because you know what has to be done and you can't do it because you need a doctor to sign on the dotted line'.* In view of this, there are occasions when the CNS is prepared to *overstep the mark,* and *hand out the panadol and things like that* regardless of a medical presence. Carol who has a patient with chest pain for whom she needs a doctor but is unable to get one straight away, says,*' putting on the oxygen . . . I think I may have needed a doctor's permission, but I just put it on anyway'.* Debra can think of a number of occasions where she has decided the patient's need for something and just *'gone ahead and done it'.* But as CNC, her position is afforded greater autonomy and such action would probably be expected of her. Not so the CNS, who, for the most part, experiences that *'things are held off until they* [the doctors] *finish theatre or whatever'.*

Another exasperating feature about waiting for a doctor is that while she could be putting her time to better use, a CNS finds herself off *tracking him down.* What is more irritating is when he finally does arrive, at gross inconvenience to a number of people, he merely *shrugs it off.*

Jay has been waiting for a doctor in the outpatients clinic:

> *He ended up arriving once I'd finally started doing something else, and it also meant the other patient who had an appointment at a specific time was kept waiting for an hour. . .*

Aside from the MO being otherwise engaged or disorganised - things can get *held off* because the MO holds no regard for the opinion of the CNS. On account of this reluctance *to take her word* - treatment may be *held off* while she has to bear witness to a patient's discomfort as they both wait for his attention. Jayne recounts an incident in which her patient is clearly suffering, and yet has not been written up for pain relief - Jayne rings the intern, who:

> *Was unwilling to give a phone order for pethidine, and couldn't see the patient straight away despite me telling him she was rolling around the bed in agony. . . .Fortunately the registrar phoned to see how she was and gave me a phone order . . . the intern eventually turned up one and a half hours later.*

Carol relates a scenario in which a registrar refuses to consent a patient for insertion of intra-arterial lines for chemotherapy because he believes the patient's portacath is to be used instead. When the CNSs try to tell him otherwise he refuses to listen. In the meantime the patient is scheduled for the procedure. Once again the CNSs contact him to organise the patient's legal consent for the procedure, as a matter of some urgency by this stage, at which point he informs them he will be unable to attend to it for at least two hours.

As it happens, a CNS is used to the idea of waiting for medicine, and will tell you *'not to hold your breath for them'. But,* she will add *'I wish they would remember we are busy too'.* Anne reveals: *'You do a lot of waiting - you wait for people to write scripts for you; for dressings they particularly want to see - with the specialists especially you expect a wait'.* So much so, she will in fact organise her day around it, as she explains: *'for example, there's no way I'd take a graft down ten minutes before my lunch hour so* [MO] *can see it; because I just know I'd never get to lunch; so I plan around it'.*

-The View from the Night-

On night duty, away from the socio-cultural world of the day, as a general rule things are not *held off.* Wolley sees the day people as having *'far more avenues to fight before they can get things*

done'. On night duty she has only an intern and a registrar and *'then the registrar rings the honorary at the end of things'*. Out of their usual environment, even a *difficult* intern is more pliable and will generally take cues from the CNS.

That is not to say she will never have similar *battles of will* with the medical staff to get them to attend a problem. On night duty, on the occasions when a doctor does make himself unavailable, it is the CNS who practically single-handedly has to deal with the problems in his place, and so, in that respect too, things are not *held off*. In her diary Wolley relives an experience in which a patient's condition is stabilised *'due more to* [her] *good management, not his* [the intern's]':

> *. . . her pressures were low and her urine output dropping off. The intern is phoned and after some time rings back. I explain the situation and that the evening RMO should have taken a FBC. The intern orders Haemacel 250 mls stat and says he will review her. No sign of that intern all night.*
>
> *I was able to do her filling pressures and thus determine that she was in fact dry and not overloaded. Without the added bonus of a CVP it looked on paper as if she could be heading towards overload, but she was not, and so we were able to rectify the problem with fluids.*

The following night she struggles again to get the same intern to attend a patient:

> *. . . one hour into the transfusion her BP dropped to 70/40 - pulse 64 - temp. 36 - resps. 14. We immediately stopped the blood; raised the end of the bed; put oxygen on, and rang the doctor. The intern ordered fluids and said he would be up later. I said "no" he should come up "now!" He said he was in 'handover' and a few curt words were exchanged between us; whereupon I reminded him that he had promised a similar thing the night before and never arrived, and I was not about to let it happen again.*
>
> [In point of fact] . . . *the doctor arrived 60 minutes later.*

A less experienced nurse would certainly not have received the back-up she needed from this MO and moreover would have lacked the confidence to insist on his being-there so forcefully - inevitably both nurse and patient would have suffered.

All things considered however, a CNS can 'better' an intern because if things get really problematic and the intern persists in taking no notice - unlike the reticent *brand new* nurse - a CNS *won't hesitate to go over their head to someone that will.*

At times a CNS perceives the medical staff very much take from the nurse and gives little in return. She says: *'they take - they take from the patients - they take from everyone; and they need to be giving a bit more.* In short she feels *abused* by medicine - *'they use us'* asserts Wolley - *'they don't pull their weight'.*

> *They'll come in and they'll write something up and they'll expect it to be done - never mind that the equipment isn't available; that the people who know how to use the equipment aren't available. They'll walk in and say 'why isn't so and so done? You're supposed to do that'. We're supposed to do everything. They take from us all the time and give us no leeway, like - 'oh I'm sorry I wrote that up late and you didn't see it', or whatever.*
>
> *They go into the patients and they will say: 'well you're going to have an op'. and they take the energy from the patient in that this patient is relying on this person for some sort of explanation, and yet they'll go in, say two words and then walk out - leaving it to the nurse to go in and explain everything . Or, like the honoraries here have poor bedside manners - they will go in, tell someone their prognosis is bad, and then they'll walk out and leave it to the nursing staff to fix things up.*
>
> *Or, they won't tell someone something, and that person knows the results are back and we can't give first notice of these things, and they will (it seems like sometimes almost deliberately), but it's absent-mindedly, not tell the patient and we know the result and we're in a dilemma because we can't tell the patient. So we have to sort of - again - track the doctor down and it's always on your knees - please come and tell this patient - it's a pleading type of thing all the time. So all our positive energy is put into pleading with these doctors and they're not giving anything back.*

If a CNS does encounter a doctor who *gives of themselves* she will tell you - *it's like manna from heaven,* because although some doctors will support the CNS, others do nothing but hinder her. Mostly she perceives they *don't hinder intentionally* but attributes their attitude to a *different way of looking at things, and nurses.* Nevertheless, there are some doctors who obstruct the intentions of the nurse because they believe a nurse does not have a *fitting opinion* about aspects of the patient's treatment, and these individuals *would hold off doing something until later simply because the nurse had suggested it.* In the eyes of the CNS such persons would not be *team players.*

Anne relates the story of a doctor who in her view, was not a *team player.* It begins when he orders a wound to be packed with betadine and Anne says to him she is sorry she *'can't do it'*, and explains that betadine has not been used for a long time, and for a number of reasons it really was not a good idea. He refuses to acknowledge her recommendations and insists upon betadine - at which Anne rejoins - *'I don't really care what you want, I'm not going to do it'.* Because this MO belongs to the ranks of a lowly intern - *'there was nothing he could do'.*

In point of fact a *term* can be characterised by the merits of the medical staff. A *good* term is filled with medical staff who, even though they may be *lazy and unmotivated*, are still amenable to doing what the senior nurses ask them to do. Conversely, a *bad* term can be highly stressful and encompass numerous clashes. So much so, that at times, a CNS will perceive the *battle is against the doctors not the disease.*

It may even be the case, a CNS can be having *almost a good day,* and yet *doctor-type things* will come along and upset it. Sometimes she will work with an MO who gives her the impression that he considers her questions *are asked only to annoy him*; not because she *wants to learn a thing or two so* she *can care more effectively for the patients.* Furthermore a CNS strongly believes that in a hospital setting it is the nurse, not the doctor, who is the major caregiver, and yet she perceives no recognition for her contribution from doctors. Consequently there are times when a CNS will feel a sense of intense dissatisfaction and annoyance that her efforts go largely unrecognised in the eyes of the average MO. *After all these years* and in the position of CNS she *still finds she is under everyone else.*

-Being-in-the-world with Senior Medicine-

While a CNS is unlikely to tolerate a tyrannical junior doctor, when it comes to a more senior one, in some instances she takes rather more than her fair share. Jay describes the time a senior MO confronts the CNSs about why a particular treatment has *'not been done'*, when in point of fact, the CNSs all feel it unnecessary for it to be carried out in the manner he advocates. The MO insists upon them *doing it his way,* and in the process criticises their usual practice which leads Jay to think: *'oh give us a break - let us do our job and you do yours.'* Jay, in despair, points out *'we never seem to win on these issues - we always seem to be intimidated or brow beaten'.*

A CNS will tell you *the average consultant wouldn't know you if they passed you on the street.* Jayne who has been on the same ward for 6 years has never been addressed on a first name basis by the consultants, despite them having been on the ward equally as long, a not unusual scenario. Moreover, as she discovers when acting-NUM, she has to be *'really strong with them otherwise they walk all over you'.* Because the honoraries are permanently affiliated with the ward, if one or more happens to be unpleasant the problem of ill-feeling intensifies, and a disagreeable surgeon has the capacity to make life fairly miserable for the CNS.

One such surgeon on [Rose Ward] is so unpopular because of his manner that he invites almost *risky* or *'winging it'* practice on the part of the CNS. Anne who is acting CNC, is asked by him to 'pull back' on a misplaced arterial line. Anne is unsure how to go about this, but as she points out:

> *. . . with someone like him, I don't want to show I don't know what I'm doing in front of him because he's such an officious little man that it's just a sign of weakness - there was no way I'm going to show that in front of him. With anyone else I'd say, 'look how do you do that'? I thought, no. . . I'm not going to ask him.*

Anne describes another situation which left her outraged because her advice to this same consultant is completely ignored. It begins when she is instructed to apply Milton 1-in-4 to a wound, and she suggests an more up-to-date alternative; which is scorned. She takes up the script:

> *I hate Milton and I compromised, I said it was 1-in-8 but it was more like 1-in-about-26 or something. A little old lady - really red and he wants me to put Milton on it. . . . I have to accept that he has the final decision, I have no objection to that - but I do object when their final decision is out of touch with modern technique.*

In defiance, Anne contacts the plastic surgery CNC and discusses the patient with her. In the meantime the consultant decides he wants to use Elase on the wound.

> *Elase! I said to him 'I don't think they make that anymore'* (snort). . . . *we did have some Elase in the treatment room, and when I discovered it I threw it all away. . .*

The plastics nurse consultant arrives: *'. . .as soon as he saw her, he said: 'oh M what do you want to use?'* The plastics Sister suggests the very same treatment Anne had recommended from the

outset. To which the consultant replies - *'Yes, well that sounds reasonable'.*

Similarly Jay, who has been on the ward for 5 years with long-stretches in the role of dressing sister (and whose experience in the treatment of surgical wounds is second to none), perceives his knowledge counts for nothing when it comes to medicine. In the following extract Jay is retelling an incident which highlights this:

> *A patient who I had been seeing about twice a week for maybe 2-3 weeks because of a persistent drainage problem . . . told me he was due to go on a long-planned holiday. . . on each visit I had aspirated his lymphocele and would have continued to do so but I advised him to go away and if the collection recurred to call into a local hospital and have it attended to. The man was no fool and my instructions were detailed.*
>
> . . . [As it turned out] *the doctor had to ring him that afternoon . . . and when he heard of the plans we had made for him to go away, he said it was ridiculous, and to cancel the holiday and to be at the hospital the next morning to have a drain re-inserted.*
>
> *Next day of course I am put in the position of being the incompetent giving wrong advice. I set up the equipment for the procedure, because I simply cannot defy a VMO, even though I disagreed. It took an hour and a half for him to appear after I had let him know we were ready. He came in (no apologies) had a quick look and decided that what he should do was - exactly what I had advised him* [the patient] *to do the day before.*
>
> *If he had been a nursing colleague or even a hospital doctor I possibly could have laughed it off, or at least given him a piece of my mind, or demanded an apology. But the confidence empowered by his position manages to overwhelm me leaving an anger that can only be held-in or misdirected.*

The remarkable aspect about these two scenarios is that the CNS accepts such 'put-downs' as *status quo,* and may even tell you, they are but one, in a number of similar incidents. And while she recognises that she *lets* them happen - her ability to master such situations, unlike her skill in other areas, does not appear to improve with age. As it stands, a CNS is sick of being *tactful* with *rude and arrogant* MOs. She is *sick of asking questions and being ignored* and is unsure about *just how assertive* she can be. Yet, as is the practice of many nurses, Anne makes light of this affair, postulating the surgeon in this case: *'thinks he's better at nursing than I am, but he just doesn't want to be a nurse!'* More sombrely, Jay just shrugs and concedes that when all is said and done, they have got: *'more power than I have around here',* and *'when it comes down to it they can s--- on you, make fools of themselves and stuff up patients and you are the one who is*

left looking and feeling like an idiot'. 'But', he declares- *'the rudeness is beyond a joke'* - pointing out that on occasions these persons have been *'addressed directly, and yet walked away without saying anything. I think it's appalling rudeness,'* he says despondently.

Apart from being downright rude a CNS will tell you many doctors are good at *patronising* nurses. What is more, Jay describes one senior surgeon with whom he finds it frustrating to argue because *'he always beats me - he has the capacity to make me feel like an absolute idiot, . . . and I actually get a bit fumbly around him'.* Jay tells of the time one of the other senior doctors showed him a useful way of applying steri-strips to a wound. One day when he was applying them, the surgeon in question entered, and asked:

> *. . . with that edge of contempt in his voice that I can't fight - what are you doing? So I explained, and he said 'rubbish - you get the tension in all the wrong direction'. 'But', I said, 'they all add up to the same tension . . .'. 'Nonsense' he said. So I thought fine, with your patients I won't do it - your patients can have steri-strips that fall off.*

Quite clearly the potential for patients to suffer in such doctor-nurse conflicts is very real.

Having suffered ignominy at the hands of an honorary; a CNS will take delight when it is the honorary who is rankled during an encounter, (albeit inadvertently). Jay tells of one such occasion:

> *Once I set him alight - that was good - with the diathermy machine (*laughing). *He says, 'just put it on the end of the forceps', and I'm thinking I can't see the forceps you've got gauze round there, and he's going, 'oh just here; just here'. But it touched the piece of gauze he was holding, and it all went up in flames. . . . And the whole world knew within quarter of an hour that I had set him and his patient alight.*

And while the CNS does not see herself as special in any way, she certainly comprehends that doctors regard themselves as special, and doctors as patients are treated by doctors as special. Jayne refers to a night when she *'specialled'* a patient she believes was a waste of *'manpower'. 'Still'*, she asserts cynically, *'I suppose he is a consultant and we have to give him better care than everybody else'.* Jayne writes in her diary how she put a leg bag on the same consultant the day of his discharge only to be instructed later in the shift to put him *'back on a long bag'.* She writes: *'which made me look pretty stupid. After all, every other radical prostate gets a leg bag prior to discharge. This one gets treated with kid gloves'.*

-Being-in-the-world as a Non Entity-

When all is said and done, a CNS does not generally consider herself valued by the medical staff; (even if she believes she works in a functional team). Of doctors, she perceives - *they don't see our role as being as important as it is* - and, *nursing is low on their list of priorities.* Above all else, she perceives that her *concern with things other than purely physical things,* that is her concern with everyday human activity - is deemed insignificant by doctors, and the *emotional support* she gives her patients is not recognised as beneficial.

Debra says:

> *As long as they get what they want done, and as long as it suits them they will back you to the hilt, but as soon as it doesn't happen that way. . . when it comes to the crunch they will always put themselves above everybody else. . . . if they had to decide between an MRI for their patient or a little chat with the CNS - the MRI would win hands down.*

> *. . . I can tell you just from going into breast oncology . . . they are more than happy to let their patients come to me, and have me counsel them and make those sorts of decisions, . . . but if they had to cut down their budget - the first thing that would go would be me - because they don't see my role as important.*

Anne believes medicine sees nurses as basically *robotic*; and *'as long as they* [the doctors*] get to chop them* [the patients] *up, and send them home - they don't care about what happens in-between'.* Yet, it is the *in-between stuff* that is so very often at the core of the CNS's operation. This belief is further borne out by the not insignificant number of doctors who will walk on to the ward and start ordering treatment for the patient *without bothering to find out what has happened in-between.* In other words, *'the ones who don't bother asking what's happened since the last time they saw the patient,'* insists Jay. A CNS will view this perspective as a *piece of meat attitude.*

Recognising the *human factor,* the CNS values her involvement with patients, while he does not. *'We're dealing with people with everyday problems, and we're dealing with people with unique problems',* says she. In a sense this is the fundamental difference between their ways of seeing-in-the-world. Jay, for example points out his firm belief in that for some patients *knowing there is a second bathroom on the floor is far more important than knowing the significance of the*

thickness of their cancerous cells - an MO would not see the logic in this.

According to Anne, the attitude of medicine toward the patient is epitomised by the morning round. She explicates:

> *The MOs seem to be of the opinion the purpose is not for talking to patients or answering their questions or telling them how they are going - it's for talking to each other. This is Mr such and such, he had a such and such - pick up the drain 'yep still too much in that' - chat amongst themselves - 'have you ceased his antibiotics? Is he still on calci-heparin?' And then its off, and quite often the patient is there going - "um hang on!".*

In the eyes of the CNS, medicine generally has a *poor bedside manner*, and furthermore gives no thought to individualism - *'where some people might be happy with that approach'*, comments Anne, *'others are not'*. As a result, the CNS finds where the patient is concerned, she is forever *filling-in* for medicine. For example, because the patient knew full well she *'wouldn't be able to understand him'* she asks Carol to sit-in on a doctor's visit so that Carol could *explain to her in "layman's terms" what he said.*

Anne too, points out:

> *A lot of doctors come in; cause problems; cause questions in the patient's minds, and go away. They don't realise they have left a large job for us to continue, or finish off, by either placating the patient, calming him/her down, or explaining what language it was that he used.*

Carol expresses her feelings:

> *You go in afterwards and first tell them what is happening in English rather than in medical terms, or just repeat it all to them because they don't understand or they don't hear half of what the doctor says anyway. So you just re-explain, or interpret, and add information, and yes, make excuses for people quite often.*

That honoraries are not around on night duty is an asset for Wolley who asserts:

> *They pop in and visit their patient who is usually in a compromising position in bed - they look and they say 'okay everything is fine', or 'everything is not fine' but always blunt and fast, and a lot of our doctors while you can't fault them on their surgery, their personal skills aren't good. They come in to see their patients and they don't hear what their patients say - they often don't hear what we say, and they leave.*

At which point the CNS expands her own horizon and steps in to appropriate the patient's voice. On the medical round Sarah's patient complains of dizziness and is ignored. Sarah says: *'they don't really care unless it's something major they just perceive it as 'oh that'll fix itself - that's nothing to worry about'.* Yet for Sarah who cares for this patient eight hours at a stretch, the reality is different:

> *It was obviously distressing her because she was vomiting and not keeping her food down. And a woman like that needs to be well nourished as part of the healing process. [She is also a diabetic and could have a hypo]. If she vomits everything she eats she's not getting much goodness out of it. So it was something we had to fix.*
>
> *And even though she said to the honorary and the resident who was with him 'I don't feel well today' they don't really take any notice - it's just 'oh all right dear' and off they go. Unless you actually go and say to the doctors 'look this lady has vomited 3 times today do you think it could be related to this or do you think it could be related to that?' - they wouldn't go and see her.*
>
> *It's us that sees her all day vomiting and all day complaining and everytime you go near her she complains about feeling dizzy.*

And yet, in a peculiar twist, it appears the very reason she is able to maintain her *self esteem in the face of medicine's arrogance,* is furnished simply because medicine does so plainly undervalue the human-side at which she is so skilled. *'Because we do know that certain things they totally ignore, are extremely important'* - asserts Jay - *'we are able to save face'.* So, because she is so much better at being human - at opening herself to the being of others and gaining access to the world of her patients; now and again the CNS feels in some way almost superior to medicine.

Certainly nursing as a discipline is not special to medicine. Medicine demonstrates its perception of nursing as unimportant by the manner in which it dismisses the nursing notes. Wolley has a patient who is breathless and yet despite the fact the nurses have documented this observation in the notes; medicine takes no action. Wolley writes, *'unfortunately doctors still don't read nursing notes - even though they are combined - when the nurse writes the word 'nursing' they tend to ignore that little bit'.*

Wolley recalls an occasion when an English RN arrives unexpectedly on the ward having contacted the Unit [the consultants] to seek permission to visit the area on a *fact finding mission* as she works in a similar specialty in the UK. The Unit apparently advised her to come in that morning and join the 'grand' round and visit the out-patients clinic etc. however they had *not bothered* to inform the ward nursing staff of the impending visit. As a result, *the poor woman arrived unexpectedly and was obviously embarrassed, as was the NUM,* and to make matters worse it turns out to be a day when not a single CNS was on-duty - which meant the NUM had great difficulty in finding someone who could orient and instruct the visiting nurse *vis-a-vis* the ward. Wolley sums up the general sentiment of the CNSs about this situation;

> *If the NUM had been made aware of her arrival the roster would have certainly been changed* [to accommodate her] . . . *The frustrations of being 'the last to know' do not escape even our small unit; where you would expect a close link with the doctors. We have a well-run ward with a succinct CNS group and we were not given the opportunity to show it. Close links with similar overseas units are as important to us as to the doctors - it's maddening that they don't see it.*

-Being-on-the-edge-of-the-world-

As it turns out, being *the last to know* is a taken-for-granted reality in the everyday lifeworld of the CNS who sees herself as *at the end of the line in the communication stakes.* Carol relates a scenario in which the decision to discontinue an intravenous infusion has been made quite some time earlier, but has not filtered down to her at the bedside:

> *She* [the patient] *had her breakfast at 6am and then at 8am I saw another tray arrive for her and I thought 'oh yeah', and then I realised she wasn't nil by mouth anymore - so there was no way she needed the dextrose. But I had to go and ask the intern if I could take it down, and as it turned out he had already mentioned it to someone - but nobody had told me.*

Similarly, Jayne carrying out a drug-round, discovers a drug which has been recently written up yet no-one has mentioned it even though she is caring for that patient. *'Oh well'* she shrugs, *'they* [the doctors] *wouldn't tell me anyway'.*

From time to time, the surgeon will explain a variation in treatment to the patient but neglects to mention it to the CNS. Anne describes a time as dressing sister she approaches a patient and

having carefully explained about dressing the wound, the patient informs her the surgeon had given a completely different picture of its care. Anne, who now looks incompetent thinks to herself: *'I wish he'd jolly well tell me these things beforehand so I don't tell the patient one thing and then they say "oh but'*, and in the next breath she admits: *'but I'm used to it actually'.* As it happens, the dressing sister considers the surgeons *'great at operations, but not to be let loose near the dressing'*, and so while the doctors might take lesions off - the care of the wound site post-surgery is, or at least should be, in her view, strictly her domain. Similarly some doctors hinder the work of the dressing-sister by giving patients advice on things they really *know nothing about. A doctor will sit there and say something that's blatantly misinformed [*about the care of a wound*] and just walk out.* It is then left to the CNS to try *and regain the confidence of the patient but not say the doctor is wrong.*

In this situation, concern for the patient outweighs any thought for her own self-respect, and the CNS has to play *a very, very, political game . . . to say he is wrong but he's not wrong - because he's just taken* the patient's *lesion out, or he's going to take them to theatre, so he can't be wrong - because in the patient's eye they have to have full faith in their doctors.* To make matters worse this very same doctor is liable to continue *brushing over the advice the CNS gives the patient,* and *repeat their wrong doing.* Not infrequently, a CNS will counteract the surgeon's instructions regarding aftercare of the wound site - although in the aforementioned instance - Anne concedes to the wisdom of his differing opinion.

Just as consultants can disempower the CNS; they can as readily empower her. Carol, who fulfilled the dressing sister role for a number of months at a stretch, became in good favour with the honoraries because she was willing to enact extra duties and use up her own time to carry out some of their private work in the outpatients clinic. Here she tells the story of how pleased she was when a consultant rewarded her by allowing her to carry out the work of a doctor:

> *An outpatient came in with a collection of fluid and the doctors decided perhaps this patient should have a drain. . . and I said 'oh well I'll get the registrar to come and put the drain in', and he said "no you do it". . . . so I did it and it was really nice to have that sort of trust. . .*

Anne has worked on the ward for many years, and yet when a consultant listens and accedes to her opinion regarding the patency of a patient's wound drain, she states, almost in surprise: - *'and*

he didn't even bother coming to have a look he just said 'no fine, take it out'. She senses that finally, in recognition of her being a nurse who *'wouldn't be doing anything stupid'*, she has been *'listened to'.* Notwithstanding, in a later situation, the same consultant decides to only *half listen* to her. In this scenario he has ordered a palliative care patient to undergo a barium swallow. Anne says she was *'outraged'* at this as she strongly believed *'the patient had been through enough'.* Anne's diagnosis of the patient's stomach ailments posits a problem with her drug regime, yet the consultant has said, *'no -it could be a polyp'.* Despite the fact that the palliative care registrar has reviewed the patient and *'his diagnosis was exactly as our diagnosis had been all week'* - Anne says, *'nobody would listen to us'.* As it turns out, she recounts: *'I couldn't stand it, so in the end I went round and I said to him* [the consultant] - *'the porters are here, and I think this is awful - I'm sorry. And he cancelled it'.* Only to order a gastrographin swallow instead. Anne says of this: *'it's still not pleasant, but it's a lot more pleasant than barium. . .'.*

Jay, as dressing sister, finds he has to assist the MOs in the outpatients clinic and that some of them expect more in terms of the CNS being a *glamorous assistant* than others. One over-riding problem for the CNS concerns the number of MOs who appear to be taking advantage of the dressing sister position to attend their private patients. Yet, *'they don't listen to us when we speak'* complains Jay - they go ahead and make the arrangements for the patient and the CNS finds it difficult to refuse, because invariably - *'there's some poor soul whose not particularly well, waiting outside'.*

One MO causes friction when he insists Jay help him out in the biopsy room during Jay's (unpaid) lunch hour. Yet a CNS will not as readily confront an honorary as a junior, and so instead of refusing outright as he would have preferred, Jay finds himself making excuses in regard to a lack of equipment and so on. On the occasions when he does spontaneously agree to be of assistance - the MO readily accepts his presence, and yet shows no regard for his expertise. Jay expounds:

> *I've just run out of energy having stand up fights, and at the same time feeling guilty because I'm not doing anything. I resent the fact he's getting paid large amounts of money for something and using the hospital facilities. . . on top of all that I think he's a lousy doctor. . . . one of the other MOs saw his information sheets and said 'we've got to get this changed' and I said 'well it's up to you I've told him, but he's not going to do it on the word of a nurse'.*

At some stage/s in her career every CNS will have been *outraged* by the attitude of a medical officer toward either herself, or nursing staff in general. Wolley is placed in a difficult position on night duty when she discovers the casenotes of a patient who is complaining of abdominal pain contain no relevant medical information. This necessitates that both she and the intern sort out the patient's problem with an inadequate history; complicated by the patient's lack of English. As she says, *'it was one of those cases where no-one knew what was going on'*. In the morning Wolley confronts the RMO about the issue, and is told the patient's relatives have requested the patient remain ignorant of her diagnosis. Wolley argues that by withholding relevant medical information in the notes, the RMO is placing the patient at risk, and that legally and morally the nurses have a right to know what is wrong with her. In any case, it was most unlikely that having the information in the notes would cause the nurses to reveal the patient's diagnosis.

When she tries to discuss the issue with him *'it's as if he has not heard a word'*. To add to the problem, later in the day he contacts the NUM and complains that Wolley is culturally insensitive, and the NUM should speak to her about it. Wolley *'saw red'* in the actions of this MO, especially as she has a higher degree in social anthropology and regards herself as *'more than aware of the issues of cultural diversity and religious restriction'*. To her, he was just - *'the type of MO who can give no credit to nurses'*.

By way of contrast, when a CNS does get on with a member of the medical staff they can work together and have fun in a lighthearted way which makes for a pleasant atmosphere. The potential for this to happen however seems contingent on many factors, not least of which are the personalities involved and the socio-politico culture of the ward. On [Violet ward] there seems to be an ability for the medical and nursing staff to be able to work alongside each other with less difficulty than on [Rose ward] for example. Interestingly [Rose ward] has a number of phnA-CNSs while [Violet ward] has less CNSs most of whom are phnB-type. Although Anne who works in the biopsy clinic with one MO; can say of him - *'we always have a good laugh'*, to the observer it is obvious their positions are not of an equal footing. As she assists him in removing a lesion from a patient's nose they exchange jokes across the patient. The patient who is well known to them both, enjoys their interaction. As incongruous partners they can at least raise some cheer in that direction.

Unfortunately as we have seen, when doctor and nurse do not work cohesively the outcome can

be destructive. Medical staff can engender feelings of anger, frustration and dislike in the CNS. Jay says: *'you want to achieve something and because of the structure of the organisation; the relationship between people and such things you can't do it'.* Jay can spend three hours in the outpatients clinic assisting one particular doctor he dislikes, and remain silent the whole time. And, he says: *'I just hate being put in that position'.*

Because most of the *things* she *wants to achieve* revolve around the patient, inevitably it is the nurse and the patient who suffer most in this conflict. Wolley believes that doctors see the doctor-nurse relationship as a power play; rather than two professionals working alongside each other. A climate of confrontation causes great tension on the ward and the CNS needs periodic debriefing. *'And that'* says Wolley *'is when they come on nights'.* Night duty enables the CNS to disengage to another time and space - a period of time-out, where together the CNSs can *release their feelings about all that has been happening.*

-Further Views from the Night-

But, the view at night can see the CNS subjected to the same marginalisation as the day-duty CNSs: the same dysfusion of horizons between medicine and nursing. It can even go so far as *a patient having to die before* a CNS *is believed,* i.e. *listened to.* Wolley has been on the ward seven years, and has extensive generalist nursing experience underpinning her specialty, yet her immediate experience of the event recounted below, bears witness to the silence of the nurse's voice as it falls on the ears of medicine - intelligent, articulate, expert voice or not.

Wolley picks up the story:

> *An elderly woman arrived from Cas with anaemia for investigation . . . she was admitted for a blood transfusion with a Hb of 5.1 . . . when the blood arrived the blood bank staff had casually written on the cross match sheet 'for transfusion using a blood warmer'. . . . handover from a medical point of view must have been pretty poor because the medical intern was very vague about the woman and knew nothing about requiring let alone ordering a blood warmer.* [Eventually a blood warmer is procured]. *The doctor came up to hook up the blood* [Wolley sets up the blood warmer] . . . *The doctor had never seen one so she was of no use.*

Once the blood was commenced and all the precautions were followed things were reasonably uneventful for two hours. The other patients were stable and so I was able to sit in with the transfusion patient. The ward protocol book stated a temperature of 40 degrees centigrade was appropriate during the transfusion - however the unit maintained a temperature of 40.2 degrees cent. . . . I deemed it to be harmless. . . . [the doctor] *agreed with me. Towards the end of the transfusion I felt the lady's chest sounded moist although her respiratory rate had not changed and she was not laboured.*
I borrowed the oxymeter and found her sats. to be 89%. I informed the RMO who ordered oxygen at 6l/min. The woman's sats. improved to 98% and she became more wakeful.

'Now', says Wolley, *'came the fun part'.*

The patient asked to use a pan and whilst attempting to put her on the pan she arrested! By this I mean she stopped breathing, she had no palpable pulse and her BP was 60/30 and fading. We lay her flat and increased her oxygen; the other RN brought the arrest trolley and called the arrest team. Meanwhile I put in a Guedel's airway and started bagging her. This was obviously enough aggravation and so her pulse increased and became stronger. By the time the team reached us she was beginning to stabilise somewhat.

Yet, instead of applaud for her efforts - Wolley confronts a very different reality which makes her *'very angry'* - she continues:

. . . the team did not believe she had had a respiratory arrest - they were extremely condescending passing it off as a 'vasovagal'; implying that we had overloaded the lady, and so they gave her IV Lasix. The woman had had 500 mls of NS over 8 hours and 250 mls packed cells over four so I doubt that the fluids given were her problem. The Sister from Casualty wrote in the notes implying there was no arrest and she did not leave me room in the notes to document what had happened prior to their arrival.

And so it would appear, even another CNS is complicit in deprecating all that she herself represents. The story continues:

The team left, they did not even do a rhythm strip to see what her cardiac state was. The patient had been incontinent during the arrest and so after letting her condition stabilise we attempted to wash her and change the bed. The lady arrested again! No pulse - no BP - no resps - dilating pupils - as before Guedel's and bagging. The team were called and I commenced cardiac massage. The arrest team arrived and worked on her for half an hour before giving up. The woman was in junctional bradycardia with no output and so after a discussion with the VMO resuscitation was ceased.

The team then left, and we had to pick up the pieces.

Clearly, for the CNS to walk the hospital with medicine, is not an easy task. There is little doubt she is the one most frequently left to *pick up the pieces* - especially the emotional pieces. And while she might even secretly profess to being *in awe* of some doctors; even *of having a tremendous amount of respect for them* - she certainly perceives them as *occupying all the power positions, and having all the say about what goes on.* That is to say, she is well aware of her lack of influence over medical decisions - especially those of senior medicine. Notwithstanding this belief a CNS will not blindly obey a doctor's orders. If she perceives a risk she will more than likely argue against the prescribed treatment. There are times however, when she wants to avoid confrontation, especially if it involves senior medicine, and so she finds other ways to exercise control. Nurses have *'always done this'*, she will tell you - *'frequently carrying it out in more subtle and surreptitious ways, sometimes almost subconsciously'.* The following extracts exemplify this notion of covert power:

-Counter Agency-

In this first scene Anne is attempting to *pick up the pieces* for a patient whom she believes the *'system'* sent home too early. It begins when she receives a call informing her the patient has been feeling increasingly unwell following discharge. As dressing sister, Anne tells the patient to come straight to the ward - following assessment she decides to send her to casualty for re-admission and escorts her there personally. Anne recalls her thoughts:

> *She didn't look very well - let's face it. I wasn't happy with her being sent home in the first place, and I saw this as a good opportunity to get her back into hospital. I don't think she should have been sent home; not with that* [wound], *that was a huge* [wound], *and she'd be just the kind to break down. And they sent her home at her age! Her son stayed at home as much as he could but he's an* [type of employment] *somewhere; no other family and to top it off they sent her home on a Saturday. So how on earth can you organise for community nurses or anything like that? So of course the poor bugger comes in sick as a dog, and I wasn't the least bit surprised.*

Very often a CNS will have an in-depth personal knowledge about her patients, and yet, as far as medicine is concerned, it serves no purpose. Quite clearly, the CNS was aware of this patient's situation at home, knew she was incapable of caring for the wound herself, and should possibly have remained in hospital until the following Monday to be sent home with community back-up. In short, the CNS realised discharge was unrealistic. Anne may even have queried this medical

decision at the time - but would have had virtually no power to alter it. As soon as the opportunity presents itself she secures the patient's return to hospital; almost 'behind the back' of medicine. As it happens because the wound has been neglected this patient requires quite extensive surgery to remedy it -had the voice of the CNS been more influential the need for this may never have eventuated.

Because *'nobody jumps at you if you don't get around to it'* - sometimes Jayne will conveniently *'forget'* to carry out certain aspects of her job. Particularly those she perceives medicine has imposed upon her, and which in her view, *'are a waste of time and resources'.* These tasks usually stem from the prevailing rituals insisted upon by differing specialists in regard to their respective patients. She cites for example, that *every single admission has to have an MSU even if they've just come in for a repeat cystoscopy; and then two days later you have to do another CSU when the catheter comes out.*

Not only will a CNS exert some control over medicine by *going behind their backs,* or *forgetting,* she can also *ignore* directives. Jayne writes about the time a patient, admitted after hours from a nursing home, was prescribed a drug with a similar sounding name to another better known one. At first Jayne misreads the script and secures the incorrect drug from another ward. Realising her error and because pharmacy was closed, she contacts the intern and the ADN to seek advice. The ADN prudently suggests the drug be omitted overnight, which the intern refuses to approve. *'It just went on from there'* says Jayne, who eventually contacts the 'first-on' (doctor) who tells her to give the drug with the similar sounding name. She continues: *'and I said, well no, it's a different drug, we're not giving it - okay? We've looked it up in the MIMS; and one's an anti-convulsant and one's an anti-anxiety.* Then she states: *'So anyway - we just ignored him'.*

Just to illustrate the amount of effort it took to sort this matter out, Jayne continues by describing how she has to make several additional phone calls, and the ADN eventually tells her to organise the intern to go to pharmacy to get the correct drug himself.
Jayne takes up the story,

> *. . . anyway as soon as we told him that, he said 'oh forget it - omit it'. So after all that - 2 hours of trying to find the drug, because he was the one who would have had to phone the pharmacist; he didn't think she needed it then.*

Anne describes the time a surgeon directs her to give a drug to a patient she has reason to believe the drug will harm. Because it is preferable to a full-on confrontation, she just basically *ignores* his instructions, and the drug remains *not given.*

Here she explains her reason:

> *. . . he wanted me to give adramycin and this man's leg was burnt badly enough from the last chemo. . . and he wanted me to tourniquet it to concentrate it in spite of his leg, and I just thought - no, I don't think so. So I didn't give it.*
>
> *I assume he knew I didn't give it - I told him I wasn't, and he just sort of laughed at me. . . And I thought no, this guy's leg will just fry up; it'll drop off - and I could just see me in front of the NRB trying to explain why I'd actually done something that was completely illogical.*

Jay takes pleasure in circumventing medical intervention by *simply not seeking it, doing it* his *way* instead. In this scenario he describes caring for the wound of a patient who is an 'outlier' meaning her surgical team are based in another area. Where a less experienced nurse would be wasting time *chasing-up* the medical officers attached to this team in order to ascertain their preferred method for treating the wound - Jay just gets on with the job. As he retells:

> *. . . her surgeon at first said follow normal protocol, but he keeps backtracking and saying: "Oh well with this patient we'll do it slightly differently blah blah". Well, seeing none of them have bothered to come up and give specific orders - I'll just do it my way. I know it's not going to do any damage, and it just gets her one step closer to home.*

When it comes to dealing with MOs, the distinction between a CNC and a CNS becomes further delineated. If she disagrees with some aspect of the treatment he is advocating, a CNC is much more likely to confront a MO, even a senior one. Debra, for example will risk *a huge fight with the doctors* more readily than a CNS. Due to the fact that a CNC is practising within her specialty at a higher level than a CNS, it is quite probable that her knowledge of the treatment of the disease may be greater even than that of some senior doctors not normally working in the area. For example, when the usual consultant is away overseas, Debra discovers the fill-in MO, who has no knowledge about a fairly recently developed oncological procedure, is willing to ignore her advice and advocate a drug regime which Debra sees as *potentially risky.* In such a case, Debra is prepared to refuse to carry out the prescribed treatment, but suffers for her dissent.

If doctors extract their 'pound of flesh', in a similar way the CNS pays a price for her exchanges with Nursing Administration (NA).

-Toeing the Line-

There is little doubt opinions about NA differ amongst the CNSs, but for the most part they are unfavourable - generally because of *all sorts of little things* that NA seem to impose on nurses. Anne believes NA *'just diabolical'* and wishes fervently nursing would *'scrap the lot of them leaving them* [the CNSs] *to get on with their jobs and run the place* [in which case] *nursing would improve 500%'.* Yet Debra (now a CNC), found them very supportive when she desperately needed a month's break from work, and views them in a slightly better light.

Generally, a CNS will see NA as being *top heavy*, filled with people who *don't have qualifications in management, or who have them from little courses at TAFE or somewhere, and who have so much power they don't know how to use it properly.* What is more they are perceived as a *very difficult group to talk to,* even to the point of being *very threatening.* To become an ADN *'you treat everybody badly'* attests Anne, who adds as an after-thought: *'don't get me wrong - there are some good ones up there. . . who treat you with respect and respect your opinion but a lot of them are still "old school"'. 'The interesting thing however'*, comments Anne, *'is, that it is the younger ones who are "old school"'.* Like the unpopular surgeon who saps energy from the CNS on [Rose ward] for example, so too the unpopular *"old school"* ADN. Known to have even senior nurses *quaking;* the *"old school"* ADN creates stress within the CNS even to the point that when asked on a round - *'how's the ward?'* - the CNS is more than likely to say to her *'oh fine'. 'When really it is absolutely not fine. They'll be bitching and complaining about it by the end of the shift'*, says Jay.

Anne, who was recently *'sent off like a naughty girl to pay her nurses registration fee',* found it hard to believe how *'badly'* she was treated by *"the old school"* NA. Because her registration was due to be updated, Anne, who had the cheque ready to post, was sent off-duty to secure it straight away. This cost her time, in addition to the $10 re-registration fee she could have avoided had she posted her application as intended.

Anne takes up the story:

> *. . .the thing was she had to have it then and there, and there was no need for that. But what could I say? . . . And then she threatened to reduce me to first year nurses wages until I got it. . . .and I thought they don't care about the times I stay back till 8.30 at night . . . or the number of times I've worked through my lunch hour. Or the things that you give. . .*

This has led to some CNSs believing that nurses in higher positions *'don't feel* CNSs *are worth much. They suddenly go away from the bedside and we're suddenly nothing,'* laments Wolley, who sees this attitude as being *'built into the 'system'. 'And we suddenly have to understand every little thing. "Oh you understand Sister; you have to understand"'.* Through her description of the impact that staff cuts have had on the lived world of the CNS, she elucidates this notion:

> *. . . at the moment we've had to cut our hours and so instead of having three people on a shift we've had this one person on a 10am till 7pm, but now that person is being used by other wards. She's not staying here . . . it's like tennis - they've been across to one ward for half an hour, here - back and forth, so the rest of the hospital is just using our cut. What other wards have done, is they've just cut that person out completely, and so they are running short, and we come and fill their space. . . and NA says, we must come and take that 10 to 7 person and 'you must understand'.*

If NA are *'bad'*, general health administration are *'worse'* - asserts Wolley, because:

> . . . they *buy something they can't pay for and then turn around and ask NA to cut back, because after all, we are where the big money goes - our wages. So NA gets told, 'we want you to cut back; to do this; to do that' - so that's where the biggest dissatisfaction is.*

Jay supports Wolley's criticisms:

> *They want to take hours off us, to rearrange shifts, and then more and more new things come up, and it's like 'oh you've got to do this, this and this'. Our in-service is 15 minutes at the end of the day - that's not in-service - someone pops up while you're still working and you take time-out for 15 minutes while they tell you something. The CNSs are expected to be more involved in those sorts of things - we're supposed to give in-service; to participate more than registered nurses in things like quality assurance and all that - but there's certainly no time allocated for it. There is no-one allocated to cover your workload while you go off and do these things.*

To add to the problem, Sarah makes it known:

> *When they bring in the eight hour nights they will do away with even more in-service time. We won't have time for education; there are very few wards where you can stop in the middle of the day and say, 'oh we'll have an in-service now', you don't have time.*

Anne believes it all boils down to nurses being depreciated - because:*'when it comes to the crunch, nurses are cheap'.*

All in all, just as a CNS perceives she is not supported by medicine neither does she see support coming from NA. Jay, who holds this point of view, dislikes acting in the NUM's position mainly because, *'it's not much fun when you've got six patients to look after, and you're supposed to be acting in-charge as well'.* A situation which arises because NA fails to recognise his difficulty, and refuses to send extra staff to relieve him of his patient load.

The CNS - unempowered and unheard in most instances, sees little distinction between her own position and that of the NUM's - it is still one that holds only *artificial power.* For example, when NA *'ring up and say we are taking one of your RNs - no matter how much she* [the NUM] *insists we need that staff member, they don't listen. It's as if the NUM doesn't know what's happening around here',* says Anne.

This is a major criticism of NA - they seem to be completely *out-of-touch*: having no idea of the reality of the ordinary everyday existence of the bedside nurse. Recently, NA promulgated a CNS review, and while it has had the effect of getting the CNS *to think a lot more about what she has to do in order to keep her status* - by the same token, it appears *the move towards endless paperwork* is on. Jay says, *'you have to spend so much time proving yourself now, that it really does impinge on your ability to do the job'.* And because NA is perceived as so far removed from the bedside, when they make an attempt to evaluate the CNS position it is looked upon as unsuccessful, because as Jay points out:

> *It's just one of those impossible tasks. They are trying to make a wonderful generic document that applies to every single CNS in the hospital; but in the end, it's so vague and obscure - it doesn't really apply to any CNS in the hospital...* [What is more] *you know there is no person further up the ladder who is going to read it...*

To NA a CNS perceives she is just a nameless face - *'they wouldn't know me from Adam'*, declares Jayne upon rescinding her CNS status - something she perceives *'NA wouldn't care about anyway'*. Anne, in order to *'ventilate her feelings'*, writes in her diary about a *'minor altercation'* she has with NA one *'nightmare'* shift when in-charge. She was sent an agency RN who in Anne's opinion was *'inefficient; incapable and even unclean'*. When she complains to NA and asks that he not be sent again, her opinions are basically ignored, and once again she feels disregarded and unvalued. Anne writes :

> *If I am a CNS and supposedly deputising for the NUM in her absence - why were my complaints dismissed? If I am such a clever nurse why are my opinions about the conduct of a casual employee treated with such contempt? . . . they were more willing to accept the opinion of an agency nurse - who is hardly ever here. . .*

When the medical staff, without further ado, take off for an interstate conference; the CNS applies to do likewise and has to resort to taking sick leave because NA refuse to give her time off. *'We've been directed to go to conferences, but you do it in your own time, we will not be given any time off'*, protests Jay. Carol, who applies for a day's leave to attend a conference (most of which she has organised to coincide with her days-off), is denied permission. *'No, we need you here to wipe bums and wash bedpans; not to go to conferences'*, complains Anne in relation to their attitude. Carol, who attends the conference regardless, writes in her diary:

> *I attended the conference. . . on the final day I rang to say I would not be in. . . The ADN who was on, said, 'and what sort of leave is this you are requesting?' I confessed to being in* [Talktown] *for the conference and said I didn't mind what sort of leave she called it. I told her I was dismayed at failing to arrange this day off as a holiday, or leave without pay - especially when we, as CNSs, were expected to remain ahead in our area etc etc. She said my loyalty to the patients was a priority. . .*

Similarly Jayne writes in her diary:

> [Daffodil ward] *is very quiet due to the surgeons heading off to a conference. Yet despite there are no admissions for a whole week, NA will not agree to any of the CNSs taking leave without pay to attend the conference.*

As it turns out three of the nurses are granted one study day each, and each is required to pay $50 to attend. Although the NUM is writing to the consultants for recompense - Jayne believes, *'you may as well get blood out of a stone'.*

However, Anne says: *'you can't just dump it all on NA; we are all just as bad'.*

Being Senior

'It's just like a playground sometimes - lots of gossip - lots of whose up to what, and telling stories out of school', rues Anne, referring to nurses and nursing in general. *'Only worse - nurses can be the most savage people towards each other. As a general rule, nurses simply don't support nurses'.* This notion appears somehow incongruous however, because a CNS will tell you that being respected and supported by other staff, principally nursing colleagues, is most important to her. Most particularly she does not want to be treated as if she *'doesn't know anything'. 'Being respected for knowing what you are doing'*, maintains Jayne, alluding to the NUM who has annoyed her by her constant redrafting of work Jayne has completed.

In fact, the NUM has a considerable influence on the success of the role of the CNS: she can readily undermine the position, or actively promote its growth and development. As in any profession there are *good* managers, and *not so good* i.e. *lesser* managers. A *good* NUM is *approachable and facilitates a professional yet compassionate ward atmosphere* - if the ward has a *positive atmosphere* the CNS will function more effectively in her role. A *lesser* NUM fails to *appreciate* the expertise inherent in the role and devalues it. That is to say, a *lesser* NUM, may to some degree, feel *threatened* by the CNS.

Jayne has to live with a NUM who will often go to lunch without *handing-over* to her, which leaves her ill-informed and appearing incapable. Furthermore, Jayne feels annoyed: *'when the NUM comes out of handover and complains the charts are not up to date when I know damn well mine are, but she's generalising'.* In this situation Jayne perceives she is being *'reduced to the level of the junior nurses'.* In another unrelated incident, Jayne discovers the patient on another ward to whom she was teaching self-catheterisation has been discharged without her knowledge, and before completion of the teaching sessions. This leaves her feeling *'extremely annoyed'* with that particular NUM, because although she believes her efforts were of considerable importance to the welfare of the patient; the NUM obviously thought otherwise.

Not all nurses are *good* nurses. Every CNS will tell you she has met a *few 'doozies'* in her time. Nevertheless, a CNS will set and maintain standards and readily critiques the performance of other nurses: be they nurses attached to the hospital or agency staff. She strongly believes *if you are going to do something, it should be done properly* - and one *does only those things that will ultimately benefit the patient.* In this way she protects the patient from substandard practice. The experienced nurses become very skilled at picking out *good* and *lesser* nurses, and will readily agree; *with some of these agency nurses one has to be careful about which patients to give them; because sometimes they are just hopeless.* Once a CNS has recognised a nurse as below average, she often takes it upon herself to *keep an eye on them.* Certainly she will report to NA an agency nurse whom she perceives as *dangerous, or not helpful or more of a hindrance.* But, as can be seen in regard to Anne's experience, her expert opinion, yet again, may go unacknowledged. On the other hand, as Carol explicates, *'the person comes back because they [NA] are shortstaffed, and they're desperate and so they assume that just to get the numbers up, any old person will do'.*

Jayne speaks of her responsibility to monitor staff performance:

> *If someone is not sure what they're doing or how to use the machines or they can't use them, then you just don't give that patient to them. . . . if you get an agency nurse for example that doesn't know, or is hopeless, and doesn't really know she's hopeless - then you just give them the easiest patients. Then check up on them . . .*

Moreover the CNS gets to know the new graduates, and although cognisant *some aren't as quick as others,* generally finds it hard to tolerate the *'idiots'* among them *who don't seem to be able to use common sense.* And while she identifies with their anxiety remembering what it was like for herself as a newly registered nurse, she still finds them frustrating to watch. Yet some she will enjoy teaching, as it *gives her a bit of a kick* to be able to say *'this is how we do it, come and watch me'.*

Jay is critical of other nurses when he sees their lack of attention compromises the patient - and, on occasions, has been known to *yell* at the offending junior. One *'pet hate'* in particular, incorporates graduate nurses' general neglect of patients at meal times: *'because'*, as he points out, *'whether you're desperately ill or not, it's really hard trying to eat lying flat on your back'.*

Jayne is frustrated at the incompetence of a registered nurse and of having to re-explain to her the treatment regime of one of the patients. This was necessary because, as she relates:

> *This morning when I got onto the ward somebody's input was supposed to total his output and the nurse who had been on nights . . . she'd gone totally haywire. . .he was supposed to have 80mls in, and there was four or five hundred going in through two IVACs. She didn't know what was going on . . .*

To make matters worse, it appears *nothing is ever done about these situations,* so the CNS confronts yet another source of frustration. In a similar vein, Annabelle, who is normally placid; *'gets angry when things aren't done* [by other health professionals - especially nurses] - *not so much on the ward, but from other hospitals, so she has to ring them up and ask why* [the patient] *has not had this or that done'.* Jayne is also frustrated *'by other people's incompetence when things aren't done'.* But her annoyance is directed at the staff in the immediate area - *'for example this morning when* [patient Y] *was going on a gatepass, and someone neglected to get her script organised'.*

By the same token, a CNS is critical of other CNSs, and will readily describe a *lesser* CNS as opposed to a *good* one. A *lesser* CNS is an undeserving CNS who is constantly asking questions concerning ward or hospital policies and procedures; is reluctant to become involved in the education of new staff and exhibits a general lack of knowledge about her area of specialty. Furthermore, she will usually lack general nursing experience by which to underpin her practice.

Apart from the profile of a *good* CNS constructed by the informants in this study - a *good* CNS is seen to be a nurse who *stands out* - obviously *efficient and organised* she has a *certain demeanour which enables her to relate well to other staff and patients.* Moreover a *good* CNS has the ability to *ask the right questions* - which means, for example, if she is relieving from another ward:

> *It is she who will come up and ask a sensible question - a question she wouldn't presume to know the answer to because of its relevance to the specific specialty of the ward. Others however, the new grad - the 3rd year student - a lesser CNS will just 'plunder' along instead of asking. . .*

-Common Sense as a Valued Commodity-

All things considered, the CNS will tell you the hallmark of a good CNS is one who has *experience* founded on a bed of *common sense.* As it happens it is not just new graduates who lack common sense - less novice nurses have also been known to be deficient in this commodity. Anne elucidates her concept of common sense:

> *If you have no knowledge of the job whatsoever you still wouldn't do anything to a patient that was completely illogical. Someone off the street would have the common sense to know something was wrong. . . . Some of them if they are not sure about something they will ask, but a lot of them they don't want to tell you; like it might be a little bit embarrassing, so, well, they think we'll just 'wing it'. Well it's alright to 'wing it' when you've got a fair idea of what's going on, but when you've got no idea, it's a bit stupid.*

Anne relates a story concerning two new graduates to illustrate her point.

> *. . . it was an evening shift and there were only two of us who were reasonably senior on the shift. Another girl had only just come over from the UK and had only been on the ward for two weeks, and there were two new grads. It was a 30 bedded ward . . . so me and the other RN took the heaviest half, and we put the UK nurse on the lighter half with the two new grads. And even though it's not an ideal situation we ended up doing task allocation down that end - we just told the UK girl you can go round and do all the IV antibiotics and get the grads to do the obs and general ward work - because this is not a night for learning. . .*
>
> *Now we'd finished our work and decided to go down and see if they needed a hand. . . the other RN just happened to walk past this woman's room and did a double-take and called out 'Anne!' and I went down. She was unconscious; she had probably eight blankets on; we lifted the blankets off and she'd obviously been incontinent several hours before. . . So we whacked a thermometer under her arm and it was 39.5 or something and she had a BP of 40 on nothing.*
>
> *So we just started. Put the foot of the bed up - got the haemacel ready - ran some stat saline while we waited for the doctor to come up - started the haemacel and did a fairly intensive fluid resuscitation. And I ended up doing an overtime; I had no choice, there were no staff on N/D, and she was so sick she really almost needed a one-to-one. We got her back. . . but I reckon it wouldn't have been much longer, and she would have been as dead as a doornail.*

Anne goes on to explain what had happened to bring all this about:

> *. . . during the shift this UK nurse had been frantic. . . hadn't even really made it to see this woman. One of the new grads went up to her and said this woman's temp is 37.8 or something, what do we do? So she said blah, blah - check it in half an hour. So they checked it in half an hour and it was 38.1 or something, and she said 'let the doctor know' and they said 'oh, but the patient is shivering' and she said, 'well throw some blankets on her and once she stops shivering take them off her'. Then she heard no more.*
>
> *Anyway, when we got to the charts we saw yep, they'd taken them, BP; temp religiously. And the temp is going up like this, and the BP is going down like that, and she was incontinent. They put more blankets on, but forgot to take them off, and because they couldn't get the thermometer in her mouth anymore because she was unconscious - they were putting it under her arm and writing they had taken it 'per axilla'. And they hadn't told a soul. . . My Mother could have come onto the ward and known something was drastically wrong with this patient - why didn't they? What happened to their common sense?*

Wolley is also aware of the practice of some junior staff to *'wing it'* rather than seeking help. Wolley uses the time on night duty to get to know other staff members and assess their level of competence -*'this is as much out of concern for their welfare as for the patient's welfare'*,she insists. Furthermore she takes it upon herself to leave *'hints'* for the junior staff on day duty, and impresses upon them all the avenues available for assistance should it be required.

-Being-detached-from-the-world-

By virtue of her role as standard-setter and monitor of standards, it is true the CNS can become unpopular, especially with the junior nurses. Wolley sheds light on this aspect of her work:

> *. . . with the NUM at the top and the CNSs as second-line managers we are the monitors, mediators and creators of protocol in every aspect of patient care and public relations. This is not an easy task . . . the CNS has at all times to pressure and cajole both other nursing staff, and (definitely) the medical staff. . . .* [a position] *which at times does not make one popular.*

Being a resource person she often has to explain how, and why a thing should be done, and occasionally she will strike a junior nurse who resents this. In addition, her role generally involves more paperwork or telephone calls; and this sometimes leads to her being viewed by

busier junior staff as wasting time on 'non-nursing' duties. Some juniors also think that a few of the CNSs shy away from certain aspects of the work because they are *'too good'* for it. The CNS seems to want to concentrate on the more specialised tasks leaving the juniors to the basics. In short, the RNs feel they *are being left to do the basic 'dirty' work.* For example, a CNS may refuse to take a pan if she perceives she has something more meaningful to be getting on with. Jay believes:

> *The distinction between junior and senior is becoming more pronounced. There is some degree of hierarchy being established, and some people who are lower on the hierarchy resent it, and some people who are higher on the hierarchy take advantage of it.*

A CNS might tell you in some ways, *it's because* she *is trying to rise above, or reduce the dirty work.* By the same token it may well be the efficiency of the advanced practice nurse, which necessarily ensures her work is completed quicker. That being the case - the CNS simply *baulks at filling the gaps for someone who takes two hours to do something quite simple.*

-Being-involved-in the-world-

Just as she acts as mediator between 'Other' (usually the patient) and the system: the CNS has acquired a standing as the *middle person* on the ward - she acts as intermediary between differing members of the nursing staff. She is often a *go-between* with the NUM at one end of the continuum, and the junior nurses at the other. This involves *keeping an eye on* the juniors, because *the NUM doesn't see what goes on at ground level.* In her role as intermediary, a CNS might find the junior nurses seek her out to negotiate with the NUM on their behalf. Sarah says the nurses will come to her if they have a problem with the roster for example. *'. . . so often I go and say to NUM you know so and so isn't happy with her days off; and try and change them for her'.*

A CNS may refer to this as her *peacemaker role.* On [Rose Ward] where there is dissent amongst the juniors in regard to the seniors; it is to Jay they voice their concerns. On [Violet ward] interpersonal problems are brought to Jayne's attention to sort out during her time as acting NUM. Without a doubt, the reality for the CNS includes periods of conflict and bad morale on the ward, even to the point of calling in the mental health team and saying *'hey fix this up'.* The

social dynamics - otherwise known as the *politics on the ward* - can be upset by just one incident, or one staff member.

On [Rose ward] however, staff conflict would appear particularly troublesome at this time. Jay says:

> *We have a couple of junior staff who are incompetent, and a couple of senior staff who think the junior staff should do their dirty work for them, and you have a whole lot of people in between.*

Jay has to sort out this *'very tricky'* situation in which he plays a *'mediator role caught between the NUM and the junior staff'.*

Yet before the advent of CNS, it is certainly the case no-one fulfilled this role - as Sarah points out:

> *What they used to do was bitch about each other and eventually it would blow up, and you'd have a big screaming match in the corridor or you'd have a ward full of tension. That's one role the CNS does a lot: people management.*

When tension on the ward involves the CNS herself, the problem is more difficult to resolve. On [Rose Ward], aside from the junior versus senior nurse problem, there is also a division amongst the ranks of the CNSs: caused predominantly by the consultants overtly favouring one CNS above the others. Carol, bearing the brunt of the disfavour finds night duty a time for catharsis. Because they inhabit a separate world, she knows she is able *to speak to the people on nights to help solve these problems.*

For all her *monitoring* of other staff; the CNS will care about other nurses, and will give credit to junior staff when due. If she sees potential in a junior to become a *good* nurse she will be 'protective' of them, and will wish for them *to become as good a nurse as she.* Wolley writing about the night of the arrest mentioned in earlier text - states:

> *This was the first arrest situation my RN partner had been involved in, and it is a shame it was unsuccessful; both from a personal and a practical viewpoint. She handled herself very well and I was proud of her.*

Anne worries about burnout in staff she sees *'coming back on their days off or staying back after the shift ends just to be with* [a certain] *patient. . . . especially the ones that are doing it all the*

time. I just think 'ah you've just got to get out'. Wolley is concerned about *the junior staff who have had little or no experience with oncology.*

She sees it as the responsibility of the CNS to:

> *Help other staff to become acquainted with the 'emotional load'; not to say 'here it is, cope with it', but to support them and let them know that whatever they are feeling is natural, and they will always have someone to talk to about it. . . .*

A CNS will try hard to work with other nurses as a team and see that they endeavour to *help each other out.* Most often this takes place on a *give-and-take* basis - *some days you might have the heavier patients, and some days the lighter patients',* explains Annabelle. On [Violet ward] even the NUM joins the team for bedmaking, and certainly 'extraordinary' events tend to pull the team together. As dressing sister, Anne for example, has to co-ordinate her day's work around the other team members, *'I can't just go in there and oust everybody else out of the way'.* In fact, a CNS usually prefers to work in a team so that the members can *bounce things off* each other, but as can be seen, on occasions the team ideal breaks down and there is *tension on the ward.*

Carol, delayed by a mix-up in theatre - notably brought about by medicine - has to catch up an hour's work when she returns, and because *'no-one knew what was happening'* no-one had *' in'* for her. In this case, she is understanding, but by the same token, she gets frustrated and annoyed when she is held up somewhere, or is particularly busy, and the other staff are aware of her predicament, and yet she finds *'everybody else sitting around doing nothing; just chatting and there's all this work to be done'.*

Certainly, as in any job there will be nurses the CNS works better with than others. Most will tell you *it definitely makes life so much easier* to work with *people who don't get flustered* especially when it gets busy - *there are a lot of flappers on the wards who just lose it completely when it gets busy.* Anne dislikes working with *'drama queens - the ones who thrive on getting to arrest scenes first'* - but really enjoys working alongside - *'the expert nurse - the one, who in the face of a hurricane could walk through and not get a hair out of place'.* Expert nurses seem to be able to 'talk' to each other without uttering a single word. By the same token, there will be occasions when the CNS will *just want to be on* her *own.*

-Living-in-common With Others-

By reason of the rapacious nature of the job, the CNS needs to give expression to thoughts about her workworld. More often than not, she will do this with other nurses, and the conversation will usually centre around the politics or ward dynamics, and is commonly referred to as a *'bitch session'*. Wolley, on night duty and removed from the world of the everyday, is concerned about the effects on the rest of the team of the *tension* brought about by the differences of opinion amongst the CNSs. Night duty is certainly a time for *one-to-one private conversations* amongst colleagues in which feelings *will be vented.* There is little doubt, this is *therapeutic* and frequently leads the CNS *to view things in a different light.* Wolley, is in fact regularly used as a *'sounding board'.*

In addition to these social matters, she will want to discuss fundamental human experiences related to her patients. Yet, to non-nursing friends there is not much talk about such things - it tends to *fall on deaf ears,* or they *don't respond very well,* and what is more, she has *to spend so much time explaining the lingo, it's pointless.* Following the *really awful time* when the patient committed suicide - the only people to whom Jay could talk about it, were other nurses. Jay surmises: *'most people on the outside just don't understand this sort of thing'.*

-The Effect of An Other-

Just as having unfamiliar or unskilled medical staff on the ward generates work for the CNS, so too the staff mix of nurses can affect the pace and intensity of the day's events. Sometimes the CNS will scan the roster book before a shift to check with whom she is working because she knows it can have a major impact on whether or not it will be a 'good' shift.

Jayne recalls an in-charge shift in which she had to contend with mostly poor quality staff, and the difference it made in terms of keeping *things running smoothly:*

> *One evening shift recently there had been 12 admissions during the day, and there were four of us on. There was me in-charge, a girl who works here but who you can't really rely on; an agency RN, and it was his first time in this hospital and he hadn't been on a ward for years, and an agency EN. . . there were six admissions that evening; three outliers - two went to theatres, and one was a stabbing, and loads of pre-ops for the following day. . . The agency RN you couldn't rely on him for anything, he didn't know how to do an admission, how to organise the notes, he didn't even know he could change a drip. . . .Cas had rung up about a stab wound, and nobody had told me he was coming and the next minute he was here. . .*

For the CNS, the 'luck of the draw' as far as the calibre of her staff, can make all the difference to the *'controllability'* of the shift, and whether it turns out to be *good* or *bad.* Having staff unfamiliar with the environment - new graduates and/or trainee enrolled nurses on a shift, (even if of satisfactory calibre) - makes it considerably more demanding.

Annabelle points out that having ENs on the ward increases her workload because there are *'a lot of things they can't do'* - compounded if they are *'brand new'.* Teaching newly registered staff or students impacts on the CNS's time quite considerably because of her own workload - but in a way it also makes it *more interesting.* For the most part, she enjoys mentoring other nurses, particularly if they are *keen, willing to learn, and not overly confident nor overly nervous.* However, the reality for most junior staff being rostered on with a CNS, is quite the reverse - their working day will be easier knowing they can rely on her expertise, a factor crucial to their survival in the early days.

CHAPTER NINE

THE PHENOMENOLOGICAL TEXT: THE PATIENTS

Being-in-the-world For the Patient

By and large 'CNSing' is a thankless and stressful task, with little recognition. There are no pats on the back. *You don't get that in nursing*; not from nursing administration, nor from medicine and certainly not from the *'system'*. On the odd occasion when someone in the organisation does tell her she's *doing a good job;* it is appreciated. But, generally it will be from the patient the CNS gains the most assurance of her worth. *'Sometimes the only person to make you feel good over the day is your patient, and they're sick'* she will observe. Debra comments she *'gets a lot from her patients - they are the only ones that need the help and certainly the only ones that appreciate it'*. In fact, a CNS will generally look upon *patients as giving back to her as much as she gives them.* When she manages to *get on top of something* which has been a problem for a patient - for example, pain, or a nasty wound infection etc. - when she gets *things like that under control,* it is very satisfying for the CNS - particularly *as much of that sort of thing is nurse initiated.* While doctors write up the analgesia for example - *they do not necessarily know what the patient's pain needs are* - it is the CNS who advises them of that.

In such cases, the CNS feels she has *achieved something* for the patient. Conversely, when she cannot seem to get them better, it's frustrating. Anne, whose patient has fungating breast cancer *just can't seem to get on top of the problems with her wound. 'It's not like the man in bed [x] who had a wound collection, and we cleaned it up and that will get better, and he will go home and everything will be fine'.*

Also on the positive side, are the expressions of gratitude patients extend to her about her work. Most patients do show appreciation for what she does, expressing thoughts such as - *'you did that so well'* and mostly she perceives *they really mean it.* At the same time, and somewhat paradoxically, a CNS finds the patients extort a substantial levy and she can easily find herself needing *a rest* from them. She may even contemplate leaving nursing altogether as an aftermath to years of patient contact. *'Constantly dealing with people on an emotional level is akin to feeling like pieces get taken out of you' says* Debra, who cites the patients as the main reason she

would ever leave nursing.

And yet she points out in the next breath:

> *I could have 5 patients that are a real pain and are really difficult to manage or have huge problems, and then one patient will give me a certain smile, or a thank you and that just puts me right back on track. . .*

On the whole a CNS *will 'like' patients* - after all *they are the reason* for her there-being. She will tell you she is a *people person* and enjoys talking to them and *getting to know* them. In fact, interacting with patients - *the person-side of nursing* brings fulfilment to her nursingworld, and is generally the greatest incentive for keeping her at the bedside. Most of her job satisfaction will stem from *building up successful relationships with patients - removing cold impersonal barriers and transforming the health professional/patient position to one of personal trust.* While from the CNS's point of view, chatting to patients is *just another basic nursing skill;* it is one basic skill of which she rarely tires. Sarah says:

> *I like to be able to go round and have a chat to them and listen to their woes and moans. Sometimes you get a smile out of them, and you think 'oh, good they must be feeling better', and you find that encouraging. I like the social aspects of work and the fact the patients get better.*

Unlike employees in isolated types of work, everyday the CNS has the opportunity to meet people from different walks of life, and because by now she is well and truly *a part of the ward,* she knows, and is known by, many people - patients and staff alike. Jay affirms this position:

> *I like the diversity of social contact. If I worked in some solitary job I might want a broader social contact outside work; as it is I don't want to make friends with all the kids and little old ladies in the street. I have enough little old ladies and things here. A lot of people are too restricted in their social contacts and when there is some social issue, they will say, 'well, no-one I know thinks like that', and you think, well, yes, but you haven't really come into contact with others. When people are the same age and in the same profession, they don't have broad involvement with a cross section of the community. These are the sorts of things I like about nursing.*

The CNS can become a consummate 'small talker'. She seeks to establish friendly relations with her patients which enables her to get to know them, and to a certain extent, they - her. As Anne points out: *'the patients don't then tend to see you as Sr so and so, they see you as Anne who I can*

talk to'. It seems the more social the ward - the greater the camaraderie - the more her job is enjoyed, and the longer she remains within it. And while it may be true that even congenial teams have moments when they become *frazzled* with each, it seems working with a group of nurses she likes, and having the time to chat to patients, has a sustaining effect. Anne:

> *I enjoy other people being around who are nice people to know, and fun people to be with. To me that's the biggest positive about this job, and if you took that away from being CNS, or just being a nurse, I'd leave tomorrow.*

What is more, she will appreciate the type of patient found in the area of her specialty. Jay, for example, describes how he was sent to relieve on an orthopaedic ward, and found *'a lot of demented people, a lot of people with alcohol problems and a lot of young louts'* - none of with whom he found it particularly easy to communicate. As things stand, the patients on [Rose ward] suit him much better. Jayne admits she does not like to look after *'old geriatrics - washing and showering them. . . anyone can do that. I don't want to do that anymore'*. She much prefers caring for patients who are acutely ill - *'it's satisfying to get them all sorted out, their IV lines, analgesia, catheters etc'*. Debra gains special pleasure from her teenage patients.

A CNS comes to recognise that even though the majority of patients will have similar diagnoses, surgical intervention, and medical treatment, each one is an individual, and she will attempt to treat them as such. Moreover she has to nurse a number of patients from among differing cultures and has discovered that *not all members of the same cultural group act in the same way when faced with the stress of illness and hospital.* Indeed, the special form of human experience brought about by hospitalisation brings out many differing ways of coping. And, with such a mixture of patients at the centre of her workworld, it necessarily is the case, a CNS will come across many diverse personalities.

And it comes as no surprise that not all patients are agreeable. Jayne says *'some of the patients you walk up to, you know you are not going to like them'*. In point of fact, the CNS has discovered *some drive* her *crazy* and can be *quite trying and require a lot of patience.* Jay for example, will tell you he's *'not very good with little old ladies and men who rave on - the ones who tell you a story for half an hour'*. He describes how he *'just waits for them to draw breath to make an excuse'* - or stands there *'just praying someone will call him away'*. And yet, he sees other CNSs enjoying this type of exchange - actively encouraging the patient's reminiscing - *'oh*

yes, and do tell me' they will say. Some patients love to talk, and the bedside nurse is a captive audience. Anne has recently been propositioned to appear in a documentary supposedly to be filmed by one patient whom she considers *'a crazy person - a real lunatic'.*

Without a doubt a CNS will have to contend with a range of unconventional behaviour emanating from patients, and will generally be disapproving of this aspect of her job. Carol recalls an elderly ex-school teacher *'charming by day, yet swinging punches by night'.* Carol says sometimes she thinks - *'when you are trying to do the right thing by these people why do they get so cranky and angry and violent?' Why do we have to put up with this nonsense?'* If she considers their action objectively of course she knows why, but nevertheless as she says, her immediate reaction is: *'to feel like swinging a punch back'.*

Sexist talk from patients induces the CNS to *switch off.* Generally it is restricted to conversation revolving around *'oh you married - why aren't you married?'* There was one patient recently according to Anne, who tried to *'crack on to the nurses all the time'*, but, she says, they all just kept a *'healthy distance'* from him. Carol speaks of a patient about whom she *'had reservations since* she *first met him'.* She explains: *'he called me 'love' and 'darling', and tried to turn things I said to him around in a suggestive way'.* Where other hospital personnel can avoid objectionable patients, or at the very least, effect a hasty retreat, the CNS has no such option. Her role sees her continually and inescapably *in contact* with the bedside. She can however, remove herself in other ways, Debra calls her technique *'dismissing' the person,* and explains:

> *Sometimes I take a dislike to people - quite a strong dislike - . . . and I prefer not to deal with that patient. I do all the basics, everything that's necessary but there's not that warmth that's between the patient and staff member normally.*

Nevertheless, a CNS can be forgiving, yet there is no doubt, just as a patient perceives a *good* and a *lesser* nurse, so too the CNS distinguishes good or bad patients. She can identify the *ideal* patient; the *difficult* one, and/or the *demanding* and *irritating* patient. The *ideal* patient is one who: *isn't saying 'do this, do that' and ringing on the buzzer every five minutes.* Moreover, the *ideal* patient is *one who might be really sick, but is really nice and what is more can speak English.* It is not necessarily that the work is easier with this kind of patient, but that there are less 'obstacles' to it.

Generally speaking, a patient will want to get better and want to be able to do things for themselves. On the other hand, the *demanding* patient is *self-centred; and wants someone to fuss over them.* Debra describes a demanding patient as someone-who thinks they are the only sick person on the ward and when she is doing something for someone who is really sick, they are demanding that she do something for them which is quite trivial by comparison. Demanding patients *whinge all the time,* and want to *tell you all their problems.* Annabelle has a demanding patient who insists she is present while he voids in a bottle even though he is capable of doing it himself. She is easy-going about it - *'I've been doing things like that for years - it's all part of his care'.*

A *difficult* patient is one who k*nows everything, and of course knows nothing;* is non compliant/unco-operative and/or who acts in an unexpected manner and who becomes even more *difficult* if incapable of understanding English. Debra:

> *. . . as soon as we put local in, he screamed and screamed and screamed and continued to scream throughout the entire procedure, and I found that a very difficult thing to deal with because I couldn't tell then what was happening, what was real, and what wasn't.*

She also recalls those *difficult* patients who come in for help, and yet do nothing but hinder their treatment program once admitted. Jay recollects a non compliant patient who *'got a pair of scissors and stuck them through the op-site* [of his wound] *to get rid of the exudate';* resulting in infection. There tend to be *'runs of patients who are really difficult to deal with',* he muses, and because managing such patients is an emotional *strain,* the CNS may *cut contact with them to a minimum.* Yet, for most of the time the CNS will *just put up with* what she regards as obnoxious behaviour, and *try and be as pleasant as possible.* Carol writes in her diary about a *difficult* patient whose behaviour was suffered by the staff without rebuke, and at the end of his stay *'the relatives thanked us for being 'so good' with him. Staff at other hospitals, they said, had been cruel to him and told him to get out. We felt like that',* admits Carol.

On occasions, when feeling 'out of sorts' and faced with a *difficult* or demanding patient the situation is exacerbated, and dealing with that patient can become *quite stressful.* At such times, a CNS having *had enough of* a certain individual, is tempted to be terse and may come straight out and say *'look why do you have to be such a pain? There are other sick people here.'* However,

this usually creates guilt because she has a deep seated belief she is *supposed to be able to put up with anything anyone throws at her - that nursing is selfless work and* she *just has to get on with it*. Debra:

> *. . . deep down that's why we're here - we want to care for sick people and then all of a sudden we're telling them off. . . . I get angry with myself if I get angry with a patient, because most of the time it's not their fault, they've got a difficult personality or whatever; or the difficulty lies with me. . . .*

A CNS is certainly *mindful of the patient as a whole,* and more often than not she will try to reason a cause for a person's *difficult* behaviour. Like Annabelle, whose patient is referred to as a *'pain'* by the nurse handing him over. After some thought Annabelle argues it might be because *'he's frightened'*. And, while she is aware it may simply be a personality clash, she goes on to suggest he *'might do better in a room with other people'*.

Because of her experience, a CNS has learnt *how to handle certain situations* involving patients. She is not a *complete push-over* and can *sum up a person pretty quickly*. Jayne sees this ability being tied in with the CNS *'becoming a bit less tolerant'*. In the following scenario, Bo describes her dealings with a patient to whom she refuses a dose of pethidine because she suspects abuse:

> *If I was more junior I would have gone and given him the pethidine without questioning because that's what he wanted. But knowing him and knowing him from his previous admissions, and knowing what he was like then - he didn't look distressed. . . . I just felt that he'd had two lots of medication within a short time and knowing the doctors were about to do a round I felt they needed to assess him again. Plus the fact that he's been off the ward and he's the same everytime - as soon as he gets an injection he does a vanishing act.*

Bo demonstrates not only her ability to stand by her convictions regarding the patient's motive for the narcotic (be they valid or not), but that the knowledge of this patient built up over a number of admissions informs her action. Here, too, she is exerting a degree of power over this patient - an aspect which appears lacking in many other areas of her nursing practice. Carol points out if she has a *difficult* patient, one who perhaps, *keeps telling her what to do* for example, she is not averse to retaining control by saying *'when you're in here, I'm the one that tells you what to do'*. In a similar vein, Jay says occasionally he uses his CNS status to exert control - *'I'm the specialist . . . so we're going to do it my way'*. Carol believes that *'showing them*

who's in-charge often gives them a sense of security'. Covert control established in more *subtle* ways; would include such things as taking her time to answer a buzzer; appearing super busy; appearing to be called away, and other strategies to limit her time at the bedside.

When all is said and done however, a CNS will mostly *be herself*, and because she is remarkably in-tune with her emotions, will more than likely readily admit she *can't cope* with a certain patient, or group of patients and *take the pressure off* by organising to swap them with someone else. This is not usually problematic - all nurses quickly become aware of *difficult* and *demanding* patients, and not all are equally as affected by them. Furthermore nurses are usually empathic enough to take turns caring for these patients. (A CNC working essentially on her own however, has no such choice).

So even though a CNS will tell you she does *take a lot of flack from patients* - generally she will be understanding of it (contrary to her attitude toward similar behaviour in doctors). It is this ability which she perceives makes her *a special person* in the overall dynamics of the ward.

Naturally, for the CNS; life is more pleasant if patients are uncomplaining. And, it is fair to say a CNS is far more likely to become upset with a complaining patient if she is on night duty. For the CNS not permanently rostered on them, night duty is seen as a time for patients to sleep - and she expects most of them to be doing just that. Behaviour normally tolerated on a day shift, can *become a bit much* on nights. (For Wolley it's different - the world of the night is normally hers). Jayne writes in her diary -

> *It would have been a quiet night except for Mrs* [ZYX] *buzzing literally every half hour for a pan with tiny amounts each time. At the start of the night she couldn't get out of bed; by the morning she was getting out by herself.*

-Being-in-the-world for Other than Patient-

Alongside patients can be found their relatives and friends. While a CNS will tell you her main concern is for the patients; she will also admit to having a responsibility towards their relatives as well. *'You don't just look after the one person in bed 10 for example, in the end you're looking after the whole family unit'*, remarks Anne. A CNS will observe and pick up on aspects of the well-being of a relative in much the same way as she does a patient, hence on occasions, a CNS

will find herself 'nursing' the relatives alongside the patient. Annabelle admits a patient whom she knows from a previous visit - his wife is relating to her all that has happened since the last admission. As she does so, she becomes distraught and begins to weep - reflexively Annabelle leaves the patient's side to place an arm around the woman in order to comfort her.

Annabelle says:

> *It happens quite often actually because it's quite major surgery they are going through and its elective so they sort of think have they done the right thing? I mean they've been told the risks, and all about it, and I guess all the moments sort of become precious. . .*

Carol, notices her patient's husband is becoming anxious because his wife has not returned from theatre. She goes to him and tells him she will ring Recovery to find out what is happening. Recovery inform her the patient is still in theatre, and knowing that would only alarm him she makes sure she proffers an explanation - this will take the form of something like: 'she probably went into theatre late because of some prior emergency', or 'the previous case was longer than expected'. *'I went and told him all that to try to calm him down and reassure him'*, Carol asserts.

In the following scenario, Carol demonstrates how she is able to juggle concern for the well-being of both patient and relative. It begins as a patient is being transported to theatre - as the trolley heads towards the lift the patient begins to weep - a silent weeping which contorts her face. Carol immediately wraps her hands around those of the patient and asks if she requires a tissue whereupon she runs back to the ward to get some. The patient, past middle-age and due for quite extensive oncological surgery continues to weep soundlessly. Carol returns and clasps her hands again - 'it's scary, isn't it?' she says softly. The lift arrives just as the patient's husband appears - Carol invites him into the crowded lift. He enters and as his wife continues to cry; Carol withdraws and allows him to comfort her. Carol is content to pat the patient's feet. The patient is wheeled along the green tunnel to the main lifts - a lift arrives and is filled with 'kitchen' women dressed in bright yellow; laughing and joking as they go about their work - the patient suppresses her tears beneath their gazes. The trolley arrives at the door of theatres and husband embraces wife, but Carol invites him into the 'airlock' and once there, coaxes him into a final farewell and he leaves.

To cover her hair Carol places a paper theatre cap on the patient's head - the theatre sister says *'there's your Christian Dior hat'*. The patient smiles wanly through her anguish. She is checked off against a list and all the while Carol is holding her hand. Carol goes to leave and the patient says to her *you will be there when I get back won't you?'* Carol nods and as she leaves she gently strokes the patient's cheek. Returning to the ward Carol meets the patient's husband who is forlorn, she takes him aside and tells him all about the ins-and-outs of theatre and recovery and so on, and when to expect his wife's return. Finally she invites him to seek a cup of tea in the tearoom. Carol looks upon the case as *'so sad'* because the patient is relatively young and her *'outcome is no future really'*. She wishes she could *'promise them everything would be fine'*, but all she can do is give them *'faith in the surgeon'*.

(Embroiled in conflict with her peers, suffering anguish from the unexpected suicide of the previous shift, Carol's day is becoming increasingly cheerless. Other than the sustenance acquired from a sense of 'togetherness' with her patients; on such a *bad day*, it is plain to see there is little caring on hand for her).

-Doing For the Patient-

A CNS's first loyalty is towards the patient, and as a result she is not averse to becoming the *tough guy*; the *nasty nurse* in order to intervene on the patient's behalf; especially with regard to over zealous relatives and friends; as Anne recalls:

> *We had one lady here, she was as sick as a dog. She'd had a laparotomy and was very unwell. She had literally 20 people in the room and they'd start arriving at 7am and get very angry with you if you started shuffling around the door - they thought we were being difficult. But she needed time-out, and in the end we banned the lot of them, and we said the husband can come in; the kids, and her mother and father but the rest of you, sorry . . .*

A CNS does this to save the patient from having to say it. Other examples of her advocacy role include organising counselling sessions for an angry patient and her husband to assist them in coming to terms with her terminal diagnosis; calling on the diet-aide to discuss the unhappiness expressed by a patient in regard to her diet; bringing to the attention of the MO a patient exhibiting signs of heamaturia, together with noticing a patient's early morning blood sugar levels have been unusually low and liaising with the MO to adjust the insulin regime.

In her role as patient advocate, a CNS is not averse to undertaking a bit of *detective work.* Closely aligned to her role of *chasing up, detective work* requires greater commitment on her behalf, and involves the possibility of pointing out to a MO an aspect regarding the patient's care that may have been completely overlooked. Wolley for example, notices an abnormality on a chest x-ray which leads her to investigate the identity of the abnormality and why it has gone unnoticed. Although it turns out to be fairly innocuous to the patient - it proves useful to learn the object is an old central catheter.

A CNS has *a good working knowledge* of the medical treatment for the condition in which she is specialised. More often than not, she knows what is best for her patient. Annabelle, for example, sits down for 10 minutes with one patient to explain the need for him to take stronger analgesics. In addition, Annabelle, knowing *'they've been putting a lot of patients on sotolol or verapermil,* questions why they *'didn't do that with* [another of her patients] *because everybody with the slightest change gets put on those medications'.* Such knowledge affords her the confidence to liaise with medical staff. In point of fact she will often suggest or remind MOs about treatments or strategies to assist in enhancing patient comfort - especially if it facilitates the patient's compliance with other treatments. Annabelle always makes sure the MO has ordered paracetamol prior to the patient's physiotherapy, for example. In this way she facilitates recovery as quickly as possible.

For the CNS, *basic nursing care,* is just that - *very basic,* and yet for the patient it means a great deal. After surgery it is usually the case, the patient, who has not given a second thought to the *ordinary simple things in life like being able to walk to the toilet or wash their own back,* suddenly finds they are incapable of carrying out such activities, and it is the nurse who steps in and redresses the deficits. Carol takes a patient for his first post-op shower, and although he assures her he can manage on his own, as she is about to leave he suddenly 'gets cold feet' and urges her to stay. Annabelle, tells her patients she is going to try and get them to do as much as they can for themselves before they go home. Yet, she takes pride in assisting her patients to have a thoroughly *good* shower because she knows they feel so much *better* afterwards - *'they feel they are ready to face the day',* she says, which makes *'such a difference to their overall outlook'.*

A CNS will also gain pleasure from seeing a patient discharged after the trauma of illness and surgery: and will have monitored the signs of progress and recovery in a patient along the route. Like Carol, who makes it known for example, that from her point of view: *'it's always good to see a woman putting on a bit of make-up to make them feel good again - if they are interested enough to do that - it's a good sign'.* Annabelle writes about one patient who has had a number of complications, and after four and a half weeks has finally regained enough independence to think about going home. *'I am so pleased for her, and that our patience with her has been well worth it; although it was quite trying at times'.* As a rule, the sicker the patient originally - the greater the reward in seeing them recover. *'Having done a good job, making someone better is satisfying'* says Anne, who writes for example:

> *Sending [*Milo*] home . . . he's the one who had the sarcoma and had a revolting dressing, and they chopped half his guts out and sewed him back together, and now he's going home and he's looking so well. It's very satisfying that he's got over all that chemo, and the surgery and he's bounced right back, and just looking so fit and healthy. And he was very happy, and his wife was very happy . . .*

Nevertheless, because it means leaving the hospital - not all patients are keen to regain their independence. Annabelle recognises a patient requiring extra-education, counselling and encouragement in preparation for his discharge. Describing the patient as *'a lonely man who feels insecure about leaving hospital'*, with the assistance of a social worker; discharge liaison sister, and his local parish priest, she organises for him to be placed short-term in a hostel immediately after discharge so that his transition to home can be eased. Annabelle is demonstrating she is not only in-the-world-*for* the patient, but in-the-world-*with* him as well.

Being-in-the-world With the Patient

-Knowing the Patient-

A CNS will tell you that being CNS is first and foremost *looking after patients*, and that patients form the centre of her nursingworld. One of the greatest strengths of her enduring presence on the ward is that she gets to know the patients. She gets to know them not only in terms of their medical problems, but also as human beings. It is a fact, more than any other health care professional the long-term bedside nurse will come closer to the nature of the patient's world - discovering more about their psycho-social situatedness than any other member of staff in the

hospital. For her, knowing the patient is *getting to know them on a personal level, what they are like, chatting to them, finding out about their family, and picking up little hints about what is going on in their lives.*

Jay expounds on this concept:

> *I actually like talking to the patients, just on a daily basis - you might be talking trivial things, but in that way you get to know them. By talking trivial things I think you are more inclined to pick-up when something is not normal without them necessarily saying anything.*

A CNS will actively seek out this information through conversation and when she *walks away from the bedside,* she *consciously finds ways to get back* in order to continue the dialogue. In this way she augments her store of knowledge about the patient which may eventually assist in providing information to further smooth their way to successful recovery. Knowing about a patient makes a difference to their care attests Wolley - *'because you're going to treat someone differently if you know their situation'.*

Moreover, when a CNS does get to know a patient, particularly those who come back a few times, she gets to know *what normal is* for that patient, which in turn helps her to *recognise when something is abnormal.* Bearing in mind that what is normal for one may not necessarily be normal for another. Sarah, for example, has a patient who is vomiting *'which isn't normal for her'.* And while she knows vomiting is possible following the type of surgery this patient has had, she perceives it to be *'a bit more than normal'.* (Like any CNS she seeks the cause of the irregularity and when finally she traces it - she brings the matter to the notice of the MOs on the 'round', *'so they can attempt to fix it').* Wolley has a patient who is dyspnoeic *'which isn't like her'.* Anne has a patient who apologises for his behaviour during the night; *'but'*, she says, *'he always says that in the morning'.*

Unlike the medical staff, a CNS will locate herself in the patient's space (Watson, 1994).

As Wolley points out:

> *The doctors just don't have that time, or they don't want that time - it's a whole different situation - you couldn't get them to make a bed so they don't have time to know what sort of social background the patient comes from - what's going on with that patient's family before they left home or any of those things. They just sit down and ask questions and then it's only what the patient chooses to tell them. Yet, you find out all these other things while you're just making their beds.*

A CNS is 'attuned' to what the patient is saying to her and as she watches his/her face she will garner non-verbal cues as well. Should she see a 'reaching out' for her, she 'presences' herself with the patient. Experience has taught her differing approaches for entering a patient's time and space. *'If a patient is handled in a certain way you can reduce their fears'*, Carol points out. *'With the right approach you can make the person who is suffering feel much better about things'.* Often-times she will use touch, and yet at others she senses it inappropriate and utilises words instead.

For many people on [Rose ward]. Anne says:

> *They get their pathology and they think well that's the end of it, I'm going to die. But, you've got to say to them 'look you can't look at this disease this way'. We try to be optimistic with them.*

This extract from Annabelle's diary illustrates how getting to know the patient assists in carrying out requisite treatment:

> *Mr* [RST] *who had coronary artery grafts is to be discharged tomorrow. I had to take his pacing wires and tube suture out. He is a very anxious man and was working up into near panic about the procedure. But, because I looked after him over the last few days; I had gained his confidence, and after much reassurance and explanation of the procedure I managed to remove the wires and sutures without a hitch. After that he was much more relaxed - his blood pressure even came down.*

Annabelle, having nursed this patient over a period of time, has established *baseline trust.* Assessing his psyche and perceiving him nervous she spends more time preparing him for the procedure. Of central importance to the well-being of this patient is Annabelle's advanced skill that enables her to carry out the procedure effortlessly thus reaffirming the patient's confidence

in her ability. A less experienced nurse may not have been so successful.

Not *knowing* a patient on the other hand, not even their medical history - makes it impossible to proffer holistic and constructive caring. Jay, for example, has to visit another ward to dress the wound of a patient who should have been on [Rose ward], but due to other medical problems has been admitted elsewhere. The woman is obviously concerned about her wound and pathology results and asks a number of leading questions, to which Jay can only respond ineffectually - as he says; *'it's difficult because I don't know her - I've never met her before'.*

There are degrees to the depth of knowledge a CNS gleans about a patient. This description from Jay unveils the concept of knowing patients on a superficial level:

> *. . . for the patients on this ward I'll know yes, that person can get up: that person must stay in bed; . . .whether they need a hand to sit up to have their meal, whether they can wash themselves in bed, or whether they actually need assistance to do it. Knowing that person probably needs a bit more attention than another, and that one can look after themselves and you're just pandering to them if you actually do anything. . . . and even the really little things like whether they like the big light on, or the little light on.*

Not surprisingly, the depth of knowledge the CNS accrues about a patient is directly proportional to the amount of time she passes with him/her. (As previously stated, a doctor spends minimal time at the bedside, and paradoxically the higher the competence of the medical officer the less time spent). A junior nurse, more concerned about the technical aspects of patient care, may spend time with the patient, yet in so doing focuses on the physical world about the patient leading her to overlook certain emotional factors. The CNS, on the other hand, is assured enough in her role to be able to deal with both. Making time to get to know and harvest *'the in-between'* information about the patient can, and does, make a difference to their overall care and outcome.

Annabelle is showering a woman who becomes breathless. She takes up the story:

> *It didn't worry me because with a history like hers I felt she probably would have an episode like that. . . . maybe she needs to go back on the Becloforte* [medication] *she came in with. She's a long time asthmatic and hasn't been having any cortisone. . . . they may have put her back on it when they did the round this morning but often times they overlook these things. . .*

The CNS demonstrates a deeper than superficial level of 'knowledge' regarding this patient. To begin with, a less experienced nurse or a relief nurse would not have known the patient's medical history to this extent. Furthermore, Annabelle having been-with the patient throughout her morning shower, and over consecutive days, has observed signs and symptoms which indicate the patient requires better control of her asthma: consequently she will make sure she *chases up* the medical staff to re-prescribe the patient's medication. What is more, she has been able to ascertain the patient's overall physical capabilities which indicate she is still in need of considerable assistance in many areas; despite her hospital stay drawing to an end. In which case Annabelle will make certain she unearths information regarding the patient's home environment with a view to promoting a realistic discharge.

It may even be the case, the CNS will *get to know* a group of patients one day, and if not caring directly for them the following shift, goes out of her way to revisit them. Carol goes back to see the women for whom she cared the previous evening. She is particularly concerned about one who is scheduled for a repeat neck dissection, and *'a bit upset about it'.* As soon as Carol enters the bay she is greeted and assailed with requests to assist with aspects of their care - *'Oh good now you're here you can do* [such and such]'. As a matter of fact, patients will often express pleasure at seeing a CNS, particularly if the ward has been recently staffed by relief or agency nurses. Without a doubt, patients prefer to be nursed by *someone who obviously knows what she's doing and who knows them.* After only one shift, Carol has developed a relationship with these women - such that would be virtually impossible in any other setting but a sick bay.

Because she is permanently rostered to the ward a CNS can get to know a patient well, especially if she sees him/her on a long term basis or the patient returns time and again. Knowing a patient in more depth enables the CNS to more accurately gauge the recovery process and give realistic encouragement along the way. For example, on [Violet ward] a patient came from the outpatient clinic to have packing reapplied to a gaping wound in the small of his back. Annabelle who performs the dressing, constantly reinforces how much better the wound is looking, which obviously pleases the patient, and yet to an observer seeing the wound for the first time, it looks extensive even at this stage.

Later Annabelle remarks:

> *Actually it's a lot better - when he first came in he had a drain in it and it really was a lot bigger and he was on IV antibiotics and a PCA for pain. It was really sore, and now you would hardly recognise him from when he was an in-patient.*

-The Special Patient-

On [Rose ward] there was one patient who had been in hospital for about six months, and *was a scream.* She became *'almost part of the furniture, even to the point if she didn't like the menu she'd cross the whole thing out and write in what she wanted, and they'd send it to her'*, recalls Anne. This patient was actually admired by the staff because *she went through so much without becoming 'neurotic' and 'hospitalised'.* The nurses eventually took her in a wheelchair to a local restaurant on *a ward night out.* Anne remembers: *'she was good value - she still pops in from time to time'.* The patient with whom a CNS *gets involved* to this extent may well become a *favourite* patient. Of a favourite patient, the CNS will tell you: *'you get close to them because you see them everyday and they get to know you. You always give them a bit of a hug and a kiss when they go'.*

Having a *favourite* patient can also be described as being *attached to*, or being *fond of* the patient. For the favourite patient a CNS will do *extra little things* and may even *run errands.* Daisy for example, and Bertha who has suffered many complications prolonging her stay over many weeks, and others who keep coming back are favourite patients of a number of the staff - even, it could be said - of the ward. Bertha, who up until last week was *so uncomplaining and a pleasure*, is now becoming quite *agitated* on the ward, and hence *harder to deal with.* Finally she is being transferred to a hospital closer to home. The nurses approach her with gestures of affection to say farewell. Carol, who is happy for her, says:

> *She's been here for a long time and I've got to know her quite well. . . . It's the best thing that could happen - unfortunately she won't live very long and it's best she is with her family in her local surroundings and enjoys what time she has left. . .*

Not every patient will be a favourite, and although a number of staff can become *attached* to the same patient; it is not necessarily the case a *favourite* of one, is the *favourite* of another. Debra says: *'there are some you don't get to know because you never look after them and some who you just can't stand. I mean we are all human beings'.* Sometimes, a CNS will go one step further with a favourite patient and develop a *real connection.* This will encompass a deep mutual regard on behalf of both patient and nurse - in a sense the original attachment becomes stronger. A patient will *connect* with a nurse because *they can't do it with a doctor: they don't spend the time with them.* While it makes her feel *good* having patients *connect* with her, it also makes her job harder because it is usually the chronically ill patients who do the connecting. For Debra, often they are in situations where she knows *'they are not going to get a lot of help, nor that the treatment is going to make a positive difference'.* Connecting with the patient implies more commitment, and usually finds the patient and nurse entering each others worlds. Because she works more closely on a one-to-one basis with a smaller group of patients, it is generally the CNC to whom a patient will *connect.* Debra says this is because the patients *'have so many nurses treat them and look after them, often just having one person to focus on is easier to handle'.*

Debra recollects one patient she was treating for fungating breast cancer with whom she *connected,* and who she greatly admired because of her *'inner beauty and strength (not evident in a lot of people)'.* Debra says of this patient; *'I treated her with chemotherapy, I gave her all sorts of things that made her sick, but she never ever associated me with what was happening - she never took it out on me'.* Debra recalls an incident concerning this patient:

> *. . . I remember one day she went for a test: a gated heart pool scan, and it took forever. Sometimes they do because the machine's broken down and they keep them waiting or whatever. I kept ringing up and was told she was okay and they were just ringing the porters and so on. But time went on and on and in the end I rang again and said 'look what's going on?' and they said 'oh the porters are still not here'; which meant she* [the patient] *had been waiting something like 2 and a half hours for a porter.*

Debra rang the porters herself and was told this patient was well down on their list of priorities.

She continues:

> *. . . I remember feeling really angry, so I went to see what was going on. I walked over there and on my way I walked past the porters' bay and I could hear them down there, and it just made me feel really really angry. When I got up there she just looked at me and burst into tears and said; 'I knew you'd come and get me, I knew you'd come and get me'. Anyway I wheeled her back on the trolley myself [not an easy task]. Cried all the way back, and she wouldn't leave the ward again unless I went with her.*

Debra describes her involvement with the patients with whom she *connects* as occasionally going *beyond the call of duty* even to the point of taking risks. In this scenario she relives her role in acting for this same patient, which although a gamble worked out well in the end:

> *Her husband was a sailor and was on a ship, and there was one point there when we thought she wouldn't be around much longer. . . . she was really unwell and we were going to pull her lines out because she wasn't tolerating things at all. But, she wouldn't have him called, she didn't want to bother him, letting him know how sick she was. Anyway, I got in contact with the ship and got him back the next day, and the look on her face when she saw him - it was just - well real gratitude. . . . As it turned out, he did spend the last few months with her.*

By and large, establishing a special bond with a nurse might be the very thing that sustains a patient through either the period of hospitalisation - or indeed through transition to death.

-Intersubjectivity-Gaining Access to a Sense of Other-

While a CNS might admit any number of patients to the ward for the same surgery each and every day, she is aware this may be the patient's first contact with a hospital and treats him/her accordingly. Whereas medicine is on hand for care of physical disease (van den Berg, 1966), and regards the patient essentially as an object at its disposal - because as an experienced nurse she perceives her primary responsibility is to provide *comfort* to a patient, a CNS is more attuned to inter-human relations and looks to the patient's emotional and spiritual needs as well. Whereas a novice would have difficulty trying to discover the reality of another's life, the CNS does it with ease. Her maturity, the confidence she possesses in her role, the past experience she brings to the encounter smooths the way and enables her to *relate* to the patient. To this end she will

endeavour to locate herself in the patient's existence, that is, to put herself 'in the place of the patient' (van den Berg, 1966:79). She will say to herself: *just think how you'd feel in their situation.*

Obviously this is easier if the patient can express their thoughts and feelings to her verbally. Unable to share even the art of common language by which to attempt a 'crossing over into the patient's world' (Watson, 1994:6), the CNS finds the task of grasping the patient's reality more difficult. Language, playing as it does, such an essential role in understanding another's ways of knowing. Nevertheless, time and experience have taught her means of communicating, and there is no doubt she is able to grasp a patient's standpoint with an insight rarely found in other hospital personnel. In many cases she is able to construct a view of their world even without spoken communication. One older non-English speaking woman is admitted with advanced fungating breast cancer, and yet within a short period the CNSs have established a mode of human contact which does not include verbal communication, and even contend they have *got to know her.*

A CNS will see to a *patient's physical comfort first and foremost,* and then *settles back to be completely attentive to their emotional needs.* She looks beyond drug therapy and explores other avenues *in order to sense how they* [the patient] *actually are.* Annabelle describes these tactics as: *'talking to the patient and trying to comfort them or making them feel physically better. Trying to find out what's going on with them and putting it right'.* Comfort is brought about in a myriad of thoughtful, but often unseen ways.

Eventually, discerning a patient's emotional state above their physical status becomes second nature. At handover for example, while a CNS may give an extensive medical account of a patient, she is likely to finish with a comment such as: *'. . . but he's a patient who is quite lonely and needs someone to sit down and talk to him'.* A doctor would rarely make the same observation. Anne recognises the young man waiting for his pathology result is *'a lot more stressed than he normally is'* - whereas to an observer he actually appears quite at ease. Annabelle illustrates the point when she discusses *some of the lung cases:*

. . . if they are diagnosed with cancer they are angry at what's happening, and generally angry at everybody and everything. Especially the ones who don't have a very good prognosis; they make it very hard. . . and in that case you have to understand their psyche and nurse them with that in mind. Basically you treat every patient as an individual. You can't just say 'everybody have a dish, and everybody do this'. Each one is different.

Carol expresses insight into the world of a patient admitted for surgery to metastases missed on a previous scan, and about which she and her husband appear to have been misinformed:

They've disappeared off the ward; they keep disappearing; they are obviously stressed out and are away by themselves trying to deal with it. . . .he's upset as well; he's got watery eyes. . .They are off trying to cope with it all themselves and digest the news they've had. . . .they are going to need a lot of support. There have been a lot of doctors standing around talking to them and we all know they don't hear much of what is said at the time, so I will need to follow that up with plain English. . . .and she's going to be really angry because she thinks she's been misdiagnosed. . ..

A CNS can become so discerning of emotional states she can predict with some confidence how a patient will *'take something'* as Anne explains:

. . . you can pick them. When I'm taking down a graft I always ask them if anybody has explained to them what the graft is going to look like - because I know damn well the doctors haven't. And then I say it's going to look dreadful and so on and so forth, and I always know the ones who are going to burst into tears, and so I have a box of tissues ready. . . . when you see the same patients - not the same personality types obviously, but having the same sorts of surgery, same sorts of prognosis you tend to be able to pick what they are like after just a two minute conversation with them.

Later on, Anne is concentrating on the job of draining a lymphocele and all the while is conversing with the patient. Where a less experienced nurse would have found it impossible to carry out both tasks at once, Anne is able to empathise with the patient's emotional state and simultaneously carry out the complex psycho-motor skill. She cares about the psychological impact the illness has on this person - *'given his position'*, she says, *'I would be nervous too'*. In a sense, she validates his feelings for him. Anne assumes every patient who comes in is anxious *'you've just got different levels of anxiety from mild anxiety to sheer terror'*. She explains further:

. . . anybody who comes back with a lymphocele you just know at the back of their minds they are all thinking 'oh, is it a recurrence of the melanoma, or is it just fluid?' . . . he was obviously quite concerned about that pain because he mentioned it twice. So I was making it quite clear to him that it was most likely because of this fluid. . . I was trying to allay his fears without allowing him to become complacent. Because when you've got melanoma - it's such a capricious disease you can't say 'oh it's nothing; don't worry about it, go home'. So I did try to allay his fears but still make him realise that it's something he's got to keep an eye on. . . . they are always pleased to know it's just fluid anyway . . . I don't even wait for them to ask - I just tell them 'wow one hundred mls!'

I've had a few [ex-patients] *ring up* [with swelling] *and say, 'Oh I've got to come in now', and no matter what's on, I say 'okay come in; it's alright we'll fix you up'. Because you can't leave people overnight thinking 'I'm dying'.*

Through the process of being-with and getting to know the patient a CNS allows the patient to re-visit their lives outside of the sick place, and on occasions she may strike deep emotional problems in their life which she is unable to manage alone. Just as she would refer a physical problem under those circumstances to another team, so too she seeks outside assistance for psychological concerns. In actual fact, referring to other teams on behalf of the patient is part and parcel of her role. Annabelle has a patient who is connected to a patient controlled analgesia machine (PCA) and over the course of her caring for him, she notices he is reluctant to use it. She questions him and it is revealed that despite the anti-emetics she is giving him, the PCA medication causes him to feel nauseous. Annabelle seeks out the PCA-Team and asks them to review the patient. As a result, he is switched to oral analgesia which suits him much better and he begins to eat and drink.

There is no doubt a CNS can be a patient's 'best friend' - she takes the patient's side and knows a great deal more about the patient's daily existence than the doctor will ever know. She is privy to the patient's life beyond the immediate horizon of the hospital - she has gone even to the borders of their previous healthy existence (van den Berg, 1966). Armed with this information she is often prepared to do battle in the patient's best interest. Wolley addresses this notion:

There was a situation here recently - a person who was in an abusive situation at home and could not go home that day because they could not have coped with that situation that day. Well, without having to tell the whole world what was happening - when the doctor said 'you can go home today', because it was Friday and there were no theatres it was easy enough to say 'she's not ready - I think she should stay a couple more days'. Well that was okay, that person got to stay, but she did not want to tell the doctor about her situation.

Fortunately for the patient this doctor took heed of Wolley's voice; had he not, Wolley says, she would have had to take him aside and explain the woman's plight. At other times, the CNS is just plain patient-advocate based on her knowledge and understanding of the harsh reality of their immediate predicament. Wolley is even prepared to challenge senior medicine on behalf of this patient - as she illumines in this scenario:

> *. . .a patient was going home, that patient could not sit down; yet, that doctor was sending him home in an aeroplane - an ordinary* [Airborne] *flight. . .In my opinion, that patient had to go via air ambulance, he would have had to stand up at the back of the plane if he'd gone on an ordinary domestic flight. He would have had to stand up where the suits hang because he couldn't sit - for the whole flight.*

> *. . . so you actually have to put your foot down in those situations and say 'well I'm organising something different, will you okay this?' and the doctor this time got such a shock; 'yes' he okayed it. I mean he wouldn't have even thought about it - he's supposed to be that man's doctor - it's ridiculous - he was the one who did the op. He knows he can't sit down - he tells him everyday 'don't sit down'.*

One of the best rewards a patient can furnish the CNS is for her to see them return for their checkups once recovered from their surgery and *they have a new lease of life.* It makes her feel *really good.* Some patient's will come back and visit just to see the nurses. Carol receives gifts from an ex-patient whom she *'has got to know quite well'.* Carol says:

> *She started knitting these coat hangers for me. . . and she promised to knit me some more but I'd forgotten about it. I just hadn't seen her for six or eight months whatever it is, and here she arrives today with a bag full of coat hangers for me. I'm delighted about them. . .*

Debra is rewarded when she receives letters from a young patient whom she treated for cancer two years ago. She admires and respects this twenty year old because *'he's getting on with his life. . . coping with issues most people would go into depression over'.* Debra has a special admiration for the oncology patients who return because they face *'that whole emotional side of being sick with chemotherapy and coming back to hospital. The sort of psychomotor throwing up anticipatory nausea just coming back into the place and the memories'.* She had one patient who would come to visit her, but because of the emotions it stirred up, could not step into the ward.

So, he would ring her from downstairs and they would meet halfway. Mostly, for her, it is the teenagers who come back: *'the adults have got other things going on in their lives'.* Debra says, *'for some reason, whenever I get really really down, one of my patients always shows up to visit. . . and that just changes my whole outlook'.*

Carol writes in her diary about a phone call she receives from an old patient who *'rings from time to time'*:

> *Today he rang me to say hello, and to ask me about some swelling under his arm. I got news of his family and friends - all first names, as if I know who they are and what relationship they are to him, what the local doctor thinks, who he beat at bowls. . .*

Yet far from being troublesome, Carol describes this call as the *'highlight of her day'.* And so it can be seen, for the most part a CNS will enjoy visits by ex-patients.

Nevertheless, with the odd patient it can start to become a regular thing, and ends up becoming *a bit too much* - almost as if *they can't make that break from the hospital.* Frequent visits or visits that go on too long, especially if they impinge on the nurses space in the tearoom for example, can turn sour. Anne explains: *'it becomes like this, I think I really don't want to have to talk to you because it's hard work. . . . basically all you've got in common with these people is the fact they are sick'.*

-Living with Death-

Not all patients have the opportunity to come back and visit however - some never make it to discharge. Generally, on [Violet ward] the patients have their operation, *do the right thing* by getting better and then go home. And the CNS enjoys that reality. But on occasions there are one or two who will die before, during or after their surgery, which still comes *as a bit of a shock.* The patient who collapsed on [Daffodil ward] in Bo's scenario earlier in the text, was subsequently transferred intubated to ICU. Even though she had only come to know the patient on a superficial level, Bo expresses a particular sadness at the plight of this patient, because she was young and her deterioration sudden, and what is more she had revealed personal details about her other life - including she was soon to be married. And, although it is true that the extent to which the CNS comes to know the patient has numerous benefits for optimum care, it is

necessarily the case, the closer the nurse becomes the more vulnerable she is should the patient suddenly deteriorate or die. Having a favourite patient die can be very traumatic for a CNS.

On [Rose ward] however, where death is more acceptable; it may be the case a dying patient reaches a stage where a CNS actually wishes it be sooner rather than later because, for this patient, death is seen *as a blessing*. In terms of caring for the dying patient sometimes a CNS might be *right in the thick of it*, and at other times *on the edge of it.*

As Carol explains:

> *If you get assigned to that [dying] patient, or you choose to look after them for a few days in a row, then you get to know them well. You take over that role of being the support person with the help of lots of other people. Whereas someone down the other end of the ward who might be in a similar situation you don't look after them for a few days, and you feel you don't know much about what is happening, so you tend to stay away.*

On [Rose ward] the CNS will tell you *'our patients face death, and the likelihood of death constantly and therefore we face it with them'*. In which case she spends time comforting and supporting patients and their families through some very difficult times, and mental counselling - keeping the human spirit alive, plays a major part in her role. The CNS recognises it is often not in-depth counselling the patient requires, just someone who can empathise with what is happening to them, and listen to what they have to say. Someone to be present who allows the patient to take part once again in the life they used to know (van den Berg, 1966). Carol describes a night she spent with Daisy; a relatively young woman with school-age children, who is dying of her disease:

> *On this night I sat with her for about an hour in the TV room where she tried to get comfortable in 'the Chair'. . .. We talked about family and school and home and general things, as well as her illness and treatment. We talked about what a 'good bloke' her doctor is. We talked about positive thinking and I told her stories of other patients whose quality of life was enhanced by a positive attitude. We skirted around the subject of death. . . Privately I admired her guts and wondered what I would be like in her situation. I made her a cup of tea and prepared to leave to do some work. Then suddenly, she said how much she appreciated my talking to her - not just now, but always, since her early admissions, and that sometimes, when I was on days off, she felt she needed me.*

There is no doubt, a CNS preserves contemporary society's 'rejection of death' (van den Berg 1966:45) and will seldom broach the subject first. Anne maintains; *'I don't like talking about death. . . I won't initiate that conversation; I leave it to them'*. Debra, for whose patients death is more tangible, comes somehow closer to her patients, (perhaps through her *connecting* phenomenon), and is therefore able to discuss it more openly. Debra has a patient who, because of her religious beliefs, is undecided about the treatment options regarding her cancer.

Debra says of the patient:

> *This is the biggest issue that has confronted her by far; she'd never had any major decisions to make for herself before; she was losing control; she was scared. The major thing was that she had to trust someone else with her religious beliefs, and her life. . . .*

Debra sits down with her and discusses her options. She continues the story:

> *We discussed death and what her 'real' death would probably be like. . . . we finished by discussing with her sisters some questions they had. I sent her home to talk with her friends.*
>
> *She rang me yesterday to tell me she was having the treatment offered. A smile came across my face - I could feel it. The relief I felt was enormous. I really believe it is her only chance. But I didn't push her, I just gave her the facts. We tossed them about, discussed her fears and I threw the decision back to her, gave her control. I feel good for her. . .*

By and large, a dying patient may come to depend on the CNS, and she accepts this. In point of fact the CNS may be entrusted with knowledge about a patient's life that even a close friend is denied. Carol, has spoken only briefly to the wife of a dying patient and has already been privy to confidential family details. Because she is the principal carer of the one who is loved, the relatives of the very ill, hurting and vulnerable, tend to lean heavily on the bedside nurse.

Nevertheless, despite her belief that being-with the patient is for their *emotional well-being* together with that of their families, the CNS will not force her attention or her opinions on them. *'If they are not interested in us getting through to them in that way, then we stick to the practical aspects'* attests Anne, *'you've got to allow people to give you only as much as they want'*. Moreover she recognises not everyone wants to confide in the particular nurse caring for them. Some of the staff have differing counselling techniques *'you can usually suss out what they* [the

patients] *are looking for, and if we know someone whose technique will suit them we'll get them to talk to them'*, maintains Wolley - who frequently finds herself communing with anxious and depressed patients at night. Wolley sees talking/listening sessions as all part of increasing the comfort of a patient.

She takes an holistic approach to comfort as she explains:

> *And while you're doing that* [listening] *you make them feel comfortable physically too. You make the bed more comfortable; you might rub their back; you might give them a hot pack; you might give them pain relief - whatever they're wanting - or if they want to see their family. I'm happy enough for the family to stay all night. That to me is making them comfortable.*

As Daisy gets closer to death, Carol discovers she is unable to provide even physical comfort - all she can do basically, is be-with her. To guide her caring, Carol imagines herself in the same position. Carol explains:

> *I suppose I feel inadequate because I can't make her comfortable. . .I just wish it would hurry up and let things go on. Let the relatives go through the pain they are inevitably going to go through, and start to recover instead of dragging it out. I hope someone will be there to hold my hand and mop my brow there must be nothing worse than dying by yourself.*

Daisy eventually dies and because she *fought the whole way,* and was *very frightened of dying,* there was a feeling of *relief* when death came, but it had quite a marked effect on a number of the staff. A CNS will tell you *some cases will be traumatic, and yet others only sad depending on the degree of attachment.* In many cases there is just empathy, *a feeling sorry for and with,* both the family and the patient. Jayne will tell you: *'in most cases it's more upsetting seeing the relatives than the patient. S/he's not there anymore, but the relatives are. If they are really upset that makes me feel upset'.* Anne endorses this view - claiming that when a patient is dying: *'of equal concern are the family because the patient is almost dead anyway'.* Bo believes there is no harm in showing the relatives that you are upset too. *'It shows you're only human'.* Anne admits she protects herself by never getting *really close* - by *distancing herself* from the patient. *'Besides'* as she points out *:'if you crack up everytime a patient dies, what use are you to everybody else? That patient is dead, we have to take care of the living'.*

For a nurse, death traditionally comes in 'three's'. On [Rose ward] it is more pervasive. Shortly after the death of Daisy another 'thirty something' patient is brought in, and *from the look of him doesn't look as if he'll last very long.*

Carol talks about what it means to live in the presence of death:

> *We had the death of a patient last week and I thought 'well, here we go again'. It's just tragic, and you look at that person and you think well he hasn't got long and you have to go through the whole routine with his wife again. Coming to terms with it, and you don't know what stage they are at, and whether they are still hoping he will get better, or are they thinking he is going to get better? It's just going over old ground I suppose. You have to go through all that sadness again.*

Aside from the odd occasions when *it all becomes a bit morbid* - the oncology CNS perceives looking after a dying patient is rewarding. In general, she has lost the patience to nurse others with lesser problems; particularly those who *act like they're dying*. Considering these patients *wimps*, she is likely to advise them to *'get real, there's nothing wrong with you'*. She considers herself better off in a ward where she senses that what she does for a patient is important to them, it may even be *the last thing anybody does do for them because they are going to die*. She will be highly protective of dying patients - Wolley as mentioned earlier, covets the moments she spends with her patients; who *'may not have too many moments left'*. All in all, a CNS will be guided by the maxims - to show respect for people even when they are unconscious and/or dying; to be aware that hearing is still viable even if the patient is unresponsive, and above all else to treat the patient in death as she would wish a member of her own family treated.

Anne recalls an incident from earlier days which she retells to junior nurses. She does this to reinforce her strong belief in the patient's senses remaining intact even if the patient appears *non compos mentis*. The episode took place on a ward she refers to as *'club veg'* (neurology).

> *I remember this one fellow, he'd had an infected AV shunt and was a little bit 'knocked off' from this - he was a big guy, really tall guy, and he used to sit there dribbling, and he had this nasogastric tube in and I'd go in there and have a chat, blah blah, how you going? And I remember one evening going in there, and the hospital hadn't paid its bill for neutrofeed bags, so we were syringe feeding everyone. And, you know how you're not supposed to use the plunger to shove the Ensure down, but you do it anyway because it won't go in otherwise; and it was blocked, so I'm pushing at it trying to get it going, and it just exploded all over the place.*

I was covered in Ensure; he was covered in Ensure; the walls were covered in Ensure, it was just all over the place. And he started laughing at me, and a week later that guy was fully conscious and he walked out. He said he knew what was happening, he just couldn't express himself, and so that's the way I look at it with all of them.

Just as the CNS is protective of her patients, so too some patients may be concerned about the well-being of the nurse and may even feel the need to protect her from what they regard might be the wrath of medicine, or even a mythical Matron. This need is evident because most patient's do not see nurses as autonomous in their practice. As an example, Jay describes an encounter he has with one patient who has returned from theatre, and whose wound has begun to leak. As dressing sister, Jay goes to investigate and informs the patient he wishes to take the dressing down, observe the leak, and redress it. Although she is not happy about this, believing a doctor should look at it first, she eventually agrees to Jay's appraisal after he explains he is actually a specialist nurse and that medicine leaves *'that sort of thing to us'*. Notwithstanding, Jay is convinced that apart from worrying he would do something *'wrong with the wound'*, she was also *'terribly worried I'd get into trouble'*.

Even severely incapacitated patients will consider the nurse. Carol goes into a very sick patient's room and asks him if he would like to stay in bed or try sitting out in a chair, to which he replies *'whatever is easier for you'*. A CNS will admire these patients; mostly for their ability to *handle things so well, considering what they have been dealt.* She will tell you about the patients she meets who *manage to smile through incredible adversity* and fill her with humility, and yet others who *forget to remind themselves how lucky they are.*

Long after they have gone, a CNS will remember the names of her 'special' patients, the ones to whom her presence made a difference in life, or death, and who in turn made a difference to her life. Such patients bring to recognition the worth of the phenomenon CNS and persuade her that perhaps the horizon of her being should encompass bedside nursing for just that little bit longer.

THE PHENOMENOLOGICAL TEXT- PATIENT INTERVIEWS

Living the Experience of Being Nursed

Time and again individual CNSs were referred to as exemplars of the approach to, and type of nursing care appreciated by each patient. And yet few, if any, of the interviewed patients were aware that the nurses in question were designated clinical nurse specialists; most saw expert nursing in the hands of older nurses which generally holds true for the CNS. The patients ranged in degree of sickness from those who were chronically ill and approaching death to those who looked forward to life with renewed vigour after major surgery. In the text that follows, excerpts from the patient interviews have been reproduced in *italics.*

-Being a Patient-

To be ill has been described as to be 'out of sorts'. To be ill means to experience things in a different way. Not only does the patient live in a body that is no longer functioning as it should, but in many ways the patient's world itself becomes ill (van den Berg 1972). Being in that state referred to as being ill carries with it the high possibility that in order to redress this state a person has to enter a hospital which means s/he has to live in a completely different environment. While the ward is a familiar place for the CNS, for the patient it is new. The sights, sounds and smells to which the nurse is accustomed will be alien to the patient. Thus a person is 'out of sorts' in a variety of ways. S/he is not his/her self, and not his/her self in an environment, which to all intents and purposes is one that s/he would not choose and which is not their own. One patient lamented *'once you get in here the one thing you are interested in is how to get out... to get back to a normal life'.* Langeveld (1983b:189) believes that human beings live corporeally and inhabit space, 'the body is no stone or tree it is my manner of being for and in the world'. Merleau-Ponty (1962) supports this view with his contention that not only do we have a body with which we can do everything, but we also *are* our body.

Yet, in a taken-for-granted body one forgets that one relies on it; a person is usually little aware of their body as they live it, and it is only in special circumstances or situations that we become cognisant of our body. Sartre (1943 cited Langeveld, 1983b), describes the taken-for-granted healthy body as 'passed over in silence'. Just the same, all human beings are in complex ways

dependent on their bodies and when the physical functioning of the body becomes damaged in any way various problems soon follow. According to Langeveld (1983:187), patients know their own bodies and its peculiarities, yet while in hospital as nurses and doctors deal with bodies belonging to others the body is encountered as an 'object'. Because of this, patients tend to experience a disturbing alienation of the body which is further compounded by their illness. The body that is ordinarily passed over is now experienced as 'too hot', 'in pain', 'uncomfortable'. As a result, the patient is emphatically put in touch with his/her body, and for some may signify total dependence. One patient pointed out despairingly, *'when you're in hospital you are reduced to a state of helplessness'.*

The body, the corporeal self, is at the centre of a person's space (Bleeker & Mulderji, 1992; van den Berg, 1972). Van Lennep asserts (1969:212) 'it is human existence itself which constitutes space'. In adults the need for an appreciation of a private place, a space which assumes personal meaning is inherent. Langeveld (1983:187) describes the notion of one's own place as reflecting who we are. Because patients in hospital become distanced from their own everyday living space they have a need to create their own space around them, a personal world wherein they can dwell (Langeveld, 1983b). At the same time the space of the patient is limited, so this space assumes the personal shape of the environment; which for the majority of patients will be the space around a bed and locker, within a bay, within a ward (van Lennep, 1969). For some this can be a crowded and threatening space that surrounds them, yet because the lived experiencing of space is dynamic and everchanging - what is threatening today may not be so tomorrow. For some, perhaps less fortunate people, hospital may be a place where a 'reshaping' of themselves and their world has to take place (Langeveld, 1983b:187).

In hospital the patient will generally be in a completely different mode of existence, he/she is a 'stranger' and becomes a 'number' in a numbered bed. A bed that not long before had been occupied by someone else. The patient goes through a process of 'inhabiting' the bed so it becomes his/hers. S/he organises his/her belongings in the locker, places her/his slippers under the bed etc. (van Lennep,1969) This teaches him/her a mode of existing which s/he does not know when at home. S/he has to learn that this room is also a room that others have a right to enter and to co-habit, and so s/he has to develop new social contacts in living in a world with other people. S/he realises s/he is just one of so many in a series of transitory patients. It is more than likely, the patient will inhabit the room without being 'at home' in it (van Lennep, 1969). It

is probable that the hospital dictates the bodily behaviour of the patient according to unyielding codes and policies, and so the patient will quickly learn to conform to whatever behaviour is considered normal (Langeveld, 1983b).

On the ward, time stands still or time flies (Langeveld, 1983b). The time intervals the patient experiences will be different for the nurse. Patients often 'live' from one meal to the next, or from one treatment to the next, and so their time is set by the hospital routine. Patients learn from cues what is going on in various parts of the ward, usually by observing aspects of the nurses routine. They will commonly say such things as, *'you can tell by the noise that the nurses' morning tea is on'*. In order to pass the time patients may set up communication networks with other patients which, after a while, may even include visitors. Often, they will just observe the goings-on in the bay noticing things about the practice of the nurses which would surprise even the nurses.

The patient in the adjoining bed usually has particular significance for a patient and more often than not a bond will be established, particularly if they suffer an illness in common. For some patients the communal world of hospital makes it difficult to find solitude, by the same token a number of others will find life on the ward lonely. Usually the patients who co-habit the room with a newcomer will assist in enculturating them to this new world. Having already been on the ward these patients know the nurses and have learnt the ward routine. In turn, the newcomer assists in introducing new patients to the system.

It can be seen that the space and time of the sickbed are dimensions different from those of the CNS, who is useful, busy, and healthy. This means the space and time of nurse and patient are unequal (van Manen, 1995). Fundamentally, the patient and nurse experience different aspects of the same thing; yet inspite of this, the nursing staff can and do have far reaching effects on the patient. Patients are quick to point out that the hospital system could not function without nurses. Nevertheless, they recognise significant differences amongst nurses in regard to their nursing practice as well as their ability to be effective in that practice. To illustrate this point, one patient recounts two events that occurred on the same shift leaving her with differing impressions about nurses. Firstly, she recalls seeing:

> *. . .one male nurse drop something on the floor when he was doing a dressing. However he didn't pick it up, he could have, but he obviously thought no my hands are clean and I'm not going to touch the floor, and I thought good for him.*

The second involved a nurse, *'who reeked of tobacco, stank, and she came in and got the thermometer and fumbled it and put both her hands all over it and then stuck it in my mouth...I nearly threw up'.*

That being the case, nurses appear to be human too, and patients are the first to acknowledge the humanity of nurses. Patients make comments such as, *'they have a pretty tedious job to do and are only human, they must get very tired and irritated'*; or *'they are rushed off their feet so much sometimes they forget to do things, but they are only human beings like the rest of us'.* Patients encounter numerous individual nurses, and it is not surprising some are more positively regarded than others. One group of nurses amongst those more highly regarded are the advanced practice ones:a group referred to by the patients as the 'experienced' nurses.

-The Experienced Nurse-

An experienced nurse has a certain *bedside manner,* and according to patients this is just *'the way they go about their job. They walk in and say who they are and that they are going to look after you for the shift, whereas others just sort of wander in, look around and off they go'.* The expert gives the patient confidence in her ability to care because she presents herself as knowing the job 'inside-out'. Similarly she will keep the patient well informed about what is happening, and what is going to happen, and what is expected of the patient, on a regular basis. This makes life less stressful for the average patient and their families, who often experience states of apprehension and confusion upon entering hospital. One patient describes this feeling as being akin to *'all at sea'.*

Some problems the experienced nurse seems to be able to fix within a couple of minutes, yet other nurses will *fiddle and fool* and make the patient wonder if they are doing the right thing. Feeling confident in the nurse makes the patient feel better in themselves because *'if they are panicking you are panicking yourself'.* Nothing appears too much trouble for the experienced nurse. Being sensitive to, and anticipating the patient's needs she seems to know exactly what the patient requires and how to put her finger on it without even asking. Such nurses have the ability to make the patient feel more comfortable. Truly recuperative sleep for patients confined to bed can only become a possibility if the caring expert straightens the sheets, arranges the pillows in just the right way, and tucks the patient in when they are ready. In this way, an optimum state of

relaxation can be reached, yet in order to carry this out successfully, the nurse must have acquired a certain amount of knowledge about the patient. It is the CNSs, by virtue of their longevity on the wards, who accrue the most knowledge in this regard.

One long term patient pointed out she would not have *'survived'* her hospitalisation without nurses, and qualified her comment by stating:

> *More so the regulars because the others don't know much about me. The agency staff they come in and are really casual because they only see me for that day so they don't get involved. The rest of the nursing staff get involved and that is important. If you just get someone coming in for the day to do what they've got to do, there's not that personal element.*

The personal element in a nurse/patient relationship develops because of the close and regular contact that occurs between the two. Experienced nurses rapidly gather information about the patient that may be relevant to their care, both in and outside of hospital. This information includes details about the patient's reality in the lifeworld beyond the hospital environs. From this an alliance between a nurse and her patient becomes more 'meaningful' than that between the patient and other health professionals in the hospital. Medical staff rarely possess knowledge of a patient's everyday existence to the same extent as the experienced nurse. A patient states:

> *Nurses know so much more about what is going on with the patient than the doctors. They are with the patient much more, and they tell the doctor what is going on. Doctors only know about cutting open and stitching up. It's the real life stuff about the patient that the nurses know.*

In the majority of cases, for a patient, a doctor will *come in, look at them, maybe nod, and then walk away*, unless the patient ventures to ask questions. On surgical wards it is first and foremost the operation site that interests medicine - which means *the doctor comes round, looks at the wound and breezes off.* As far as patients are concerned it is the expert nurse on the ward who *fills them in on what is happening to them.* As information givers the nurses put *the patient's mind at rest.* One patient called it a *'confirming'* role, and mentioned it was Carol who would give her all the information she needed and clear up any misconceptions. Moreover, as the nurse gets to know her patient, so too the patient gets to know the nurse. Knowing the nurse facilitates the personal element in a nurse/patient relationship which ultimately empowers the patient as an agent in the hospital environs.

There is *no 'mucking' around* with the experienced nurse. The patient who is about to receive an injection for example, might feel uneasy and comment, *"I don't like injections"*, and the nurse will reply *"that's okay"*, yet she continues with the job and gets it over swiftly and skilfully making *small fry of the patient's fears.* One patient remarked, *'because they seem to know what they are doing, the good ones give you confidence'.* She describes an incident the previous evening when the CNS had discovered the patient's blood pressure had dropped and had immediately lowered the back of the bed. *'An experienced one just seems to be able to come in and do it. It seems so easy and no great problem, it's as if it's automatic'.* Another patient retells his experience of having his drainage tubes removed by a CNS, *'she wasn't rough it was very smooth and then when it came to the bigger one, well she just told me to take a big breath and hold it and that was it, it was gone'.* The perception of agency staff on the other hand, is that they *'just don't seem to know what they are about'*, and with regard to new nursing staff *'they just look lost'.* Neither position being of much comfort to the patient.

Expert nurses have learnt to read character and the patients report they can observe the nurse altering her behaviour depending on how she has perceived a person. The expert is seen applying psychology throughout the day in order to avoid conflict and enhance communicative relations with each person with whom she comes into contact. One patient commented about the light-hearted relationship he had established with Anne, *'that comes from her being able to gauge human character in different people. . . because she has recognised that side of me, it has helped me, with her I can just keep my normal personality going'.*

Administering to the needs of differing patients over the years has enabled the expert to develop a certain understanding of what it is like to be a patient. As shown in previous text, this allows her to take the side of the patient and put herself in, what van den Berg (1972:47) describes as, 'the patient's existence', the patient's 'world'. For example, if the patient has a wound, the expert will be cognisant of the patient's desire to know how the wound is progressing. She realises it is something they will not know themselves, but in which they have a vested interest. Therefore, an expert nurse, will not only undertake a wound dressing with great care, but while she attends to the wound, she will be informing the patient *without medical jargon but the plain facts and reasons, how and why it is going like it is.* Furthermore, her interest will be such that at a later stage she will return to see how that wound and the patient are progressing.

Because the passage of time enables nurses to learn a great deal about the psychology and physiology of patients, the expert nurse is cognisant that a chronically sick patient will often know more about their illness than many health personnel. As a result, long term and returning patients will more than likely have differing needs upon entering hospital, and the expert nurse has learnt to listen to her patient in regard to negotiating essential nursing care. Less experienced nurses are not so discerning. One patient recalls her anger when, despite it being her third admission for the same condition, a young graduand insisted the patient was not to concern herself with any aspects of her care because she, the nurse, possessed all of the knowledge.

Additional qualities of experienced nurses include a more attentive orientation toward patient needs and emotions and medical requirements. For example, they will seek out the patient's need for a sleeping tablet or pain killer without waiting for the patient to ask. What is more, they show an interest in the patient, and listen to their concerns. These attributes of the permanent staff are in sharp contrast to those of relief staff from an agency who come across as being noticeably *different* and at times *very off hand.* Or, even the junior nurse who has to constantly look to the senior nurses for guidance and reassurance.

-The 'Better' Nurse-

In time, patients become aware that not only are some nurses more experienced than others, some are also 'better'. Patients get an instantaneous *feeling* about this kind of nurse. *'You can tell as soon as they walk in with some of them, there is just something special about them, and the way they act'.* Annabelle for example, is not only an experienced nurse, but is also one of the 'better' nurses. Annabelle conducts herself in such a way that her patients believe she not only likes nursing, she *loves* it. This is distinct from the nurse who goes about her job as if it is a chore, (even though she may be efficiently fulfilling her tasks). The 'better' nurse is perceived by the patients as more *dedicated.* Annabelle is seen as a dedicated nurse because not only does she obviously enjoy her job, but she appears to care about her patients. Her caring is evident in the interest she takes in them and the manner in which she treats them as somehow special, not merely as a number in the bed, or as *part and parcel* of the daily routine. In addition, patients perceive that Annabelle appears to care about her fellow nurses - they see her mentoring them. The belief in something exceptional about Annabelle is further borne out because in order to see a procedure finalised she is not averse to staying back when she should be off-duty.

The 'better' nurse is the nurse who steps in/or takes over a task for the patient at just the right moment, averting the need to be called; which in general, the majority of patients feel uncomfortable about (in fact, most of them will only utilise the call bell as a last resort). Moreover, she anticipates their requirements, avoiding future discomfort stemming from the need to seek help. However, in the event a call bell is rung, a 'better' nurse will answer it promptly and willingly. 'Better' nurses always consider the welfare of the patient, both in a physical and psychological sense, and will go so far as to suggest strategies to the patient to enhance their well-being, even if it involves more effort for themselves. One young patient recalls his appreciation at a nurse's suggestion she wheel him, *bed and all,* onto the verandah for *'a change of scenery'.* An elderly man recounts his discomfort stemming from a 'drip' in his hand, and of his relief when the nurse suggested that if he drank lots of water and managed to void, she would remove it. This meant however, that throughout the night she was not only assisting him to drink but also standing him out of bed so that he could successfully pass urine. By comparison a less fortunate patient with a bladder infection, instructed to drink in order to aid her recovery, recalls her anguish one night when she was directed by the noncaring nurse not to drink so much because *'I'm not bringing you pans all night'.*

Perhaps the most salient feature of the 'better' nurse is her ability to bring a *little bit of cheerfulness to the bedside.* She is a happy friendly nurse who in her ideal form exudes a bubbly disposition. Even if *her back is breaking and she is 'spitting chips'* she will hide these feelings from the patient. Hence, unlike some others, she will never burden the patient with her own problems. Bright personalities and good moods in nurses *feed off* onto others and assist the patient towards a quicker recovery than if they are lying there sick and *someone calls in sour-faced.* Furthermore, as distinct from those nurses who just do the job and disappear, given the time, 'better' nurses will stop to chat. In many cases the social chit chat of these nurses enables the patient to regain contact with reality, as well as lifting the spirit of the patient who is feeling downhearted. A patient remarked; *'you'd be surprised when you are feeling low how it helps when a nurse comes to talk to you, not even especially about medical things'.*

'Better' nurses seem more friendly and compassionate than others. 'Better' nurses make the patient somehow *feel at home,* as *part of the family,* and although busy, act as if nothing concerning the patient is *too much trouble.* Moreover while other nurses may indeed carry out effective nursing care, 'better' nurses *'pick up your feelings too'* while they are doing it, and *'will come and cheer*

you up'. One patient recounted that Carol had made an extra fuss of her the previous morning because all of the patients in the bay had gone off to theatre, and Carol had perceived the patient might be feeling *'tearful at being alone'*. Patients also refer to a predicament that every patient who has ever been confined to bed for any length of time will recall, the dehumanising prospect of having to use a bedpan. If the patient's condition in any way permits it, the 'better' nurse will rescue the patient from this undignified plight and convey them to the toilet on a commode chair. One patient sums up her feelings about such an action by a nurse, *'that made all the difference, it was such a relief!'*. Lesser nurses will not undertake this obligation for the patient. The patient expressed surprise she had not been offered the alternative of using a commode before even having to consider the use of a bedpan; this, she said, had left her dreading the thought unnecessarily. *'In fact,* she points out, *'the patient over there had to use a bedpan twice before she was offered a trip to the toilet on the commode'.*

Patients will describe lesser nurses as *'the young ones who don't care and keep you waiting. They set you up and then they disappear and don't come back for hours'*. Yet, even though patients realise they may have to wait, in what one patient called, *'the land of wait awhile'*, what is apparent, is that waiting is not the crucial issue; of much greater import is a noncaring attitude. Patients do not expect compassion from doctors, but they do expect it of nurses. Prepared to wait for a busy caring (compassionate) nurse, they are perturbed by what they see as a noncaring attitude portrayed in a nurse who lacks concern/respect for their feelings and dignity.

There is no doubt, that for a number of patients it will always be the case one or two nurses will not meet their expectations. However, for any patient who has ever been in hospital for an extended length of time, or who has had re-admissions, encounters with lesser nurses will have been offset by the memory of at least one act of kindness by a 'better' nurse. An act which made a difference to the life of that patient. One elderly man remembers how touched he had been by the action of one such nurse on a day when he was being discharged. He had been obliged to get his own luggage and walk down the corridor and outside to his transport, yet the nurse had spontaneously picked up his bags and carried them for him. Another, recounts how once he had become upset at the memory of his recently deceased wife and began to weep whereupon an experienced nurse had come in and put her arms around him, and he believed that a *'wonderful thing to do'*.

By and large, working amongst a group of sick people who are separated from their families and far removed from the real world, provides a plethora of opportunity for nurses to effect 'wonderful things' for patients to appreciate. It became evident that in living the experience of being nursed, a number of patients identify another much appreciated type referred to as the 'special' nurse.

-The 'Special' Nurse-

Although a 'better' nurse will certainly care about all of her patients, the 'special' nurse will care just that little bit extra, for one, maybe two, of her patients. The 'special' nurse is usually an expert and a 'better' nurse, but not necessarily so, (she may well be a nurse who has developed a unique rapport with a particular patient). Nevertheless, she is the nurse who is perceived as doing *'the little things'* for a patient that others do not. Not every patient will experience a 'special' nurse. A patient describes how a particular CNS always made sure she had a bowl for a wash at night and would rub her back for her before she went to sleep. *'If you've been laying in bed for so long, it is the most beautiful feeling to have a back-wash'.* She told of how she was 800 miles from home and for her it meant a great deal that one of the nurses was a bit more caring than the others. One long term patient identified a number of 'special' nurses. She describes them as those who give her a cuddle when she is upset and give her words of encouragement, and see to the 'little things' for her, in contrast to those who just inquire, *'you right?'*, and walk off. The 'special' nurses, she believes, had made all the difference in terms of her healing and recovery process. Special nurses it seems, are especially therapeutic.

CHAPTER TEN

EXPLANATION AND DISCUSSION OF THE PHENOMENON

Introduction

The goal of this study was to gain knowledge and develop insights into advanced nursing practice, specifically the role of the CNS. This thesis, which has tracked the course of this objective began by 'turning to the phenomenon', revealing the interest and commitment underpinning its investigation (van Manen, 1984:39). Two subsequent chapters explored the origin/s of the CNS, and located the role within nursing's cultural heritage. Having contextualised the CNS, the succeeding chapters turned to methodological concerns and the processes involved in gathering the lived experience 'data'. Chapter six described the writing and editing of the phenomenological text. The phenomenological text in the preceding chapters set out to 'capture' essential aspects of the lived through experience of expert nursing in an attempt to understand, describe and validate that domain of nursing practice. Its purpose was to bring to light the phenomenon called 'CNSing'.

This chapter continues by further 'calling into question' or 'problematising' the current state of affairs for CNSs (Crotty, 1996) and provides, firstly, a summation of a number of key issues emerging from the phenomenological text. Interdispersed with the researcher's commentary are assertions, drawn from the NUMs of each of the wards (regarding their perceptions of the work and 'worth' of the CNS), together with those of three of the medical staff affiliated with those wards. The researcher also calls on her own observations of the phenomenon in the field. The discussion then turns to the role of the CNS as it currently stands, and because traditional phenomenology is not just descriptive, but is also interested in 'what might be' (Crotty; 1996), some suggestions are included that might assist in further refining the position CNS. The chapter concludes the thesis with some closing remarks concerning future research and the phenomenon in general.

This study has unveiled many 'faces' of a CNS but the phenomenon (that is the experiencing of the 'thing') was the CNS - and while one looked at the CNS, one saw a CNS, but on each occasion

a 'different' CNS was seen, because a different action was usually involved. As a result, intelligible connections between the differing perspectives were explored in order to make sense of the CNS's world so that it could be transformed into another 'view', a more informed understanding. To this end a phenomenological text was created in which an account of the lifeworld of the CNS was presented as an exhibit to lay before the reader. Her lived experience has been captured and illuminated in a synthesis of the way/s it appeared before the researcher so that the reader can come to a better understanding of *what it is a CNS is* and *what it is like to be* a CNS.

Nurses have long been cognisant of the difficulty in describing what they do (Benner, 1984; Fenton, 1985; Lumby, 1991a,b; Cameron-Traub, 1991; Kermode, 1993). Nightingale (Skeet, 1980) herself, was of the opinion that nursing comprised more than a series of tasks based on medicine's ways of being, knowing and doing. In an effort to grasp the substance of their work, in the past, nurses have tried to define nursing through standards, and more recently competency-statements. Yet, because of the traditional medical model of measurement, standards have always been task-oriented and reductionist, and increasingly, nurses have become aware that the nature of nursing has not been made explicit in these standards of the past. As a result, nurses have begun to question whether traditional approaches to explicate practice are, in fact, perhaps attempting to measure the immeasurable.

No nurse works in isolation. As a specialist surgical nurse, the CNS supposedly works as part of a 'team' and her nursing is 'experienced' by many people, patients and relatives included. Nurses' actions therefore, are inextricably linked to the context within which they take place. The communal world in which she works impinges on what she can and cannot do. The phenomenological text in the preceding three chapters has revealed the forces exerting an influence on the ward environment, specifically on the CNS, who appears to be at the centre. Whilst hospital job descriptions and lists of tasks regarding what a CNS is assumed to be, are available, this study sought to evoke the CNS's experiences as authentically lived. The object in the lifeworld, the CNS's reality, had to emerge out of the experience of the CNS, and not as one arising from a group of people detached from the lifeworld, hypothesising and making inferences about it. The list of tasks presented at the beginning of this thesis for example, are aspects people have attributed to the CNS role, and yet until recently no-one has really made sense of them. No-one has sought to determine if such rhetoric is truly reflective of her world at work. In a

legislative controlling manner, competencies tend to classify and categorise nurses and nursing, and can be likened to erecting fences about them in an effort to hold them in. Competencies posit the lifeworld into convenient little boxes that can then be ticked. They do not for example, get to the 'busyness' of the nurse's work, to the feelings of 'undoneness' or of being 'out-of-control'. They do not reveal the negative side to her work or the 'capricious' or 'temperamental' nature of the job.

As yet, no-one had attempted to describe the lifeworld of the CNS in a realistic 'manner' in order to discover what the job is like as presented to nursing through the experiencing of it by the CNS herself. Neither had they inquired as to what it is about the practice of this group that makes in fact, a difference to the patient? Difference comprising a part of being hospitalised, of the process of care, not necessarily being of cure. In these days of economic rationalism, the value of the CNS needs to be rendered visible, and her role at greater cost than the average RN, justified. If such an undertaking is not forthcoming there is a possibility CNS numbers will be reduced, or worse still, the position lost altogether.

In attempting to place a value on the contribution made by the CNS, this study sought to reconstruct the concept of the experienced bedside nurse, called a CNS, and to look at her lifeways and re-interpret them and reveal the meaning that experienced nurses ascribe to their daily work at the bedside. It has also attempted to uncover dimensions of functioning normally hidden in their experiencing of the phenomenon, and yet without which they would not be what they are.

This study was undertaken with a view to better define and clarify the role of the CNS for the discipline of nursing and in an effort to expand the 'depth, breadth and rigor of nursing knowledge and expertise', strengthen the 'integrity of the profession', and enhance the 'career opportunities and benefits available to nurses' (in Pratt, 1994:6). Because it has been contextualised and grounded in direct experience, the phenomenological text attempts to offer a deeper and more believable insight into the life of a CNS than does a set of standards, a list of tasks or competency-statements for example, or even a description theorised and organised under a set of themes. The text furnishes an insight into the meaning of being a CNS, and illustrates just how multi-faceted is her life, the sum of the whole of the phenomenon CNS so obviously greater than the parts. The phenomenological text portrays the richness, complexity and depth in the

phenomenon, that is the CNS. If anything, it shows that her world is very much about being in-control because should she lose hold of even one aspect of it, there is much that could fall apart.

The authenticity of the phenomenological text is tested by the CNS herself. When she reads the phenomenological text she should say 'yes, I know what you mean'. For some, this textual display of their world will be sufficient, while others will seek additional explanation and discussion of the text's findings. They will ask of the researcher, 'having gathered and interpreted the experiences of the phenomenon, what then are your inferences from it?'

Living the Experience of Being a CNS - What is a CNS?

The phenomenological analysis of the CNS reveals that she sees little difference in her role compared to that of an experienced RN. As it is, the CNS sees the line of distinction between the two roles as having been blurred from the very outset of the career structure. For the less career oriented phn-B CNS this does not appear too great a problem, but for the career minded CNS it is disappointing since she was hoping for increased opportunities and less of the same.

A CNS can feel a sense of self-assuredness stemming from her longevity on the ward, but she is also aware of the drawbacks that prevent her from fulfilling her task to the best level. These may include physical and/or environmental issues as well as those of a more fundamental nature, such as the 'system' working against her best interests and preventing her from developing professionally. Feeling constrained in her role, she believes she cannot make full use of her talent and those attributes she knows she has to offer nursing. Gradually, she comes to a realisation she has no-where to go in terms of expanding her role at the bedside because this necessarily implies losing her status and becoming a 'beginner' all over again. Therefore, as she may once have done had she been an RN, she is reluctant to move to pastures anew. Wilson-Barnett, (1995:2) reports on the fact that specialist nurses in the UK system have reported feeling trapped in a career cul-de-sac 'where they would have to return to a lower paid position in a general field in order to have better future opportunities'. She also backs up the findings of this study by suggesting that after a time, nurse specialists find their role somewhat 'restricted' because 'the range of clinical problems becomes repetitious and unchallenging'.

That is not to say a CNS dislikes the ward on which she works. On the contrary, she feels comfortable in her specialty; she just wants more from it. She is looking for an increased challenge from her job, one that draws on her experience and makes full use of that common-sense she so highly values. A CNS would also like to be recognised as a practitioner who can act independently and use her initiative. However, raising the status of a CNS, also has to overcome what she sees as its 'tokenness', because in the past anyone who applied for the position was basically granted it.

A CNS situated on her home-ground enacts nursing without wasting time. Knowing precisely what she is doing she works fluidly, and through countless visible and invisible ways she contributes to the smooth running of the ward. She has 'dwelt' on the ward long enough to know its operation 'inside and out', the protocols, (specific and general), how and from where to order stocks, the preferences of different consultants and all about the nursing and much of the medical care of the patients within that specialty. She knows who to page for what, and what to page for whom, and when and where.

In a study on management style, Mintzberg (1994), profiles a manager who had 'spent years as a nurse on the ward' and so unlike other health professionals who drifted in and out, for this manager the ward was her 'territory' (p31). The same could be said of the CNS. In addition, he describes the *pattern, pace* and *style* of her day's work and how she seemed to 'direct the traffic' (p32). 'Everything seemed to flow together in a natural rhythm', which was due to her ability to 'communicate, control, lead, link and "do" all at once' (Mintzberg, 1994:34). To differing degrees, these aspects could be applied to the CNS.

Certain central characteristics emerging from the experience of the CNS appear bound up in the phenomena of her knowing, being and doing. Aspects of which include:

Being-in-the-world: Sharer of self - Being involved - Co-ordinator; Supporter; Mentor; Mediator; Interactor (with patients and others in the social environment); Comforter; Minder.

Doing-in-the-world: Sharer of expertise; Practitioner of expert nursing.

Knowing-in-the-world: Sharer of information - teacher; resource person. Expert Knower; Monitor of standards.

In addition to the above, she has the versatility to wear different hats (or as in this case, different 'coloured tags'), that is, the ability to take on multiple functions, both legitimised roles e.g. NUM, and non-legitimate roles e.g. porter, cleaner, ward clerk, even furniture removalist. Having seen the same operations carried out by the same surgeon on patients with the same problems, she enacts the same nursing care she has perfected over the years. And, because she has her 'finger on the pulse' at all times, she acts as a stop-gap safety measure for all aspects of bedside care. In addition to which, she has developed the skill to look ahead and foresee problems. She fulfils the role of consultant to other wards who may have patients with the same specialty condition. (This 'in-control' position is antithetical to the situation should she be sent to relieve on another ward, in which case she is often obliged to wait for others to come and show her certain aspects of a patient's care related to that specialty).

As we have seen from the text, aspects such as her advocacy role are obvious, the way in which she buffers the patient from the 'system': her ability to prioritise more quickly and carry out several tasks at the one time. The text has highlighted her interventionist role, whereby she can immediately see tasks that have not been undertaken; when the patient is at risk; what to do in the event of the patient's condition deteriorating, and can differentiate between degrees of a patient requiring medical attention. We have seen how she develops an appreciation that something is about to happen, and when it does, can act swiftly, knowing what measures to take in an effort to either reverse the problem, or halt/alleviate its progress until medicine arrives. When medicine does arrive she works alongside, assisting, anticipating and accommodating the treatment. (Further to that are the times when her knowledge of medical treatment is greater than that of some junior medical staff so that she ends up instructing them). Recognising the shortcomings of the intern, she knows how to get assistance quickly and is not afraid to bypass certain personnel in order to get the attention the patient needs.

The text has attempted to describe the unpredictable nature of the CNS's workworld, that the pace and substance of her lifeworld can change from one minute to the next. She can 'wax' through critical periods where she shoulders a considerable degree of responsibility and demonstrates complex knowledge and skills, and yet 'wane' through periods of carrying out, what to her, are monotonously repetitious 'doing without thinking' jobs.

On the whole however, the phn-A CNS sees her days filled mostly with mundane and routine tasks, and as a result she will purposefully seek out the different and more complicated tasks. However, there is some variety, because untoward events crop up and as the senior nurse she will always be sought to assist. Due to her longevity in the job, a CNS *thinks* like an experienced nurse. In the course of her working life, she has been privy to death and its accompanying sadness; as a result, such matters have become part and parcel of her lifeworld, and to an extent she has become desensitised to them.

Nurses are almost always thought of only in terms of their association with the patient, and yet obviously in reality, the CNS co-habits her workworld with a number of different hospital personnel all of whom exert an influence on her day-by-day, and to a certain extent, she on them. From the text it became clear that these 'lived others' can have a bearing on the ability of the CNS to happily and indeed maximally fulfil her role. As the text reveals, medicine and nursing administration, neither of which is shown in a positive light, have important parts to play in the social construction of her lifeworld. Both are constituents of the 'system', an aspect of the CNS's lived experience serving to wield a somewhat limiting and negative force on her practice. In effect the 'system' serves to 'keep her in her place'. With its rules, protocols, policies, guidelines and procedures, (because that is the simplest and most cost effective way of ensuring optimum safety for the patient), it has determined all registered nurses be reduced to an average. That is to say, if all bedside nurses are governed by the same rule book and are precluded from initiating those procedures which for the below average or average nurse might carry more risk, the 'system' can rest easier.

Yet, because she is too bright[1] and too keen to be content with just average practice, the phn-A CNS in particular, finds herself constantly 'struggling' against the 'system'. And, while environmental constraints, that is the bureaucratisation of her work, serve to wear her out; these other impediments, the 'system's ability to hold her in check, and the ways in which her expertise is underrated and belittled by some of the main agents dictating to the 'system' - find the phn-A CNS in particular, describing herself as a *Clinical Nurse Survivor.* From this, it could be said that 'CNSing', particularly for the phn-A CNS, is about 'surviving'.

1

Cordiner (1968) describes studies that have shown, amongst other traits, British and American nurses have above average intelligence.

There are times when her experience and self-assurance in the role enable her to employ strategies that allow her to circumvent some of the 'system's' dictates. As the text has revealed, there are occasions when she loses the battle and may at such a point quit nursing altogether. At other times, having overcome her dejection, usually with the assistance of a period of leave she complies with the 'system', seeking to protect the patients from it, while avoiding confrontation herself.

As became evident in earlier chapters, much has been written about nurses' domination by medicine and the ensuing poor relations between the two disciplines (Street, 1992a.b; Delacour, 1991; Beaumont, M. 1987; Melosh, 1982; see Dingwell & McIntosh, 1978; and more). This study supports the view that the impasse still exists, and appears little changed from the days of the researcher's own experience/s. It can be seen from the text that being-in-the-world with doctors has an influence on the CNS's workworld, the extent to which, one would suspect, most non-bedside nurses nowadays would be unwilling to acknowledge. The text leaves one in no doubt however, that medicine has an enormous influence on the structural constraints of her practice. The power plays, the disregard for her expert input; the failure to communicate directly; the rudeness and indifference that is shown to her; the lack of influence on her behalf. And yet, there is 'luck', and there are some doctors with whom she can work harmoniously.

A CNS, as this study shows, does have a different relationship with junior doctors than that of senior doctors. And as expected, she introduces and familiarises junior medicine to the world of the ward. A CNS can readily recognise a 'good' doctor as opposed to a 'bad' one. The extent to which she does exert a degree of influence on younger medicine (or perhaps one should say the extent to which she is intolerant of certain doctor-type behaviour), has surfaced as a phenomenon that seems to have increased. However, even though she will readily challenge junior doctors about issues, she does not feel similarly at ease confronting senior ones. It would appear that to a certain extent, in spite of the advent of a tertiary education for nurses and the inception of the clinical career ladder, 'medicine' remains largely in control, and quite clearly the ability of the medical staff, even of one lone individual, to create tension on the ward and disturb the harmony of its nursing operation, is a real possibility. This has direct implications for patient care, because in this event, doctor and nurse will be at odds, and there will be little or no constructive communication between them regarding the progress or otherwise, of the patient.

To all intents and purposes the expertise of the CNS is not acknowledged by medicine, and she has become resigned to being ignored, and 'not listened to' by MOs and other members of the 'system'. In her critical ethnographical work, Street (1992a:149) describes this phenomenon as that of the visibility and invisibility of the nurse and links it to the concept of power. When Jay was asked why he endures poor behaviour from medicine he saw it as part of the fundamental nature of nursing.

He explains:

> *You take a lot of s--- off people, it's part of the job. . . even apart from nurses being the bottom line, it's the job. If we don't take those pans; if we don't take that abuse and try and turn it round and make something constructive of it because that person is angry or whatever, if we don't do those things, if we don't wash their backs, we're not doing the job.*
>
> *If the nurse doesn't do those basic things no-one else will, they are the reason s/he is there and yet to be doing such basic chores and then to turn around and be assertive is a very difficult task. To spend eight hours literally taking s--- off people, it's then very hard to turn around and start demanding some rights. It's too great a psychological shift to then say to a doctor; 'I'm not going to take this from you.*

Bucknell (1995), refers to this dilemma in her address surrounding the question of caring and politics and whether indeed the two are compatible. (In fact, this issue has been raised by a number of nurse scholars and was addressed in chapter three in the section entitled 'Nurses as Carers').

On the other hand, when doctor and nurse do work co-operatively and respect each other's input, the atmosphere on the ward is markedly different and can positively influence a patient's outcome. In short, doctor and nurse communicate for the benefit of the patient. Both disciplines are working towards a common goal and it is certainly in the MO's interest to recognise that the experienced nurse with her attentive eyes, ears and hands can be an ally. By virtue of her constant and informed presence, her 'knowing' the patient, she is in effect, a reliable window to the patient's world. Just as she has in relation to the 'system', a CNS has developed survival techniques that allow her to inhibit the power of medicine over her practice.

Although a doctor expends minimal energy where nursing is concerned, the nurse expends considerable energy on the doctor, be it in waiting on or for him, chasing him up or just generally feeling resentful toward his behaviour. Without a doubt the medical staff can make the CNS's job more demanding - so much so, that she can perceive the *'battle is against the doctors and not the disease'*. One of the biggest sources of her frustration is having to hold off on some aspect of patient care knowing full well she is capable of carrying it out, but cannot, either because it has to be sanctioned by medicine or it has to be undertaken by medicine, usually in the form of an intern, who more often than not requires her guidance anyway. Wolley for example, frequently effects life saving manoeuvres on night duty, many of which strictly speaking should be undertaken by medicine. It would appear however that when resources are stretched, as they are on night shifts, for the CNS to take the initiative is acceptable, while at any other time, she would be considered insufficiently trained for such action. Benner (1984:168/9) refers to these kinds of undertakings as 'outside the boundaries of nursing', and points out that:

> While managing life-threatening emergencies in the absence of a physician is not the planned, formal role of the nurse, it is required of the nurse in actual practice, and more documentation and legitimization of this function would probably improve the nurse's preparation for it. . . I was struck that nurses do not seek the opportunity to function in this role, nor do they feel rewarded for outstanding performance in the face of limited resources and great odds. Usually they feel sad because the system has not worked as it should.

The experienced phn-A does seek the opportunity to function in roles such as this, but is deterred because her participation is not encouraged by the 'system', nor indeed by nursing services.

Nursing administration it would appear contains 'new age' NAs and the 'old school' type NA. Much of the time, the old school type NA is destructive to nurses and nursing, and contributes to the stress and burn out experienced by a CNS. In the main, NA are seen to be 'out-of-touch' with the bedside, non-supportive of nurses in general and forever burdening the CNS with paperwork to justify the existence of CNSs. It could also be said, that nurses' relationships with other nurses remains hierarchical, and thought should be given as to whether the position of CNS has compounded this situation. In terms of their role, except for paperwork, these nurses have been given nothing new at which to apply themselves. The lack of anything new at the bedside can see the CNS opting out of basic tasks in preference to those that interest and challenge her. An offshoot of this is task allocation, with the junior nurses being given the least attractive duties to fulfil.

In a hospital, just as the nurse is at the centre of the patient's world, the patient is the centre of hers. The greatest strength for nursing lies in the fact that she is in contact with the patient 24 hours a day. Her attentiveness to the patient, her 'being-with' has also been referred to as 'being-there' (Pearson, 1984, also Heidegger, trans. 1962:182) and/or 'presencing' (Paterson and Zderad, 1976; Benner,1984; Benner and Wrubel, 1989; also in Heidegger, trans. 1962: as 'to presence oneself'). A CNS enjoys being present for the patients. However, just as she waits for medicine, the patients frequently find they wait for her. Nevertheless, in this alien and intimidating *'land of wait awhile'*, mostly they are prepared to do so. For she is their bit of human contact representing the 'milk of human kindness', and their gratefulness for her presence, reinforces it.

Being-with the patient leads to another overriding benefit for nursing - she gets to *know* him/her. Knowledge of the patient has important advantages for their welfare, not least of which is that it gives rise to opportunities for individualised caring which 'can be used to therapeutic effect' (Pearson, 1991:193). Through being-with and getting to *know* a patient, the CNS begins to listen to the patient and 'develops a feel' for them. Furthermore, there are degrees to the depth of her *knowing* the patient, as the text has revealed. After a while she is able to discern the 'hidden communication' surrounding the patient; whether it be physiological or psychological or both. Sometimes, for example she will perceive a 'trend' in a patient's condition before it even shows up in their blood test results (their 'numbers'). One 'nurse-friendly', or should it be said 'enlightened' senior MO, related the following scenario to illustrate his regard for the finely-tuned perceptive powers of senior nurses:

> *Recently we had a patient about whom the nursing staff said: 'it looks like he's dying, but we don't know why'. And they were right. And, none of us could find out why, but the patient proceeded to die. And, I guess that was a negative outcome, but in terms of nursing it was a positive awareness of what was happening to the patient. . . .I didn't know why this patient was deteriorating, but he clearly was, and yet other people* [doctors], *would come along and say 'Mr. so and so's okay, no change from yesterday'. But he wasn't okay, he was changing. The senior nurse on said: 'I think he's dying', and three days later he was dead.*

Benner's work (1984), supports the notion of an intuitive grasping of patient problems by the experienced nurse. The section in the phenomenological text regarding how she makes a 'difference' through her performance (in contrast to less experienced nurses), clearly demonstrates that the CNS is functioning at the level of Benner's expert.

A CNS believes good nurses are 'special', in part because they are not afraid to expose their humanity. Thus she looks to the human side of life, and not uncommonly will also pick up the emotional pieces left over on the ward by medicine. And yet, it is not difficult to apprehend from the text that she perceives her subjective input; that is her 'human-to-human relatedness' (Travelbee, 1966) remains mostly overlooked and undervalued. In point of fact, the gender bound cure versus care, science over art, divisions appear as entrenched as ever. Yet for her, the 'in-between' caring aspects of her work, the interaction which takes place with the patient between grand rounds, is very meaningful and is often the key to locking her in at the bedside.

Just as the CNS has had to come to terms with dealing with many different personalities amongst other health care professionals, so too she meets and cares for many diverse patients. She can identify varying personalities and has developed a formula to deal with a number of them. Having cared for persons with the same physical and possibly psycho-social problems many times over, in general, a CNS knows what is best for her patient in terms of their illness. Because she *knows* the patients in a *different* way to that of medicine, when necessary she is able to take issue with the doctors (and the 'system') for the sake of the patients, although she is not always successful.

The chief objective of the CNS as she sees it is to provide *'comfort'* to the patient. Comfort has been described as a 'care measure' and falls under the broader concept of caring (Leininger, 1986). In order to provide comfort she will most often place herself in the patient's shoes. She shows genuine concern for their stresses in being hospitalised, and although she will be concerned for some more than others, generally she has every patient's best interest at heart. In point of fact, a CNS gains the most satisfaction and reward from her job through her involvement/socialisation with the patients.

A CNS has developed special skills in social discourse and is approachable and friendly and has the ability to converse with people from all walks of life. Should she leave nursing, her enviable public relation skills would be much sought after. Ersser (1991:54) refers to a component of this phenomenon as 'the presentation of the nurse' and sees it as an overall ability to 'make contact' with people. McMahon and Pearson (eds. 1991) and Taylor (1994) for example, would see it as part of the skill of 'ordinariness in nursing', and support the notion that its application can be a useful mechanism to promote patient healing.

Moreover, because she is confident and at ease in her role, where appropriate she introduces light-hearted humour, which is therapeutic not only for the patients, but also for herself and her peers. Liukkonen (1990, cited Astedt-Kurki & Liukkonen, 1994:185) describes the humour used by the institution nurses in her study, as 'light-hearted teasing'. There is no doubt, the CNSs made use of this form of humour. Liukkonen suggests however, that light-hearted teasing requires a solid familiarity with the patient's life history so that the patient is never offended. Kramer (1974) points out that nurses can only make use of humour when they feel secure in their roles. Confident in her work, the assured CNS who *'knows'* the patients, more than any other health care professional, is most suited to using humour in patient interactions.

A CNS legitimizes the patient's feelings - *'it's okay to feel anxious I would be too'*. She gives hope, *'this wound is looking good'*, or *'you look much better'*; she encourages progress by giving patients events to look forward to, for example *'you should be able to get up tomorrow'*. She knows the 'system' and can anticipate aspects of it on their behalf, *'tell your wife to come and pick you up after lunch tomorrow because your script is sure to take ages'*, and so on. She looks to the little things that make such a big difference to a patient's physical and emotional well-being, such as personal hygiene. She will go out of her way to make sure that first shower after a week confined to bed is as good as she would wish for herself. At just the right moment she will make a cup of tea in just the right way, and will remember to buy the newspaper should the 'trolley' come while the patient is attending physio for example. Looking to their comfort means she shows an interest in the well-being of the patient, and does in fact really *care*. (Although, just like most other modes of being, there will be degrees to the extent of caring, those patients she 'connects' with for example, she will *care* for more deeply). Mason (1985:40) supports the idea that such 'rituals' are of enormous benefit to the patient.

These are some of the ways in which she effects a difference to the patient's care in acts that are mostly immeasurable. All of these aspects of her role, are believed to be the crux of the *'more than that'* of advanced nursing, and all would be encapsulated in the notion of *'comfort'*. These are all the things expert nurses do that other health care professionals do not.

As in any job, and as a CNS will tell you, there are good CNSs and bad CNSs. A good CNS is good not perfect, she will make mistakes, by the same token they are usually minor in nature. Yet, she picks up on the not so minor mistakes of other health workers and will often save the

patient undue complications; at times, potentially life-threatening. She has learnt to take risks and cut corners, but does so safely. For the patient, the CNS provides a link to the outside 'normal' world. She will also care for the significant others of her patients and see that as part of her role. The patient rewards the CNS by getting better and going home. Some patients have special meaning and will return to visit, which she appreciates. Other patients die, and although the CNS has long since come to terms with that, more often than not she will feel some sense of emotion, be it relief or regret, but always it is enveloped in sadness. A number of patients, even those who are very sick still consider the well-being of the nurse, she acknowledges this, and is touched by it. Because she is constantly reminded of her own mortality she appreciates her own healthy life 'just that little bit more'. Nevertheless, it must be said that although the patients sustain her, they also contribute to role exhaustion - a very real possibility in her worklife.

Different categories of nurse are not formally recognised by patients. They do not know for example, that CNSs are advanced specialist nurses as opposed to ordinary RNs on the ward. They do however, identify differing qualities in the nurses (described in the phenomenological text) and there are certainly preferred nurses, and nurses who are more 'known' to patients than others (particularly to the long-term, or regular patients). Patients identify the qualities of an 'experienced' nurse, the 'better' nurse and the 'special' nurse. In general, the CNS was personified as a 'better' or 'special' nurse, and inherent within those categories was her expertise. The ability of the nurse to 'be with' the patient has been documented as essential to a caring relationship (Paterson & Zderad, 1976), and the phenomenological text exemplifies this aspect of the nurse-patient experience. Attention is again drawn to the work in McMahon and Pearson (eds. 1991) and that of Taylor (1994) to highlight the therapeutic nature of experienced caring nursing such as that portrayed by the CNS. Nursing that is carried out with a sense of 'shared affinity' so that nurses and patients relate to each other as 'ordinary' human beings (Taylor, 1994:230).

Out of all of this however, one could not say that the experience of the long-time registered nurse would be dissimilar to that of the CNS. Nevertheless, there do seem to be aspects of the job that indicate the CNS occupies a special place within the general schema of things. These are described in the following section and in the opinion of the researcher can be linked to her permanent attachment to the ward, (although as some of the CNSs argued this is not necessarily a good thing. Specialising it seems, can be likened to knowing more and more about less and less).

Aspects Unique to the Role of CNS

Apart from the extra dimensions of her role as defined in her job description, the CNS appears to have created additional duties for herself as senior bedside nurse. In a sense, she is more committed to the ward than the RN. RNs do their work and go home, whereas the CNS looks to 'putting something' back into her work environment. It would appear she has become a kind of (unofficial) deputy ward co-ordinator operating under the NUM and overseeing aspects of patient care, (specifically, those patients nursed by nurses other than CNSs or experienced RNs). Hence the staff mix on the ward makes a big difference in terms of the amount of responsibility and co-ordination she undertakes each shift. By being attentive to the proceedings on the ward, she has taken on the responsibility of making sure the bedside nursing is being competently carried out. She is a 'monitor of standards' both of the junior nurses, and to some extent the medical staff. In this way she becomes a defender of safe practice and guardian of the patients' well-being. This has come about because even though she will have the responsibility of her own patients she still feels obligated, as the recognised senior, to oversee the well-being of all of the patients on the ward.

Further to that, the CNS has become a type of ward 'mother'; looking after the physical and psychological welfare of junior nurses. In this capacity, she acts as a 'go-between' for the juniors and the NUM. It is to her the juniors come with their problems and it is to the NUM she then reports, and visa versa. This is her 'peacemaker' role - not only is it put into play vertically but also horizontally, and so she is sought to act as the go-between, to settle disputes amongst the nurses themselves. Thus, she does a considerable amount of 'relating to others' in her role. In this way, she displays traditional feminine qualities in women's ways of relating socially with and between others, and consequently comes to see the ward from many perspectives. In the community of the ward, one NUM considered the CNS a 'people-manager'. Moreover, her experience has given her a sense of judgment so that she knows when her approach should be considerate and caring and when it should be firm and caring, not only with the juniors, but also with patients. So it can be seen, she is very much *involved* in the 'goings-on' of the ward, more so than the RN.

As one NUM said, a CNS has become a key figure - 'a mine of information' - and 'a huge asset as far as being a resource person'. She has become a role model in her own right and is an integral

person to whom the junior nurses look up, and it was also observed that the fewer the CNSs on the ward the greater their input and influence. It is fair to say, the CNS exerts some considerable influence on maintaining the ward on an even keel.

However, there are times when the CNS's monitoring and mediating role makes her unpopular. For while she has some 'control or command over others' (Ferguson, 1985:89), aside from her expertise, it is only *referent* power, and if she makes herself unpopular the less advanced nurses can and do, choose to ignore her. Stevens (1976:30), refers to expertise as professional authority, but again points out there are no assurances that other staff will voluntarily seek expert assistance, even if they do perceive the advanced nurse as more knowledgeable than themselves.

Reflections of the Researcher

Undoubtedly, the profile of nursing is changing, but if the profile has changed what of the 'substance' of nursing. Has the change been merely cosmetic? This research looked to 'living' with the CNSs in their workworld and was based on the researcher's background as a former advanced practice nurse, so a comparison is available and it is not altogether favourable because the 'body' of nursing in the clinical field appears to be 'bed-ridden'. It would appear that while nursing has developed a career structure designed to keep these experienced nurses at the bedside, the health care 'system' is not changing as rapidly as other events in nursing, and senior nurses are still being subjected to the same regressive elements experienced ten years ago. In chapter one, reference was made to a recent study, entitled 'Issues Relating to Specialty Nursing Vacancies - 1995' carried out on behalf of the NSW Health Department by the management consultant group, KMPG Peat Marwick. It supports many of the findings of this work. Some of the issues raised by the focus groups in that study included for example, the question of 'outdated demarcation rules' which inhibit the nurse's ability to work effectively; a frustration with a lack of responsibility and autonomy; a remote and essentially out of touch nursing administration and management (in other words, the 'system'); poor working relationships with medical officers, the impact of the NUM on the role, and basic working conditions that could be improved. The report also states:

> The general view was that it simply wasn't worth moving into specialty areas. CNS status in particular was denigrated as having onerous criteria in terms of post-graduate education requirements and additional workload whilst offering minimal monetary reward (KMPG, 1995:Abstract).

Without a doubt there are competent CNSs who are not being acknowledged nor rewarded for the work they are doing, and this is a powerful source of discontent. Nor is their level of experience sufficiently recognised and their professional structure is vague.

For example, when asked about his perception of the role of the CNS, an intern stated:

> *I realise there's a hierarchy, but I'm not aware of all the distinctions. . .This is one of the problems I have with the nursing staff, in that I'm not really aware of how much they know or don't know. . . I mean some people are supposedly experts in their fields but know very little about the stuff outside their fields, for example general medicine, and I think the same thing happens with nurses. I don't know what their training is and what depth they go to in their study and what problems they are allowed to and not allowed to handle. Certainly the hospital has protocols you come to know and love, and you work out they are allowed to do this and not this, and they are allowed to diagnose this, but not this, and this is when they have to call you in. But I'm totally unaware of the level of understanding of most nursing staff and that applies to the CNS.*

This lack of 'awareness' of the expert nurse is an indictment of medicine's failure to recognise the contribution of nursing. One senior medical officer, who has been on the same ward for many years commented, *'I've never quite got to the bottom of this status system, no'.*

The CNS is often more knowledgeable in certain aspects of medicine than a junior doctor, and this has been highlighted. Lublin and Gething (1993) in their study, looked at RNs as teachers of junior doctors. This study also points to the significant contribution the senior nurse makes to the learning of interns and this should be acknowledged. As noted earlier, during the course of this study three MOs were interviewed about their perceptions of the CNS. When asked about the teaching function of the senior nurse, the intern recalled the following scenario:

> *Oh yes, well there are quite a few occasions actually when I've thought, 'ah, this will be alright', and yet she's* [the experienced nurse] *busted me for it. But that's alright. She said 'no, listen that's wrong; what you're doing is wrong'. On this occasion it was with a CVP reading that I thought was alright for that person, but she'd had more experience, and she said 'no'. And she made me go and fix it up.*

(At this hospital nurses have been restricted from performing CVP readings for a number of years because they are deemed incapable of ascertaining reliable measurements).

The text has revealed the CNS can lead an enormously complex professional life which can be filled with variety, but at the same time there is a great deal of 'sameness' in it. Much of her work she takes for granted and affords little value. Perhaps this is because as Debra has pointed out;

CNSs get *'very blase about things, and tend to underestimate what* [they] *do'*. Her narrative is rich and exciting yet she is bored. She will say 'oh that, I'm always doing that' and it will be something quite extraordinary of great importance to the welfare of an other, but she will see it as ordinary and everyday and unimportant, just something she believes she has to do. At the end of her day when she is asked what she did, a CNS will still tell you about the visible, measurable elements, that she has completed so many dressings and given out so many sets of pills. She does not see the 'more than that' aspect, the invisible fabric of her work. Lumby (1991b:7) draws attention to this phenomenon when she writes: 'each day nursing involves acts which would be interpreted as "heroic" in the public sense, but not given a second thought by nurses'. Lumby believes the nurses's depreciation of her work is tied in with the fact that it is caring and caring appears to be an art, since 'it is not considered analytically and not valued as highly as scientific thought'. Waterworth (1995:14) delineates a similar understanding in her study on therapeutic caring. She suggests that nurses 'do not pat themselves on the back', nor are they 'good about saying where they have made a difference', because they have a tendency 'to see what they do as ordinary'.

As an experienced nurse, the CNS perceives she has essentially the 'same' job she had as an RN, undertaking the 'same' tasks as an RN, on the 'same' ward, on patients who have the 'same' problems utilising the 'same' skills. For her it seems, nothing has changed except those things that have a direct link to medicine, such as technology and drugs. And yet, she will tell you she does not want to be a doctor, nor indeed for that matter a NUM. That is not to say she is satisfied with her role as it stands. In general, a phn-A CNS wants to put her talents to better use. She is looking for increased autonomy in her practice and to be able to use her own initiative in instigating and carrying out the care of her patients. The CNS could be seen to be living in a world where she knows what she could do to make a difference to patient care, but perceives she is not able to do it. This is a source of deep dissatisfaction, and she seeks greater autonomy to overcome the problem. As the KMPG Peat Marwick study (1995:3) suggests, *'CNS is a title not a position'*. It is not surprising therefore that a phn-A CNS at some stage is going to become tired of the 'system' and all that it represents. For many, there is no hope for the future, and many do say if there is

something certain it is that they will be *'leaving bedside nursing.'*

Just as in other professions, where one CNS is content with her little niche, and seeks no more from it, the career CNS (phn-A) who has ambition, is ignored. It is to these nurses that nursing does such a disservice.

In the past, the majority of nurses have not sought careers, today the socio-political climate for women is changing. Bedside nurses are no longer 'filling in' until they get married, they are looking for greater professional commitment. The ambitious CNS wishes to make a career out of bedside nursing. She seeks, for example, to be able to attend conferences, but does not wish to do battle each time she requests time-off, preferring to be encouraged to do so instead. And, contrary to popular belief, many actually welcome the idea of preparing and delivering in-service lectures. By and large, she seeks a role with more recognition, she wishes to see less CNSs and the criteria for attainment of the position to be more stringently applied. She wants to be acknowledged for her excellence and is prepared to work just that bit harder for it. Pearson (1987:45) draws attention to the notion of 'expanding' as opposed to 'extending' the nursing role, expansion being 'concerned with a "deepening" and development of the role, drawing on those skills and areas of knowledge which are uniquely nursing'. He believes the role of the nurse contains elements so central to the well-being of the patient that the development of a clinical career structure ought to be founded on a 'deepening' of these aspects.

The fact that a CNS is constantly on-call and unable to leave the ward area is an aspect of her job which detracts from the possibility of her expanding her nursing knowledge and acquiring greater autonomy. She is unable for example, even in quiet periods to take time out for self directed study in the library, and even when absorbed in an in-service lecture will frequently find herself answering calls for attention. Autonomy could be gained in other ways, more particularly by addressing policy issues dictated by the 'system' which curtail her practice. Certain on-going rituals require scrutiny, for example on [Rose Ward] the staff were still directed to go to teabreaks at specific times, regardless of convenience in terms of workload.

Carol, mature aged, had once been a high-school teacher, and has also managed her own business before turning to nursing. Carol 'caused' problems on the ward because she sought greater autonomy, and yet in aspiring to it was thought to be fawning to medicine. She favoured the

dressing sister job because it set her apart and allowed her to use her own initiative in planning her day[2], in choosing how to dress a certain wound, for example. In her role as dressing sister, in order to assist the doctors, she would work through her lunch break expecting to take time off later when things were not so busy. The other CNSs, believing the doctors were taking advantage of them, refused to follow her example. Nurses, are not paid for their lunch breaks, and so their unwillingness to forego them is not altogether surprising. It does, however impede attempts at independent practice because in a profession it is perfectly reasonable to expect to be able to organise one's routine around the workload, not the workload around the routine.

Carol's past experience as a female science teacher had seen her perceived as rare and therefore treated as special, sentiments she was most unlikely to receive in her position as nurse. However, in helping out the medical staff with certain procedures during times the other CNSs would not, Carol was made to feel 'special' by medicine. Patient-directed rather than institution-directed, and preferring to meet medicine on an equal footing than play games, Carol courted disaster as a nurse in a traditional hierarchical bureaucracy like a Schedule 2 hospital. 'Caught between two opposing groups', she found herself neither belonging to medicine nor indeed to nursing (Short et al. 1993:49). And, because she was perceived to be ingratiating herself with medicine, she was subjected to some horizontal violence as well.

As mentioned, an advanced nurse is seen as someone who is presumably 'better' at her practice (Pearson, 1984). The CNS sees herself as 'not different, not special, just better'. As she presented during this study the CNS is someone whose practice is unquestionably better. Nevertheless, there are some who seek more from the role, and clearly expected more from it. The CNS, particularly phn-A CNS, is in nursing because she wants a career, not just a job, and wants in fact to be seen not just as better, but as 'different'. Benner (1982a:402) supports this notion of difference when she writes:

> The complexity and responsibility of nursing practice today requires long-term and ongoing career development. This in turn requires an understanding of the differences between the experienced nurse and the novice.

2

The CNSs stated that if many of the tasks they do perform as dressing sister, (which make the job so much more interesting and challenging), were to be formalised, they would no longer be allowed to carry them out.

Several years ago, the nursing profession in NSW was intent on ensuring a situation where every patient in hospital was nursed by a registered nurse. This meant the second level nurse, the enrolled nurse, would gradually be phased out. To date, this has not occurred and the plans have been abandoned for many reasons not least of which have been the expense in initiating such a move, together with certain recruitment problems. As things stand, the second level nurse remains and her numbers are in fact increasing at the expense of the registered nurse. And although there are clear guidelines set down delineating the role of the enrolled nurse it is not uncommon to find her working in a ward carrying out exactly the same job as the registered nurse, even the CNS for that matter. The only difference is that she hands over some of the drug-related tasks pertaining to her patients, to the RN. Despite the fact that the profession has clearly stated the enrolled nurse is to work under the supervision of the RN, in the hospital at which the CNSs were observed, with the exception of the NUM, this did not appear to be taking place. Certainly, for quite a while, the researcher was under the impression one of the enrolled nurses on one of the wards was registered. Her uniform appeared the same and her allocated work looked very similar. Little wonder the CNS feels disenchanted when she perceives herself as *'no different to an enrolled nurse'*.

A newspaper article (Patty, 12.9.1993) cited a recent study by Herdman, who looked at the issue of 'deskilling' in nurses and found that senior nurses were claiming their work was becoming increasingly 'junior' - one nurse said the work in the wards was 'plain housework'. Another said her work was 'demeaning, thankless, unrewarding, heavy and dirty'. Although Herdman's study has been disputed by various nursing bodies, it could be suggested that the phenomenological text in this study has highlighted a number of similar perceptions. Although the CNSs realise that basic tasks are an important component of their role, they do look for other more challenging aspects to off-set these.

The introduction of the CNS role should have enabled the experienced nurse to excel at the bedside, and there is no doubt many of them do, but the position is not recognised for what it is, mainly because she is not 'different' and her 'excellence' is overlooked. The top nurse excels at the bedside regardless of her position, and so administrators take-her-for-granted and as a result the 'system' eventually loses her. This notion is borne out by the huge gap currently in the work-force created by a dearth of specialist nurses from five-to-six years post-registration (Nagy and Lumby cited Lewis, 19.9.1994:5), and by the necessity to conduct a study such as that recently

undertaken by KMPG Peat Marwick (1995).

This failure of the 'system' to appreciate the contribution of the CNS, is most founded in the absence of a career structure that encourages professional improvement. As it stands, there are far more impediments - historical and gender related - that positively retard nurses 'getting on' with their chosen careers than there are encouragements. Many of these have been recounted in the literature reviewed in former chapters. In becoming a CNS it is assumed a CNS can identify and define what her role/job is. In spite of the shortcomings as outlined, the CNS's position is still sought by nurses. It remains a position, however loosely defined, that is seen as being 'senior' and with added responsibilities. To some extent it is a 'coveted' job and because of this it is assumed a CNS would be content with her role.

And yet, this research has shown that most CNSs are not content with their 'lot' (and reasons have been given). If there is a beginning as far as remedying the situation it could be argued that it should be with accreditation. This involves limiting the number of CNSs and raising the 'competency requirements' of those wanting to become one. She must be seen as part of a group of bedside nurses who excel at their work, to be seen as outstanding and a nurse who is valued and has been rewarded by the 'system'. She should be afforded greater autonomy to utilise her skills, and be seen to be doing a more exacting job than the other nurses on the ward. Experienced nurses want 'decision-making responsibilities in their own right' (Moloney, 1992:47).

The expertise of the CNS needs to be afforded greater recognition and her power base expanded. One way she can expand her power base is by recognising and valuing her own skills and the contribution she makes to the ward. Benner (1984) makes mention of meaningful incentives and reward systems for nurses. She states: 'clinical promotions, to be real promotions and not just wage increases, must offer new challenge and variety to the nurse's role. . . '(p203). Benner (1984:195) cites Yankelovich (1974), who points out that 'workers want to feel proud of their work, they want to feel competent'.

Yankelovich (1974, cited Benner, 1984:196) outlines three psychological gains which a person seeks from their work:

a) The opportunity to advance to more interesting, varied, and more satisfying work that also pays better and wins more recognition than the current job.
b) The desire to do a good job at whatever one is doing.
c) The yearning to find self-fulfilment through 'meaningful work'.

By 'meaningful work' people usually mean - work:

i) In which they can become involved, committed and interested.
ii) That challenges them to the utmost of their capabilities.
iii) That allows them to participate in decision making (Extracted from Benner, 1984:196).

From this study, it would be fair to say that nursing administration should take it upon themselves to acknowledge that 'nurses, as individuals and as a profession, need and want power' (Ferguson, 1985:93). The power is not power 'over' others, but power that can be utilised 'with' others. And, as Ferguson (1985) suggests, she needs power commensurate with her knowledge and expertise as the most senior caregiver closest to the patient. This 'qualitative' power gives her 'the ability to do and act', and facilitates the achievement of desired results (Ferguson, 1985:89). It is not enough to be seen to be 'different', it has to be accompanied by an 'authoritative' or 'institutional' based power that is not necessarily reliant on 'social' or 'adopted' power as determined by work circumstances, for this she must have administrative support. She must be seen to hold legitimate as well as expert and referent power. Silver (1986a:44) supports this assertion by pointing out that clinical roles are 'doomed to failure without administrative support and understanding'. Most especially her position as an expert nurse needs to be endorsed by the NUM.

In addition, consideration needs to be given to the policy that sees a CNS forfeiting her status should she seek to increase her expertise by moving to a different area. This ruling appears to be stifling the professional aspirations of the phnA-CNS and adds to her inertia and feelings of discontent by being 'tied' to a ward she no longer finds challenging. Affording the CNS the opportunity to move to new areas while preserving her 'expert' label, would retain this expert at the bedside, yet at the same time instil new energy and interest into her nursing work. This study has clearly shown that the skills which make a difference in terms of her nursing the patient, are skills that are transferable.

Moreover, the CNS must be allowed to attend conferences and similar educational sessions, given access to computer network facilities, and encouraged to set up associations with other CNSs and/or join those that currently exist. The medical profession has to made more aware of

her role and expertise. Medicine has little idea of what she is capable of being, doing and knowing. Working harmoniously alongside each other would, on the one hand, foster insight into the knowledge and skills of each other, while on the other, promote sensitivity of the part each performs in the never-ending 'drama' of hospital life. Perhaps the time has come for nursing to attempt to bridge the nurse-doctor divide, to deconstruct the discourses of distrust and dislike and reconstruct an understanding based on reconciliation and respect. Maybe, as Baker and Diekelmann (1994) suggest, collegial collaborative relationships can be built up through the sharing of narratives in which an understanding of each other's lived experiences are fostered.

Perhaps the postmodern era presents an opportunity for a move toward multidisciplinary education and research.

In a similar vein to medicine, it is time for nursing administration to refocus and approach its experts with more understanding. With less CNSs, her salary could be increased so that she receives remuneration in excess of the 'thereafter' RN. It might even be plausible to have differing levels of CNS, a three-tiered construct for example would furnish extra goals to attain and ensure a more perceptible future at the bedside.

Some would argue the constraints in expanding the role of the CNS are too overwhelming and the costs too high. Stevens (1976:30) has suggested 'clinical specialism is structurally ill-adapted to the typical bureaucratic management system'. Wright (1991:107) alludes to the 'struggle between the twin poles of professionalism and bureaucracy'. Thompson (1990:272), asserts that 'the wisdom of nursing is gradually being eclipsed by the politics of hierarchical bureaucracies'. It can be seen therefore, that nurses are aware that on the whole, institutionalised contexts are incompatible with nurses' interests (see also Retsas, 1995; Holden, 1991). If one reads the phenomenological text describing the CNS's lived experience and then considers the job description and list of functions regarding her role posed at the outset of this thesis, and in appendix A, it could be postulated that the expectations of the role are unrealistic and out-of-touch with the patriarchal system on which her workworld is based. Clearly, the 'system' as it is presented in the text, 'blocks' attempts by the CNS to fulfil her job description. This is a fundamental contradiction, in part created by medicine's prejudicial view of what the role of expert nurses should be.

The challenge for nurses then, is to consider the structural constraints on their practice and determine ways in which they can work to remove or ameliorate the effect/s. To develop, as Wright (1991:107) advocates, the skills of 'change agency'. Similarly, Benner (1984:199) calls for 'restructuring and sweeping changes' so that clinical nursing as a career can be 'brought in step with career opportunities in other fields'. In effecting such changes, some might see the potential for the CNS role to encroach on the domain of the intern. However as Daffurn (1993:10) has pointed out, although 'professional boundaries are merging, with many nurses and doctors asking where the line should be drawn', the 'questions and arguments are no different from the ones used at the turn of the century when only doctors were proficient in taking body temperature and blood pressure'. And, if nurses concentrate on 'deepening' their role rather than merely 'extending' it as Pearson (1987) suggests, the problem should not arise.

Although her role is different, overseas evidence suggests the specialist nurse *is* cost-effective (Wilson-Barnett, 1995). Having mapped her universe and observed the paths she treads each day, this study hopes to show that the role of the CNS in this State has been justified. The belief that 'expert nurse clinicians make life saving differences to patients' (Benner, 1984: 31) has been borne out, and the CNSs stories in this text verify that assertion. There can be no doubt, DRGs miss the bulk of her practice. There is no means to determine funding of the 'more than that' of her expertise. The fact, for example that she listens to her patients, gets to know them, develops a 'feel' for them and picks up on those subtleties often missed by other health care personnel, is inestimable in monetary terms. And yet it has been said, that DRGs may well 'shift the nursing focus back to meeting only the patient's physical needs', which means the emphasis will once again be solely on medicine's contribution (in Marriner Tomey; 1994:360). Ironically, it was a senior medical officer who so adequately summed up the DRG dilemma when he pointed out:

> *I understand the economic rationalists, but when I'm sick I don't really want an accountant looking after me.*
> *And if I'm going to die, I want someone to hold my hand while I'm dying.*

As previous chapters have shown, nurses have traditionally been seen to be 'powerless', a view rooted in the political and structural elements of the 'system' in which they work. Street's (1992a,b) critical analyses of the hegemonic nature of the health-care system, the culture of bureaucracy in which nurses work, is all about power/knowledge relationships. Speedy (1987), takes a feminist stance when she attributes nurses' lack of power in health-care to the politics of

sexuality. Certainly, the CNSs perceived very limited power in their roles. What power they did have was most often displayed covertly, because what 'power' they did have was not based on 'formal' power as that endorsed by the 'system' but power that comes from trust - 'social power'. People trust nurses (Chao, 1992), nurses become patient's confidantes, they do, see and feel intimate things of and about patients. Nurses have access to people at their most vulnerable, most insecure, most despairing moments. Nurses have in reality, great power, the power to improve the quality of patient care. The power to make a difference in the life or death of a patient; which includes care of their relatives. She even has power through her knowledge of the space on the ward (Street, 1992a), and undoubtedly she has power through her expertise (Ferguson, 1985).

Mason (1990:14) suggests the time has come for nurses to shun historical perspectives on power, and to 'individually and collectively recognize, acknowledge, and publicize their expertise'. By 'standing up and taking credit for their good work' (Chenevert, 1993), nurses can look to 'dismantle obstacles to progress' (Retsas, 1994:25). In other words, nurses need to become more political. Mason (1994:15) offers ways in which this can be carried out: for example, by testifying before government hearings, telling stories of expert nursing care to friends, neighbours, other health care professionals, administrators and the public, and by interacting with the media to effectively bring nursing expertise to public notice.

In this study nursing's expertise has been preserved in a phenomenological text for the comprehension of others. Storied accounts, such as the phenomenological text, motivate nurses to consider how nursing will obtain the power to influence the 'system' (Geanellos, 1995:60). Certainly, in bringing to light the lifeworld of the advanced practice nurse many shortcomings within the 'system' have been exposed. One might question indeed whether it is not up to the CNS herself to exert some influence on the hierarchical nature of the bureaucracy within which she works, in order to make that world more satisfying. One might suggest for example, that the CNS be more assertive in her interpersonal relationships with the 'system's' Others. And yet, while this approach appears sound, used in isolation it overlooks the socio-political context and the entrenched power relationships that operate within that workworld, (aspects that have certainly come to light in this study), and that allow stability to be maintained for the patients. The phenomenological text has shown that nurses run the wards and keep the 'system' afloat even though for much of the time, they themselves feel alienated from it and believe they have little power to influence it. Expert nurses run the wards so that medicine can operate. Without nurses

and most especially, the senior ones, such as the CNS, the 'system' would be unworkable. Medicine would not be able to continue to practise and hospitals would close their doors. In this chapter, strategies have been suggested to enhance the quality of the work experience of the CNS and these have included reviewing the clinical career structure, widening her power base, and making the position more elite. But there can be no doubt that the 'system' itself has to undergo some fundamental changes, and these must include recognition of the increased professionalisation of nursing and the vital role expert nurses play in the well-being of the patient. Furthermore, means for increasing the input by CNSs in regard to the care of their patients in an atmosphere of professional collegiality are urgently required.

'Nurses. We can't live without them', (Dept. of Health,1994) there is an undeniable truth in this statement. If the 'system' does not take better care of its CNSs, its 'precious resource' as Fralic (1988:5) puts it, the great tragedy for nursing and indeed humanity, is that not only will this resource be wasted, as some of it already is, but that when she ups and leaves, her real skills will be lost forever.

Recommendations for Future Research

This study has considered some of the historical, social/cultural and political dynamics in which the discipline of nursing operates and has revealed, it is hoped, what it is like to be a CNS in today's nursing world, at least in NSW. This is not the full picture, because as Husserl (1970) argued the full presence of a thing can never be experienced, there are always more possibilities for its being given. As such, the phenomenon CNS is accessible to an infinity of experiences, and so her lifeworld is always open to further exploration, and interpretation. But, it has attempted to give the fullest possible 'living' picture of a CNS in her world as it stands.

It is the researcher's contention that research needs to be carried out to ascertain the attitude, values and beliefs of medical staff in regard to nurses. If one was to undertake a similar study into the lifeworld of the medical officer one could describe how nurses are represented in their lived experience. Penetrating both perspectives may assist in bridging the gap to greater understanding. Alternatively, because nurses invariably are blind to their practice and tend not to see even each other's practice (Street, 1992a), it may throw more light on the role of the senior nurse to seek the perceptions of medicine. Similarly, an insight into the lived experience of nurse

administrators might reveal issues that would facilitate a coming together of real world and 'bureaucratic' nurses.

Perhaps most importantly, nursing needs to concentrate on discovering ways to change the 'system' so that it becomes more collegial. A 'system' that accords nurses the power to expand nursing's authority within health-care organisations, and enables them to shape their own future rather than have others shape it for them. Research into this area is long overdue. Such research endeavours should move nursing toward its rightful place in society (Mason, 1990).

Closing Remarks

In the Peat Marwick Report to the NSW Health Department on 'Issues Relating to Specialty Nursing Vacancies' (KMPG, 1995), the authors wrote (p22): 'perhaps the most potentially worrying aspect of the results for the NSW Health Department is the *depth of bitterness and disenchantment* so many nurses revealed during the sessions' (their emphasis). Similarly, in this study, interacting with the phenomenological text unveils a great many negative aspects to life on the ward, particularly for the phn-A type CNS. In light of the expert nurses's reality, it is hardly surprising there is a current dearth of experienced nurses. Certainly, the text raises that inexplicable question surrounding why some nurses remain at the bedside, while many others leave. Yet, as the literature has revealed, nurses have long been cognisant of the adversities clouding the bedside, and it would appear they have little changed.

In a phenomenological study exploring the perception of patients regarding caring and noncaring behaviour in nurses, Rieman (1986) came to the conclusion that one of the reasons nurses display noncaring actions in their work, is because nurses themselves have not been valued or cared for as individuals. And yet, in this study, the text has revealed it is the patients who are mainly responsible for keeping the CNS at the bedside. The social processes involved in their nursing, together with the satisfaction in being able to alleviate discomfort and/or promote recovery, rewards the CNS in a number of ways. In the researcher's opinion, it is precisely the fact that she is not valued or cared for as a nurse that makes the CNS value and care for her patients.

Other factors such as the mastering of new skills is undoubtedly an incentive, and the uncertainty of daily events serve as intermittent reinforcers to keep her in the clinical environs. The

camaraderie amongst the seniors, the social interaction, the hospital 'gossip' commit her to it. Napthine (1994) writes of the healthy effects of gossip, and refers to such informal communication as 'professional socialisation'. Thinking like nurses, the CNSs can often be seen communicating amongst each other without the use of words. They are secure in a culture so different, and yet for them, so familiar. One might even suggest that nurses are nurses, but that nursing is not always nursing. Those nurses who *truly nurse* will always be nurses and even when they have left it, will miss 'the bedside'.

It would seem fitting to end this phenomenological journey into the meaning of advanced practice, with a statement uttered at the one of the first meetings with the CNS, Jay. These words have travelled the course of this research and although undeniably subjective, seem to encapsulate the capricious nature of the world of the CNS. By so doing they also sum up the unanswerability of the question concerning the 'mysticism' of nursing (that is, the question concerning why, despite all the negative experiences, these CNSs stay, or should it be said, *survive*, at the bedside).

When asked what it was like to be a CNS, this expert nurse replied:

'I don't know how much longer I can take it, but on the whole I like it'.

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BIBLIOGRAPHY

Aamodt, A.M. 1989, 'Ethnography and epistemology: Generating nursing knowledge', in *Qualitative Nursing Research: A Contemporary Dialogue,* ed. J.M.Morse, Sage Publications, Newbury Park.

Agan, R.D. 1987, 'Intuitive knowing as a dimension of nursing', *Advances in Nursing Science,* 10, 1, 63-70.

Allen, D., Benner, P. & Diekelmann, N.L. 1986, 'Three paradigms for nursing research: methodological implications' in ed. P. Chinn, *Nursing Research Methodology: Issues and Implementation,* Aspen Publishers, Rockville.

Anderson, J.M. 1991, 'The phenomenological perspective', in *Qualitative Nursing Research: A Contemporary Dialogue*, Revised edn, ed. J. Morse, Aspen, Rockville.

Anderson, E.L., McCartney, E.S., Scheiber, J.A. & Thompson, E.A. 1989, 'Productivity measurement for clinical nurse specialists', *Clinical Nurse Specialist, 3,* 2, 80-84.

Anderson, G. & Hicks, S. 1986, 'The clinical nurse specialist - role, overview and future prospects', *The Australian Nurses Journal, 15,* 8,.36-38 & 53.

ANRAC Nursing Competencies Assessment Project: NCAP, 1990, *Report to the Australian Nurse Registering Authorities Conference,* Volume One(a): The Project Report; Volume Two(b): Assessment Technology; Volume Three(c): Archive and Data, Assessment and Evaluation Unit Education Dept., The University of Queensland.

Appleton, C. 1994, 'The gift of self: A paradigm for originating nursing as art', in *Art and Aesthetics in Nursing,* eds. P.L. Chinn & J. Watson, National League for Nursing Press, New York.

Arbon, P. 1995, 'Nursing exemplars: are they de-contextualised?' *Nursing Inquiry, 2,* 185-186.

Aristotle, 1942, *'The Poetics of Aristotle',* translated by P. H. Epps, University of North Carolina Press, New York.

Aroskar, M.A. 1980, 'The fractured image: The public stereotype of nursing and the nurse', in *Images and Ideals: opening dialogue with the humanities,* eds. S.F. Spicker & S. Gadow, Springer, New York.

Ashley, J.A. 1976, *Hospitals, Paternalism, and the Role of the Nurse,* Teachers College Press, New York.

Ashley, J.A. 1980, 'Power in structured misogyny: Implications for the politics of care', *Advances in Nursing Science, 2,* (April), 3-22.

Ashton, G. A. 1977, *Essentials of Intellectual Retardation,* McGraw Hill, Sydney.

Astedt-Kurki, P. & Liukkonen, A. 1994, 'Humour in nursing', *Journal of Advanced Nursing, 20,* 183-188.

Astrom, G. & Norberg, A. & Hallberg, I.R. 1995, 'Skilled nurses' experience of caring', *Journal of Professional Nursing, 11,* 2, (March-April), 110-118.

Atkins, S. & Murphy, K. 1993, 'Reflection: a review of the literature', *Journal of Advanced Nursing, 18,* 1188-1192.

Attrill, H. 1988, 'W.A. outlines its career structure', *The Australian Nurses Journal, 17,*6, (December-January), 38-39.

Australian Government Public Service Press, 1994, *Style Manual,* 5th edn. AGPService, Canberra.

Australian Health Ethics Committee, undated, Draft Discussion Paper *'Assessment of Qualitative Research: Information for Institutional Ethics Committees',* National Health and Medical Research Council.

Aydelotte, M. K. 1984, 'Foreword', in *From Novice to Expert, Excellence and Power in Clinical Nursing Practice,* by P. Benner, Addison-Wesley, Menlo Park.

Bailey, R.F. 1984, *A Survival Kit for Writing English,* 2nd edn, Longman Cheshire, Melbourne.

Baker, C., Wuest, J. & Stern, P. N. 1992, 'Method slurring: the grounded theory/phenomenology example', *Journal of Advanced Nursing, 17,* 1355-1360.

Baker, C. & Diekelmann, N. 1994, 'Connecting conversations of caring: Recalling the narrative to clinical practice', *Nursing Outlook,* (March-April), 65-70.

Baker, R. 1980, 'Care of the sick and cure of disease: Comment on "The fractured image"', in *Nursing Images and Ideals: opening dialogue with the humanities,* eds. S.F. Spicker & S. Gadow, Springer, New York.

Bartjes, A. 1991, 'Phenomenology in clinical practice', in *Towards a Discipline of Nursing,* eds. G. Gray, & R. Pratt, Churchill Livingstone, Melbourne.

Bartky, S. 1993, 'Foucault, feminity and the modernization of patriarchal power', in *Feminist Philosophies: Problems, Theories and Applications,* eds., J. Kournay, J. Sterba & R. Tong, Harvester Wheatsheaf, New York.

Bass, M. 1993, 'Novice CNS and role aquisition', *Clinical Nurse Specialist, 7,* 3, 148-152.

Bassett, C. C. 1994, 'Nurse teachers' attitudes to research: a phenomenological study', *Journal of Advanced Nursing, 19,* 585-592.

Beaumont, M. K. 1987, 'The nursing struggle', *The Australian Nurses Journal, 17,* 3, (September), 48-51.

Beaumont, M.K., Grimes, M. & Sudano, L. 1986, 'A program for career structure: The process of implementation', *The Australian Nurses Journal, 16*, 4, (October), 36-39.

Belenky, M.F., Clinchy, B.M., Goldberger, N.R. & Tarule, J. M. 1986, *Women's Ways of Knowing: The Development of Self, Voice and Mind,* Basic Books, New York.

Benner, P. 1982a, 'From novice to expert', *American Journal of Nursing,* (March), 402-407.

Benner, P. 1982b, 'Issues in competency-based testing', *Nursing Outlook, 30,* 5, 303-309.

Benner, P. 1983, 'Uncovering the knowledge embedded in clinical practice', *IMAGE:Journal of Nursing Scholarship, 15,* 2, 36-41.

Benner, P. 1984, *From Novice to Expert:Excellence and Power in Clinical Nursing Practice,* Addison-Wesley, Menlo Park.

Benner, P. 1985, 'Quality of life: a phenomenological perspective on explanation, prediction, and understanding nursing science', *Advances in Nursing Science 8,* 1, 1-14.

Benner, P. 1990, 'Response to hermeneutic inquiry' in *Advancing Nursing Science Through Research Volume 2,* ed. L.E. Moody, Sage Publications, Newbury Park.

Benner, P. 1994, 'The tradition and skill of interpretive phenomenology in studying health, illness and caring practices', in *Interpretive Phenomenology - Embodiment, Caring, and Ethics in Health and Illness,* ed. P. Benner, Sage, Thousand Oaks.

Benner, P. and Wrubel, J. 1982, 'Skilled clinical knowledge: The value of perceptual awareness', *Nurse Educator,* (May-June), 11-17.

Benner, P. & Tanner, C. 1987, 'Clinical judgment: How expert nurses use intuition', *American Journal of Nursing, 87,* 1, 23-31.

Benner, P. & Wrubel, J. 1989, *The Primacy of Caring: Stress and Coping in Health and Illness,* Addison-Wesley, Menlo Park.

Benner, P., Tanner, C. & Chesla, C. 1992, 'From beginner to expert: Gaining a differentiated clinical world in critical care nursing', *Advances in Nursing Science, 14,* 3, 13-28.

Bennett, M. 1991, 'Teenage mutant nurse researchers', Proceedings First International Conference: Centre for Nursing Research, eds. G. Gray & I. Mayner, Royal College of Nursing, Adelaide.

Berger, P.L. & Luckmann, T. 1966, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge,* Penguin Books, Harmondsworth.

Bergum, V. 1991, 'Being a phenomenological researcher', in *Qualitative Nursing Research: A Contemporary Dialogue,* Revised edn, ed. J. Morse, Aspen, Rockville.

Bernet, R., Kern, I. & Marbach, E. 1993, *An Introduction to Husserlian Phenomenology*, Northwestern University Press, Evanston.

Bleeker, H. & Mulderij, K. J. 1992, 'The experience of motor disability', *Phenomenology and Pedagogy, 10,* 1-18.

Blumer, H. 1972, 'Society as Symbolic Interaction', in *Symbolic Interaction: a reader in social psychology*, eds. J.G. Manis & B.N. Meltzer, Allyn & Bacon, Inc., Boston.

Bogdan, R. & Taylor, S. J. 1975, *Introduction to Qualitative Research Methods: A Phenomenological Approach to the Social Sciences,* John Wiley & Sons, New York.

Bonawit, V. 1989, 'The image of the nurse: the community's perception and its implications for the profession', in *Issues in Australian Nursing 2*, eds. G. Gray, & R. Pratt, Churchill Livingstone, Melbourne.

Bottorff, J. L. & Morse, J. M. 1994, 'Identifying types of attending: Patterns of nurses' work', *IMAGE:Journal of Nursing Scholarship, 26,* 1, (Spring), 53-60.

Bowden, P.L. 1995, 'The ethics of nursing care and the ethic of care', *Nursing Inquiry, 2,* 1, 10-21.

Braham, J. & Ward, S. 1993, 'Competencies - The foundation for future nursing exams', *Canadian Nurses Journal,* February, 39-41.

Breust, M. 1989, 'Institutionalization versus living in the community:psychiatric deinstitutionalization and nursing in New South Wales', in *Issues in Australian Nursing 2*, eds. G. Gray, & R. Pratt, Churchill Livingstone, Melbourne.

Brink, P. 1989, 'Issues in reliability and validity', in *Qualitative Nursing Research: A Contemporary Dialogue*, ed. J. Morse, Aspen Publishers, Rockville.

Brown, L. 1986, 'The experience of care: patient perspectives', *Topics in Clinical Nursing*, July, *8*, 2, 56-62.

Bucknell, M. 1995, 'Caring and politics: an uneasy combination for nurses?', *Contemporary Nurse, 4,* 1, 2-4.

Bull, R. & Hart, G. 1995, 'Clinical nurse specialist: walking the wire', *Contemporary Nurse, 4,* 1, (March), 25-32.

Bullock, A., Stallybrass, O. & Trombley, S. (eds.) 1988, *The Fontana Dictionary of Modern Thought*, 2nd edition, Fontana Press, London.

Butler, J. 1990, The Identification and Assessment of Competencies: The Nursing Project and its Implications, Paper written for the National Office of Overseas Skill Recognition, Australian Government Printing Service, Canberra.

Calkin, J.D. 1984, 'A model for advanced nursing practice', *The Journal of Nursing Administration,* (January), 24-30.

Cameron, S. 1989, 'Competencies for registration of nurses in Australia', *in Issues in Australian Nursing 2*, eds. G. Gray & R. Pratt, Churchill Livingstone, Melbourne.

Cameron-Traub, E. 1991, 'An evolving discipline', in *Towards a Discipline of Nursing,* eds. G. Gray & R. Pratt, Churchill Livingstone, Melbourne.

Campbell-Heider, N. & Hart, C.A. 1993, 'Updating the nurse's bedside manner', *IMAGE:Journal of Nursing Scholarship, 25*, 2, (Summer), 133-139.

Candy, P.C. 1989, 'Alternative paradigms in educational research', *Australian Educational Researcher, 16,* 3, 1-11.

Carpenter, M. 1978, 'Managerialism and the division of labour in nursing', in *Readings in the Sociology of Nursing,* eds. R. Dingwell & J. McIntosh, Churchill Livingstone, Edinburgh.

Carpenter, M. 1980, 'Asylum nursing before 1914: A chapter in the history of labour', in *Rewriting Nursing History*, ed. C. Davies, Croom Helm, London.

Carper, B.A. 1978, 'Fundamental patterns of knowing in nursing', *Advances in Nursing Science, 1*, 13-23.

Carper, B.A. 1992, 'Philosophical inquiry in nursing: An application', in *Philosophic Inquiry in Nursing,* eds. J.F. Kikuchi & H. Simmons, Sage Publications, Newbury Park.

Carr, W. & Kemmis, S. 1986, *Becoming Critical: Education, Knowledge and Action Research,* Deakin University Press, Victoria.

Catalano, J. S. 1980, *A Commentary on Jean-Paul Sartre's "Being and Nothingness"*, University of Chicago Press, Chicago.

Chalmers, A.F. 1979, *What is this thing called Science?*, University of Queensland Press, St. Lucia.

Chao, Y. 1992, 'A unique concept of caring', *International Nursing Review, 39*, 6, 181-184.

Chaska, N.L. (ed.) 1990, *The Nursing Profession:Turning Points,* C.V. Mosby, St. Louis.

Cheek, J. & Rudge, T. 1994, 'Been there, done that? Consciousness raising, critical theory and nurses', *Contemporary Nurse, 3*, 2, (June), 58-63.

Cheek, J., Gibson, T. & Gilbertson, J. 1995, 'Competencies: really or merely useful?' in Issues in Australian Nursing 4, eds. G. Gray & R. Pratt, Churchill Livingstone, Melbourne.

Chenevert, M. 1993, *The Pro-Nurse Handbook,* 2nd edition, Mosby, St. Louis.

Chenitz, W.C. & Swanson, J. M. 1986, *From Practice To Grounded Theory: Qualitative Research in Nursing*, Addison-Wesley, Menlo Park.

Chinn, P.L. (ed.) 1986, *Nursing Research Methodology: Issues and Implementation*, Aspen Publication, Rockville.

Chinn, P. L. 1988, 'From the Editor: Knowing and doing', *Advances in Nursing Science, 10*, 3, (April), vii-viii.

Chinn, P. L. 1994, 'Developing a method for aesthetic knowing in nursing', in *Art & Aesthetics in Nursing*, National League for Nursing Press, New York.

Chinn, P.L. & Jacobs, M.K. 1987, *Theory and Nursing: a systematic approach*, 2nd edition, The C.V. Mosby Co., St.Louis.

Chinn, P.L. & Kramer, M. K. 1991, *Theory and Nursing: a systematic approach*, 3rd edition, Mosby Year Book, St. Louis.

Chinn, P.L. & Watson, J. (eds.) 1994, *Art & Aesthetics in Nursing*, National League for Nursing Press, New York.

Chladenius, J. M. 1986, 'On the interpretation of historical books and accounts', in *The Hermeneutics Reader: Texts of the German Tradition from the Enlightenment to the Present*, ed. K. Mueller-Vollmer, Basil Blackwell, Oxford.

Christensen, J, 1990, *Nursing Partnership - A Model for Nursing Practice*, Daphne Brasell Associates Press, Wellington.

Christian, J. L. 1973, *Philosophy: An Introduction to the Art of Wondering*, Rinehart Press, San Fransisco.

Clark, G. 1989, 'To be or not to be - it's time to market nursing's image', in *Issues in Australian Nursing 2*, eds. G. Gray, & R. Pratt, Churchill Livingstone, Melbourne.

Cobb, A. K. & Hagelmaster, J. N. 1987, 'Ten criteria for evaluating qualitative research proposals, *Journal of Nursing Education, 26*, 4, (April), 138-143.

Cochrane, J. 1989, 'Influencing the politics of health reform', in *Issues in Australian Nursing 2*, eds. G. Gray & R. Pratt, Churchill Livingstone, Melbourne.

Cody, W.K. 1994, 'Meaning and mystery in nursing science and art', *Nursing Science Quarterly, 7*, 2, 48-51.

Cody, W.K. & Mitchell, G.J. 1992, 'Parse's theory as a model for practice: The cutting edge', *Advances in Nursing Science, 15*, 2, 52-65.

Cole, E. B. 1993, *Philosophy and Feminist Criticism - An Introduction*, Paragon House, New York.

Colliere, M. F. 1986, 'Invisible care and invisible women as health care-providers', *International Journal of Nursing Studies*, *23*, 2, 95-112.

Cordiner, C. M. 1968, Personality testing of Aberdeen student nurses, *Nursing Times*, February 9th, 178-180.

Cornell, J. A. 1992, 'Countdown to casemix management: An educational perspective'. *Proceedings of the 5th National Nursing Education Conference*, Faculty of Nursing, Sydney.

Cottingham, J. 1995, 'Descartes, Rene (1596-1650)', in *The Oxford Companion to Philosophy*, ed. T. Honderich, Oxford University Press, Oxford.

Cousins, M. & Hussain, A. 1984, *Michel Foucault*, MacMillan, London.

Cowling, W. R. 1993, 'Unitary knowing in nursing practice', *Nursing Science Quarterly*, *6*, 4, (Winter), 201-207.

Crandall, B. & Getchell-Reiter, K. 1993, 'Critical decision method: A technique for eliciting concrete assessment indicators from the intuition of NICU nurses', *Advances in Nursing Science*, *16*, 1, (September), 42-51.

Creighton, H. & Lopez, F. 1982, *A History of Nursing Education in New South Wales*, 2nd edn, Frank Lopez, Sydney.

Cribb, A., Bignold, S. & Ball, S.J. 1994, 'Linking the parts: an exemplar of philosophical and practical issues in holistic nursing', *Journal of Advanced Nursing*, *20*, 233-238.

Crick, M. 1989, 'Shifting identities in the research process: an essay in personal anthropology' in *Doing Fieldwork: Eight Personal Accounts of Social Research*, ed. J. Perry, Deakin University Press, Geelong.

Criddle, L. 1993, 'Healing from surgery: A phenomenological study', *IMAGE:Journal of Nursing Scholarship*, *25*, 3, 208-213.

Crotty, M. 1994, 'Phenomenology and Nursing Research - New wine in old wineskins' Workshop, Faculty of Nursing, University of Sydney, July 15th.

Crotty, M. 1996, *Phenomenology and Nursing Research*, Churchill Livingstone, Melbourne.

Curthoys, A. 1988, *For and Against Feminism: A Personal Journey into Feminist Theory and History*, Allen & Unwin, Sydney.

Daffurn, K. 1993, 'The role of the intensive care nurse - their choice', *Australian Critical Care*, *6*, 2, 10-15.

Daffurn, K. 1994, 'Intensive care and DRGs - where are we up to?' *Australian Critical Care*, *7*, 1, 13-15.

Darbyshire, P. 1994, 'Skilled expert practice: is it 'all in the mind'? A response to English's critique of Benner's novice to expert model', *Journal of Advanced Nursing, 19*, 755-761.

Darbyshire, P. 1995, 'Lessons from literature: Caring, interpretation, and dialogue', *Journal of Nursing Education, 34*, 5, (May), 211-216.

Davies, C. (ed.) 1980, *Rewriting Nursing History*, Croom Helm, London.

Davies, B. & Eng, B. 1995, 'Implementation of the CNS Role in Vancouver, British Columbia, Canada', *Clinical Nurse Specialist*, 9, 1, 23-30.

Davis, M.Z. 1986, 'Observation in natural settings', in *From Practice to Grounded Theory*, eds. W. C. Chenitz & J. M. Swanson, Addison-Wesley, Menlo Park.

D'Cruz, J.V. & Bottorff, J.L. 1986, *The Renewal of Nursing Education:A Cultural Perspective of Continuities and Change*, La Trobe University Health Service, Melbourne.

Dean, M. & Bolton, G. 1980, 'The administration of poverty and the development of nursing practice in Nineteenth-century England', in *Rewriting Nursing History*, ed. C. Davies, Croom Helm, London.

Delacour, S. 1991, 'The construction of nursing: ideology, discourse, and representation' in *Towards a Discipline of Nursing*, eds. G. Gray & R. Pratt, Churchill Livingstone, Melbourne.

Delacour, S. & Short, S. D. 1992, 'Nursing, medicine and women's health: a discourse analysis', in *Issues in Australian Nursing 3*, eds. G. Gray, & R. Pratt, Churchill Livingstone, Melbourne.

Dent, J. 1994, 'The ANRAC competencies in context', *The Lamp*, (August), p35.

Descartes, R. 1968, *Discourse on Method and the Meditations*, translated by F.E. Sutcliffe, Penguin Books, London.

Dey, I. 1993, *Qualitative Data Analysis, A User Friendly Guide for Social Scientists*, Routledge, London.

Diekelmann, N. L. 1993, 'Behavioural pedagogy: A Heideggerian hermeneutical analysis of the lived experiences of students and teachers in baccalaureate nursing education', *Journal of Nursing Education, 32*, 6, (June), 245-254.

Dingwell, R. & Mcintosh, J. (eds.) 1978, *Readings in the Sociology of Nursing*, Churchill Livingstone, Edinburgh.

Doering, L. 1992, 'Power and knowledge in nursing: A feminist poststructuralist view', *Advances in Nursing Science, 14*, 4, 24-33.

Dreyfus, H.L. 1993, *Being-in-the World: A Commentary on Heidegger's Being and Time*, The MIT Press, Cambridge.

Dreyfus, H.L. 1995, 'Philosophy of Action: Heidegger contra Husserl and Searle', Visiting Lecture, University of Sydney, September.

Duffield, C., Donoghue, J. & Pelletier, D. 1995a, 'CNSs' perceptions of role competencies: One Australian perspective', *Clinical Nurse Specialist, 9,* 1, 13-22 .

Duffield, C., Pelletier, D. & Donoghue, J. 1993, 'The road to quality: Clinical manager or clinical expert', Paper presented at the University of Newcastle, National Nursing Conference, Quest for Excellence, 2-3 July.

Duffield, C., Pelletier, D. & Donoghue, J. 1995b, 'A profile of the clinical nurse specialist in one Australian State', *Clinical Nurse Specialist, 9,* 3, (May), 149-154.

Dunlop, C. 1994, 'Is a science of caring possible?' in *Interpretive Phenomenology*, ed. P. Benner, Sage, Thousand Oaks.

Edwards, B. 1994, 'Telephone triage: how experienced nurses reach decisions', *Journal of Advanced Nursing, 19*, 717-724.

Emden, C. 1991, 'Ways of knowing in nursing' in *Towards a Discipline of Nursing,* eds. G. Gray, & R. Pratt, Churchill Livingstone, Melbourne.

English, I. 1993, 'Intuition as a function of the expert nurse: a critique of Benner's novice to expert model', *Journal of Advanced Nursing, 18,* 387-393.

Ersser, S. 1991, 'A search for the therapeutic dimensions of nurse-patient interaction', in *Nursing as Therapy,* eds. R. McMahon & A. Pearson, Chapman Hall, London.

Everson, S. J. 1981, 'Integration of the role of Clinical Nurse Specialist', *Journal of Continuing Education in Nursing, 12,* 2, 16-19.

Fawcett, J. 1993, 'From a plethora of paradigms to parsimony in worldviews', *Nursing Science Quarterly, 6,* 2, (Summer), 56-57.

Fenton, M. V. 1985, 'Identifying competencies of Clinical Nurse Specialists', *Journal of Nursing Administration, 15,* 12, 31-37.

Fenton, M. V. 1992, 'Education for the advanced practice of Clinical Nurse Specialists', *ONF* 19, 1, (Supplement), 16-20.

Ferguson, L. 1993, 'Casemix update', *Australian Critical Care, 6,* 2, 16-17.

Ferguson, V.D. 1985, 'Two perspectives on power', in *Political Action Handbook for Nurses,* eds. D.J. Mason. & S.W. Talbott, Addison-Wesley, Menlo Park.

Field, P. A. & Morse, J. M. 1985, *Nursing Research: The Application of Qualitative Approaches,* Croom Helm, London.

Firestone, W.A. 1987, 'Meaning in method: The rhetoric of quantitative and qualitative research', *Educational Researcher, 16,* 7, 16-21.

Ford, M. 1990, 'The nurse specialist: A cornerstone of quality patient care', *Journal of MAG, 79,* 101-103.

Forsyth, S. 1995, 'Historical continuities and constraints in the professionalization of nursing', *Nursing Inquiry,* 2, 164-171.

Foucault, M. 1977, *Discipline and Punish: The Birth of the Prison,* trans. A. Sheridan, Vintage Books, New York.

Fralic, M. F. 1988, 'Nursing's precious resource: The Clinical Nurse Specialist', *Journal of Nursing Administration, 18,* 2, (February), 5-6.

Fraser, N. & Nicholson, L. J. 1990, 'Social criticism without philosophy: An encounter between feminism and postmodernism', in *Feminism/Postmodernism,* ed. L.J. Nicholson, Routledge, New York.

Futrell, M., Wondolowski, C. & Mitchell, G. 1993, 'Aging in the oldest living in Scotland: A phenomenological study', *Nursing Science Quarterly, 6,* 4, (Winter), 189-194.

Gadamer, H-J. 1975, *Truth and Method,* 2nd revised edn, trans. W. Glen-Doepel, Sheed & Ward, London.

Gadamer, H-J. 1976, 'Editor's Introduction' *in Philosophical Hermeneutics,* trans. D. E. Linge, University of California Press, Berkeley.

Gadow, S. 1995, 'Clinical epistemology: A dialectic of nursing assessment', *Canadian Journal of Nursing Research, 27,* 2, 25-34.

Gagen, M. 1984, 'Career structure - Background', *The Australian Nurses Journal, 14,* 4, (October), 47-48.

Geanellos, R. 1995, 'Exploring nurses' storied accounts of practice', *Contemporary Nurse, 4,* 2, (June), 56-60.

Gelven, M. 1989, *A Commentary on Heidegger's Being and Time,* Revised edn, Northern Illinois University Press, DeKalb.

George, J. B. (ed.) 1980, *Nursing Theories: The Base for Professional Nursing Practice,* 2nd edn, Prentice/Hall International Inc., Englewood Cliffs.

Germain, C. P. 1993, 'Ethnography: The Method', in *Nursing Research:A Qualitative Perspective,* eds. P.Munhall & C. Oiler Boyd, National League for Nursing Press:New York.

Giddens, A. 1976, 'Introduction'; 'Some schools of social theory and philosophy'; 'Agency, act-identifications and communicative intent' & 'Positivistic dilemmas' in *New Rules of Sociological Method:A Positive Critique of Interpretive Sociologies,* Hutchinson, London.

Gioiella, E.C. 1993, 'Meeting the demands for advanced practice nurses', *Journal of Professional Nursing, 9*, 5, (September-October), p. 254.

Giovannetti, P. 1985, 'DRGs and nursing workload measures', *Computers in Nursing, 3*, 2, 88-91.

Girard, N. 1987, 'The CNS: Development of the role' in *The Clinical Nurse Specialist: Perspectives on Practice*, ed. S. W. Menard, John Wiley & Sons, New York.

Gonczi, A., Hager, P. & Oliver, L. 1990, 'Establishing competency-based standards in the professions', *NOOSR Research Paper No. 1*, Australian Government Publishing Service, Canberra.

Gray. G. (ed.) 1990, *The Australasian Nurse Registering Authorities Conference (ANRAC) Competencies*, Nurses Board of South Australia, Adelaide.

Gray, G. 1991, 'Developing competencies for nursing practice', in *Proceedings of First International Conference Nursing Research: Pro-active vs Reactive*, Centre for Nursing Research Inc., Adelaide.

Gray, G. & Pratt, R. (eds.) 1989, *Issues in Australian Nursing 2*, Churchill Livingstone, Melbourne.

Gray, G. & Pratt, R. (eds.) 1991, *Towards a Discipline of Nursing*, Churchill Livingstone, Melbourne.

Greeneich, D, 1993, 'The link between new and return business and quality of care: Patient satisfaction', *Advances in Nursing Science, 16*, 1, 62-72.

Greenwood, J. 1993, 'Reflective practice: a critique of the work of Argyris and Schon', *Journal of Advanced Nursing, 18*, 1183-1187.

Greenwood, J. 1994, 'Action research: a few details, a caution and something new', *Journal of Advanced Nursing, 20*, 13-18.

Grene, M 1957, *Martin Heidegger*, Bowes and Bowes, London.

Grussing, P.G. 1984, 'Education and practice: Is competency-based education closing the gap?' *American Journal of Pharmaceutical Education*, 48, (Summer), 117-124.

Guba, E. G. & Lincoln, Y. S. 1988, *Effective Evaluation*, Jossey-Bass Publishers, San Fransisco.

Guignon. C. (ed.) 1993, *The Cambridge Companion to Heidegger*, Cambridge University Press, Cambridge.

Hamilton, P. 1974, 'Introduction'; 'Phenomenological-sociological approaches to the sociology of knowledge'; 'Conclusions' *in Knowledge and Social Structure: An Introduction to the Classical Argument in the Sociology of Knowledge*, Routledge & Kegan Paul, London.

Hampton, D.C. 1993, 'Implementing a managed care framework through care maps', *Journal of Nursing Administration, 23*, 5, (May), 21-27.

Hampton, D.C. 1994, 'Expertise: The true essence of nursing art', *Advances in Nursing Science, 17*, 1, 15-24.

Hardy, L. K. 1984, 'The emergence of nursing leaders - A case of in-spite of, not because - of', *International Nursing Review, 31*, 1, 11-15.

Harre, R and Lamb, R (eds.) 1986, *The Dictionary of Personality and Social Psychology*, Blackwell Reference, Oxford.

Harrison, L. & Cameron-Traub, E. 1994, 'Patients' perspectives on nursing in hospital', in *Just Health: Inequality in Illness, Care and Prevention*, eds. C. Waddell & A. R. Petersen, Churchill Livingstone, Melbourne.

Hazelton, J. H., Boyum, C. M. & Frost, M. H. 1993, 'Clinical Nurse Specialist subroles: foundations for entrepreneurship', *Clinical Nurse Specialist, 7*, 1, 40-45.

Heidegger, M. 1962, *Being and Time*, translated J. Macquarrie, & E. Robinson, Blackwell, Oxford.

Heidegger, M. 1982, *The Basic Problems of Phenomenology*, Revised Edition, translated A. Hofstadter, Indiana University Press, Bloomington.

Heidegger, M. 1984, 'Transcendence and temporality', in *The Metaphysical Foundations of Logic*, translated by M. Heim, Indiana University Press, Bloomington.

Heidt, P.R. 1990, 'Openness: A qualitative analysis of nurses' and patients' experiences of therapeutic touch', *IMAGE*:Journal of Nursing Scholarship, *22*, 3, (Fall), 180-186.

Henderson, V. 1964, 'The nature of nursing', *American Journal of Nursing, 64*, 62-68.

Heron, J. 1981, 'Philosophical basis for a new paradigm', in *Human Inquiry, A Sourcebook of New Paradigm Research*, eds. P. Reason & J. Rowan, John Wiley & Sons, Chichester.

Heron, J. 1981, 'Experiential research methodology' in *Human Inquiry, A Sourcebook of New Paradigm Research*, eds. P. Reason & J. Rowan, John Wiley & Sons, Chichester.

Heywood, L., Gonczi, A. & Hager, P. 1992, 'A guide to the development of competency standards for professions', *Research Paper no 7, National Office of Overseas Skills Recognition*, Australian Government Publishing Service, Canberra.

Hickson, P. & Holmes, C. 1994, 'Nursing the postmodern body: A touching case', *Nursing Inquiry, 1*, 1, (November), 3-14.

Hindle, D. 1994, 'Funding intensive care in the DRG age: An overview', *Australian Critical Care*, 7, 3, 8-11.

Hogston, R.1995, 'Quality nursing care: a qualitative inquiry', *Journal of Advanced Nursing, 21,* 116-124.

Holden, R. 1991, 'In defence of Cartesian dualism and the hermeneutic horizon', *Journal of Advanced Nursing, 16,* 1375-1381.

Hollinger, L.M. & Buschmann, M.B.T. 1993, 'Factors influencing the perception of touch by elderly nursing home residents and their health caregivers', *International Journal of Nursing Studies, 30,* 5, 445-461.

Hollinger, R. 1994, *Postmodernism and the Social Sciences; A Thematic Approach,* Sage Publications, Thousand Oaks.

Holt, F.M. 1986, 'A theoretical model for clinical specialist practice', *Nursing and Health Care, 5,* (October), 445-449.

Howard, R.J. 1982, 'Introduction: Origins of the problem' and 'Ontological hermeneutics' *in Three Faces of Hermeneutics: An Introduction to Current Theories of Understanding,* University of California Press, Berkeley.

Huether, S.E. 1987, 'Foreword', in *Theory and Nursing: a systematic approach,* eds. P.L. Chinn & M.K. Jacobs, C.V. Mosby, St. Louis.

Husserl, E. 1970, *The Crisis of European Sciences and Transcendental Phenomenology,* Translated by D. Carr, Northwestern University Press, Evanston.

Jacob, E. 1988, 'Clarifying qualitative research: A focus on traditions', *Educational Researcher, 17,* 1, 16-24.

James, C.R. & Clarke, B.A. 1994, 'Reflective practice in nursing: issues and implications for nurse education', *Nurse Education Today, 14,* 82-90.

Jameton, A. 1977, 'The nurse: When roles and rules conflict', *Hastings Center Report,* 7, 22-23.

Jasper, M. A., 1994, 'Issues in phenomenology for researchers of nursing', *Journal of Advanced Nursing, 19,* 309-314.

Jay, N. 1981, 'Gender and dichotomy', *Feminist Studies,* 7, 1, (Spring), 38-55.

Jenkins, E. 1989, 'Nurses' control over nursing', in *Issues in Australian Nursing 2,* eds. G. Gray, & R. Pratt, Churchill Livingstone, Melbourne.

Jenkins, E., King, B. & Gray, G. (eds.) 1982, *Issues in Australian Nursing,* Churchill Livingstone, Melbourne.

Jensen, K.P., Back-Pettersson, S.R. & Segesten, K.M. 1993, *Nursing Science Quarterly, 6,* 2, (Summer), 98-104.

Johnson, G. R. 1994, 'The phenomenon of death: a study of Diploma in Higher Education nursing students' reality', *Journal of Advanced Nursing, 19,* 1151-1161.

Johnson, J. L. 1991, 'Nursing science: Basic, applied, or practical? Implications for the art of nursing', *Advances in Nursing Science, 14,* 1, 7-16.

Jolley, M. & Brykczynska, G. (eds.) 1993, *Nursing: its Hidden Agendas,* Edward Arnold, London.

Jorgensen, D. L. 1989, *Participant Observation: A Methodology for Human Studies,* Sage Publications, Newbury Park.

Kalisch, P.A. & Kalisch, B.J. 1987, *The Changing Image of the Nurse,* Addison-Wesley, Menlo Park.

Kellehear, A. 1989, 'Ethics and social research', in *Doing Fieldwork: Eight Personal Accounts of Social Research,* ed. J. Perry, Deakin University Press, Geelong.

Kelly, B. 1990, 'Respect and caring: Ethics and essence of nursing', in *Ethical and Moral Dimensions of Care,* ed. M. M. Leininger, Wayne State University Press, Detroit.

Kenway, J. & Watkins, P. 1994, *Nurses, power politics and post-modernity,* A Monograph, University of New England Press, Armidale.

Kermode, S. 1993, The power to be different: is professionalization the answer? *Contemporary Nurse, 2,* 3, (December), 102-109.

Kermode, S. & Brown, C. 1995, 'Where have all the flowers gone? Nursing's escape from the radical critique', *Contemporary Nurse, 4,* 1, (March), 8-15.

Ketefian, S. 1987, 'A case study of theory development: moral behaviour in nursing', *Advances in Nursing Science, 9,* 2, 10-19.

Kidd, P. & Morrison, E.F. 1988, 'The progression of knowledge in nursing: A search for meaning', *IMAGE:Journal of Nursing Scholarship* 20, 4, (Winter), 222-224.

Kikuchi, J. F. & Simmons, H. (eds.) 1992, *Philosophic Inquiry in Nursing,* Sage, Newbury Park.

King, K.E. 1994, 'Method and methodology in feminist research: what is the difference?' *Journal of Advanced Nursing, 20,* 19-22.

King, M. 1986, 'Career Structure in the USA', *The Australian Nurses Journal, 15,* 9, (April), 46-47.

Kitson, A.L. 1986, 'Indicators of quality in nursing care - an alternative approach', *Journal of Advanced Nursing, 11,* 2, 133-144.

Kitson, A.L. 1987, 'Raising standards of clinical practice - the fundamental issue of effective nursing practice, *Journal of Advanced Nursing, 12,* 3, 321-329.

Kitson, A.L. (ed.) 1993, *Nursing Art and Science*, Chapman & Hall, London.

Kitson, A. L. 1993, 'Formalizing concepts related to nursing and caring', in *Nursing Art and Science*, ed. A. Kitson, Chapman & Hall, London.

Koch, T. 1990, 'A new clinical career structure for nurses: trial and evaluation. The South Australian experience', *Journal of Advanced Nursing*, 15, 869-876.

Koch, T. 1994, 'Establishing rigour in qualitative research: the decision trail', *Journal of Advanced Nursing, 19,* 976-986.

Koch, T. 1995, 'Interpretive approaches in nursing research: the influence of Husserl and Heidegger', *Journal of Advanced Nursing, 21,* 827-836.

Kockelmans, J. J. 1965, *Martin Heidegger: A First Introduction to His Philosophy,* Duquesne University Press, Pittsburgh.

Kockelmans, J. J. (ed.) 1967, *Phenomenology: The Philosophy of Edmund Husserl and Its Interpretation,* Doubleday & Co., New York.

Kockelmans, J .J. 1975, 'Toward an interpretive or hermeneutic social science', *Graduate Faculty Philosophy Journal, 5,* 1, 73-96.

Kockelmans, J. J. 1987, 'Heidegger, Martin', in *Thinkers of the Twentieth Century,* ed. R. Turner, St. James Press, Chicago.

Kondora, L. L. 1993, 'A Heideggerian hermeneutical analysis of survivors of incest', *IMAGE: Journal of Nursing Scholarship, 25,* 1, 11-16.

Kramer, M. 1974, *Reality Shock - why nurses leave nursing*, The C.V. Mosby Co., St. Louis.

Kramer, M. 1990, 'Holistic nursing: Implications for knowledge development and utilization', in *The Nursing Profession: Turning Points*, ed. N. Chaska, C.V. Mosby, St. Louis.

Kuhse, H. 1993, 'Caring is not enough: reflections on a nursing ethics of care', *The Australian Journal of Advanced Nursing, 11,* 1, (September - November), 32-42.

Kyle, B.A. & Kinder, S. 1990, 'Costing out nursing: Combining PCSs, DRGs, and standards of care', *Health Care Supervisor*, 8, 2, (January), 46-56.

Laing, R.D. 1967, *The Politics of Experience and the Bird of Paradise*, Penguin Books, Harmondsworth.

Laing, M. 1993, 'Gossip: Does it play a role in the socialization of nurses?' *IMAGE:Journal of Nursing Scholarship, 25,* 1, (Spring), 37-43.

Langeveld, M. J. 1983a, 'The stillness of the secret place', *Phenomenology and Pedagogy, 1,* 1, 11-17.

Langeveld, M. J. 1983b, 'The secret place in the life of a child', *Phenomenology and Pedagogy, 1*, 2, 181-191.

Larson, P.J. 1984, 'Important nurse caring behavious perceived by patients with cancer', *Oncology Nursing Forum, 11*, 6, (November-December), 46-50.

Lather, P. 1986, 'Issues of validity in openly ideological research: Between a rock and a soft place', *Interchange, 17*, 4, (Winter), 63-84.

Lauder, W. 1994, 'Beyond reflection: practical wisdom and the practical syllogism', *Nurse Education Today*, 14, 91-98.

Lawler, J. 1991, *Behind the Screens - Nursing, Somology, and the Problem of the Body*, Churchill Livingstone, Melbourne.

Lawler, J. 1994, Report on Expectations of the Nursing Service of St. Vincent's Private Hospital: A Pilot Study of Adult Patients Admitted for Elective Surgery, The University of Sydney.

Leininger, M. M. 1978, 'Part One' of *Transcultural Nursing: Concepts, Theories and Practices*, John Wiley and Sons, New York.

Leininger, M. M. 1981, (ed.) 'The phenomenon of caring: Importance, research questions and theoretical considerations'; 'Cross-cultural hypothetical functions of caring and nursing care'; 'Some philosophical, historical and taxonomic aspects of nursing and caring in American culture' *in Caring: An Essential Human Need*, Charles B. Slack, New Jersey.

Leininger, M.M.1986, 'Care facilitation and resistance factors in the culture of nursing', *Topics in Clinical Nursing, 8*, 2, (July), 1-12.

Leininger, M.M. (ed.) 1990, *Ethical and Moral Dimensions of Care*, Wayne State University Press, Detroit.

Leonard, V.W. 1989, 'A Heideggerian phenomenological perspective on the concept of the person', *Advances in Nursing Science, 11*, 4, 40-55.

Leonard, V.W. 1994, 'A Heideggerian phenomenological perspective on the concept of person', in *Interpretive Phenomenology*, ed. P. Benner, Sage, Thousand Oaks.

Levesque-Lopman, L. 1988, *Claiming Reality: Phenomenology and Women's Experience*, Rowman & Littlefield Publishers, New Jersey.

Lewins, F. 1987, *Writing a Thesis*, Australian National University, Canberra.

Lipson, J. G. 1991, 'The use of self in ethnographic research', in *Qualitative Nursing Research: A Contemporary Dialogue*, Revised edn, ed. J.M. Morse, Sage, Newbury Park.

London, F. 1987, 'Should men be actively recruited into nursing?' *Nursing Administration Quarterly, 12*, 1, 75-81.

Lowenberg, J. S. 1993, 'Interpretive research methodology: Broadening the dialogue', *Advances in Nursing Science, 16,* 2, 57-69.

Lublin, J. & Gething, L. 1993, 'RNs as teachers of junior doctors', *The Australian Journal of Advanced Nursing, 10,* 2, (December-February), 3-9.

Lumby, J. 1991a, 'Threads of an emerging discipline: praxis, reflection, rhetoric and research', in *Towards a Discipline of Nursing,* eds. G. Gray & R. Pratt, Churchill Livingstone, Melbourne.

Lumby, J. 1991b, *Nursing, Reflecting on an Evolving Discipline,* A Monograph, Deakin University Press, Geelong.

Lumby, J. 1994, *Exploring the experience of a life-threatening illness,* A Monograph, The University of New England Press, Armidale.

Lupton, D. 1995, 'Perspectives on power, communication and the medical encounter: implications for nursing theory and practice', *Nursing Inquiry, 2,* 157-163.

Lusis, S. A. 1995, Validating the CNS role in acute care through research, Clinical Nurse Specialist, 9, 5, 264-268.

Macann, C. 1993, *Four Phenonemological Philosophers: Husserl, Heidegger, Sartre, Merleau-Ponty,* Routledge, London.

MacDonald, J. 1993, 'The caring imperative: a must?' *The Australian Journal of Advanced Nursing, 11,* 1, (September-November), 26-30.

Mackenzie, A.E. 1994, 'Evaluating ethnography: considerations for analysis', *Journal of Advanced Nursing, 19,* 774-781.

Maeve, M. K. 1994, 'Coming to moral consciousness through the art of nursing narratives', in *Art and Aesthetics in Nursing,* eds. P.L. Chinn & J. Watson, National League for Nursing Press, New York.

Malin, N. & Teasdale, K. 1991, 'Caring versus empowerment: considerations for nursing practice', *Journal of Advanced Nursing, 16,* 657-662.

Mangan, B. 1989, 'Clinical experts - Stand up and be counted', *Confederation of Australian Critical Care Nurses Journal, 2,* 3, 16-20.

Marais, E. & Marais, M. 1976, *Lives Worth Living - the right of all the handicapped,* Souvenir Press, London.

Marriner, A. 1986, *Nursing Theorists and Their Work,* The CV Mosby Co., St. Louis.

Marriner-Tomey, A. 1994, *Nursing Theorists and Their Work,* 3rd Edn, Mosby, St. Louis.

Marsh, C. 1988, 'Laying new career paths: A Western Australian experience', *N.Z.Nursing Journal,* (June), 14-15.

Mascord, P. 1990, 'Using job descriptions to identify educational needs of clinical nurse specialists', *Confederation of Australian Critical Care Nurses Journal, 3*, 2, 14-19.

Mascord, P. 1992, 'The career structure and lifelong education', in *Issues in Australian Nursing 3*, eds. G. Gray & R. Pratt, Churchill Livingstone, Melbourne.

Mason, D. J. 1985, 'The politics of patient care', in *Political Action Handbook for Nurses:Changing the Workplace, Government, Organizations and Community*, eds. D. J. Mason & S. W. Talbott, Addison-Wesley, Menlo Park.

Mason, D. J. 1990, 'Nursing and politics: A profession comes of age', *Orthopaedic Nursing, 9*, 5, (September- October), 11-17.

Massarik, F. 1981, 'The interviewing process re-examined' in *Human Inquiry, a Sourcebook of New Paradigm Research*, eds. P. Reason & J. Rowan, John Wiley & Sons, Chichester.

Masson, V. 1990, 'A good nurse', *Nursing Outlook*, (January-February), p11.

Maynard, C. 1994, 'The ANRAC competencies; a comment on method', *The Lamp*, (August), 29-34.

McCurdy, J.F. 1982, 'Power *is* a nursing issue', in *Socialisation, Sexism and Stereotyping: Women's Issues in Nursing*, ed. J. Muff, C.V. Mosby, St. Louis.

McGee, R.F., Powell, M.L., Broadwell, D.C. & Clark, J.C. 1987, 'A Delphi survey of oncology clinical nurse specialist competencies', *Oncology Nurses Forum, 14*, 2, 29-34.

McKee, C. 1991, 'Breaking the mould: A humanistic approach to nursing practice', in *Nursing as Therapy*, eds. R. McMahon & A. Pearson, Chapman & Hall, London.

McMahon, R. 1991, 'Therapeutic nursing: Theory, issues and practice', in *Nursing as Therapy*, eds. R. McMahon & A. Pearson, Chapman & Hall, London.

McMillan, M.A. & Dwyer, J. 1989, 'Changing times changing paradigm (1): from hospital training and college education in Australia', *Nurse Education Today*, 9, 13-18.

Meissner, J.E. 1986, 'Nurses: Are we eating our young?' *Nursing 86*, (March), 51-53.

Meleis, A.I. 1991, *Theoretical Nursing: Development and Progress*, 2nd edn, J.B. Lippincott Co., Philadelphia.

Melia, K.M. 1982, 'Tell it as it is - qualitative methodology and nursing research: understanding the student nurse's world', *Journal of Advanced Nursing, 7*, 327-335.

Melosh, B. 1982, *'The Physician's Hand' - Work Culture and Conflict in American Nursing*, Temple University Press, Philadelphia.

Menard, S.W. (ed.) 1987, *The Clinical Nurse Specialist:Perspectives on Practice*, John Wiley & Sons, New York.

Merleau-Ponty, M. 1962, *Phenomenology of Perception*, translated by C. Smith, Routledge, London.

Mewett, P.G. 1989, 'Making a research topic; A continuing process', in *Doing Fieldwork: Eight Personal Accounts of Social Research*, in ed. J. Perry, Deakin University Press, Geelong.

Miles, M.B. & Huberman, A.M. 1984, 'Drawing valid meaning from qualitative data: Toward a shared craft', *Educational Researcher, 13,* 5, 20-28.

Miles, M. B. & Huberman, A.M. 1994, *Qualitative Data Analysis,* 2nd edn, Sage Publications, Thousand Oaks.

Millen, N. 1989, 'Surveying the social universe', in *Doing Fieldwork: Eight Personal Accounts of Social Research,* ed. J. Perry, Deakin University Press, Geelong.

Minichiello, V., Aroni, R., Timewell, E. & Alexander, L. 1990, *In-Depth Interviewing - Researching People*, Longman Cheshire, Melbourne.

Mintzberg, H. 1994, 'Managing as blended care', *Journal of Nursing Administration, 24*, 9, (September), 29-36.

Mitchell, G. J. 1993, 'The same-thing-yet-different-phenomenon: A way of coming to know - Or not?' *Nursing Science Quarterly*, 6, 2, (Summer), 61-62.

Mitchell, G. J. 1994, 'The meaning of being a senior: Phenomenological research and interpretation with Parse's theory of nursing', *Nursing Science* 7, 2, (Summer), 70- 79

Mitchell, G. J. & Cody, W.K. 1992, 'Nursing knowledge and human science: Ontological and epistemological considerations', *Nursing Science Quarterly*, 5, 2, (Summer), 54-61.

Mitchell, G.J. & Cody, W.K. 1993, 'The role of theory in qualitative research', *Nursing Science Quarterly*, (Winter), 170-178.

Mitchell, G.D. (ed.) 1979, *A New Dictionary of Sociology,* Routledge and Kegan Paul, London.

Moloney, M. M. 1992, *Professionalization of Nursing: Current Trends and Issues*, Lippincott Co., New York.

Moore, T. 1991, *Cry of the Damaged Man: A Personal Journey of Recovery,* Picador, Sydney.

Morse, J. M. 1991, 'Qualitative nursing research: A-free-for-all?', in *Qualitative Nursing Research - A Contemporary Dialogue,* Revised edn. ed. J. Morse, Sage, Newbury Park.

Morse, J. M. (ed.) 1991, *Qualitative Nursing Research - A Contemporary Dialogue,* Revised edn, Sage, Newbury Park.

Morse, J. M., Bottorff, J. L. & Hutchinson, S, 1994, 'The phenomenology of comfort', *Journal of Advanced Nursing, 20*, 189-195.

Muetzelfeldt, M. 1989, 'Fieldwork at home', in *Doing Fieldwork: Eight Personal Accounts of Social Research,* ed. J. Perry, Deakin University Press, Geelong.

Muff, J. (ed.) 1982, *Socialization, Sexism, and Stereotyping - Women's Issues in Nursing*, C.V. Mosby Co., St. Louis.

Muff, J. 1982, 'Handmaiden, battle-ax, whore: an explanation into the fantasies, myths, and stereotypes about nurses', in *Socialization, Sexism, and Stereotyping - Women's Issues in Nursing,* ed. J. Muff, C.V. Mosby Co., St. Louis.

Munhall, P.L. 1982, 'Nursing philosophy and nursing research: In apposition or opposition?' *Nursing Research, 31,* 3, (May-June), 176-181.

Munhall, P.L. & Oiler, C.J. 1986, *Nursing Research: A Qualitative Perspective,* Appleton-Century-Crofts, Norwalk.

Munro, B.H. 1995, 'CNS Role: An International Perspective', *Clinical Nurse Specialist, 9,* 1, p12.

Murphy, J.W. 1988, 'Making sense of postmodern sociology', *The British Journal of Sociology, xxxix,* 4, 600-614.

Nahas, V.L. 1989, 'Clinical Nurse Specialists: Issues and concerns', *Confederation of Australian Critical Care Nurses Journal, 2,* 1, 33-37.

Napthine, R. 1994, 'Did you hear about...? in defence of gossip', *Australian Nursing Journal, 1,* 6, (December-January), 29-30.

National Health and Medical Research Council, 1991, *The Role of the Nurse in Australia,* Australian Government Publishing Service, Canberra.

Naylor, M.D. & Brooten, D. 1993, 'The roles and functions of Clinical Nurse Specialists', IMAGE, *Journal of Nursing Scholarship, 25,* 1, (Spring), 73-78.

Nelson, S. 1995, 'Humanism in nursing: the emergence of the light', *Nursing Inquiry, 2,* 36-43.

Neyle, D. & West, S. 1991, 'In support of a scientific basis', in *Towards a Discipline of Nursing,* eds. G.Gray & R. Pratt, Churchill Livingstone, Melbourne.

Nightingale, F. 1980, *Notes on Nursing - What It Is, What It Is Not,* Churchill Livingstone, Edinburgh.

NOOSR, 1993, 'The development of competency-based assessment strategies for the profession', *Research Paper No. 8,* Commonwealth Govt., Canberra.

NTB, 1992, 'National Competency Standards: Policy and Guidelines', 2nd edn. National Training Board, Canberra.

Nuccio, S.A., Gunta, K.E., Riesch, S.K. & Westen, B.A. 1993, 'A survey of 636 Staff Nurses: perceptions and factors influencing the CNS role', *Clinical Nurse Specialist, 7,* 3, 122-128.

Oates, R. 1993, 'The cost of quality/skilled staff - an argument for cost-effective manpower planning and employment', *The Lamp*, (June), 28-29.

O'Connell, B.& Radloff, P. 1995, 'Is holism an appropriate philosophy for nursing?', *Nursing Inquiry, 2*, 1, p59.

O'Connor, N. 1993, *Paterson and Zderad Humanistic Nursing Theory*, Sage Publications, Newbury Park.

Oiler, C. 1982, 'The phenomenological approach in nursing research', *Nursing Research, 31*, 3, (May-June), 178-181.

Oiler-Boyd, C. 1990, 'Critical appraisal of developing nursing research methods,' *Nursing Science Quarterly, 3*, 1, (Spring), 42-43.

Oiler Boyd, C. 1993, 'Toward a nursing practice research method', *Advances in Nursing Science, 16*, 2, 9-25.

Omery, A. 1983, 'Phenomenology:a method for nursing research', *Advances in Nursing Science*, (January), 49-63.

O'Rourke, M.W. 1989, 'Generic professional behaviours: Implications for the clinical nurse specialist role', *Clinical Nurse Specialist, 3*, 3, 128-132.

Palmer, R. 1969, *Hermeneutics: Interpretation Theory in Schleiermacher, Dilthey, Heidegger, and Gadamer*, Northwestern University Press, Evanston.

Parker, J. 1988, 'Theoretical perspectives in nursing: From microphysics to hermeneutics', *Proceedings of the 3rd Nursing Research Forum: Shaping Nursing Theory and Practice.* La Trobe University, Melbourne.

Parker, J. 1991, 'Being and nature: an interpretation of person and environment', in *Towards a Discipline of Nursing*, eds. G. Gray & R. Pratt, Churchill Livingstone, Melbourne.

Parker, K. P. 1990, 'Caring and gnosis: Moral implications for nursing', in *Ethical and Moral Dimensions of Care*, ed. M. M. Leininger, Wayne State University Press, Detroit.

Parkes, R. 1992, 'Nursing competencies: Applying a competency based training system to nursing', *The Australian Nurses Journal*, 21, 7, (February), 19-21.

Parkes, R. 1991, 'Competency based training: Australia moves to a competency based system of training and education', *The Australian Nurses Journal, 21*, 5, (November), 12-13.

Parse, R. 1981, *Man-Living-Health: A Theory of Nursing*, John Wiley & Sons, New York.

Parse, R. 1987, *Nursing Science:Major Paradigms, Theories, and Critiques*, W.B. Saunders Co. Philadelphia.

Parse, R. 1992, 'Human becoming:Parse's theory of nursing', *Nursing Science Quarterly, 5*, 1, (Spring), 35-42.

Parse, R. 1993, 'The experience of laughter: A phenomenological study', *Nursing Science Quarterly, 6*, 1, (Spring), 39-43.

Pateman, C. 1989, 'Feminist critiques of the public/private dichotomy' in *The Disorder of Women:Democracy, Feminism and Political Theory,* Polity Press, Cambridge.

Paterson, B.1991, *Excellence and Expertise in Nursing*, A Monograph, Deakin University Press, Geelong.

Paterson, J. & Zderad, L. 1976, *Humanistic Nursing,* John Wiley & Sons, New York.

Patton, M. Q. 1990, *Qualitative Evaluation and Research Methods,* 2nd edn, Sage Publications, Newbury Park.

Pearson, A. 1984, 'The essence of advanced nursing is being there', *Nursing Mirror, 159*, 8, (September 5), p16.

Pearson, A. 1987, 'The unique role of the nurse', *Senior Nurse, 6,* 4, (April), 45-48.

Pearson, A. 1991, 'Taking up the challenge: the future for therapeutic nursing', in *Nursing as Therapy,* eds. R. McMahon & A. Pearson, Chapman & Hall, London.

Peerson, A. 1995, 'Foucault and modern medicine', *Nursing Inquiry, 2*, 106-114.

Percival, E.C., 1992a, 'Contemporary issues in the regulation of nursing', in *Issues in Australian Nursing 3*, ed. G. Gray, & R. Pratt, Churchill Livingstone, Melbourne.

Percival, E.C. 1992b, 'An extension of the ANRAC competencies study across all areas of nursing practice in NSW', *Macsearch Report to the NSW Nurses Registration Board,* University of Western Sydney, Macarthur.

Perry, J. 1989, ed. *Doing Fieldwork: Eight Personal Accounts of Social Fieldwork,* Deakin University Press, Geelong.

Perry, J. 1989, 'Voice-overs' in *Doing Fieldwork: Eight Personal Accounts of Social Fieldwork,* ed. J. Perry, Deakin University Press, Geelong.

Peter, E. & Gallop, R. 1994, 'The ethic of care: A comparison of nursing and medical students', *IMAGE:Journal of Nursing Scholarship, 26*, 1, 47-51.

Phillips, J. R. 1993, 'Researching the lived experience: Visions of the whole experience', *Nursing Science Quarterly,* (Winter), 166-167.

Phythian, B. A. 1993, *A Concise Dictionary of Correct English*, Hodder & Stoughton, London.

Pilkington, F.B. 1993, 'The lived experience of grieving the loss of an important other', *Nursing Science Quarterly*, *6*, 3, (Fall), 130-139.

Pilkington, W. & Wood, J. 1986, 'Job satisfaction, role conflict and role ambiguity - a study of hospital nurses', *The Australian Journal of Advanced Nursing*, *3*, 3, (March-May), 3-14.

Plager, K.A. 1994, 'Hermeneutic phenomenology: A methodology for family health and health promotion study in nursing', in *Interpretive Phenomenology: Embodiment, Caring and Ethics in Health and Illness*, ed. P. Benner, Sage, Thousand Oaks.

Poiner, G. 1992, 'Understanding and knowledge: Feminist methodologies', *Working Papers in Women's Studies Number 8*, Women's Research Centre, University of Western Sydney, Nepean.

Polanyi, M. 1958, *Personal Knowledge - Towards a Post-Critical Philosophy*, Routledge & Kegan, London.

Pratt, R. 1987, 'Raising the standard of clinical practice in nursing', Paper presented Royal College of Nursing International Conference, (November), London.

Pratt, R. 1993, 'Staff mix and nursing care - Extracts and commentary', *RADGAC Research Project*, University of Sydney, Sydney.

Pratt, R. 1994, 'The challenge of specialisation: The Australian experience', *Collegian*, *1*, 1, (October), 6-13.

Pratt, R., Burr, G. & Leelarthaepin, B. 1992, *Staff Mix and Nursing Care*, A RADGAC Research Report.

Pratt, R., Burr, G., Leelarthaepin, B., Blizard, P. & Walsh, S. 1993, 'The effects of all-RN and RN-EN staffing on the quality and cost of patient care', *The Australian Journal of Advanced Nursing*, *10*, 3, (March-May), 27-39.

Price, P. 1993, 'Parents' perceptions of the meaning of quality nursing care', *Advances in Nursing Science*, (September), *16*, 1, 33-41.

Psathas, G. 1972, 'Ethnomethods and phenomenology', in *Symbolic Interaction: A Reader in Social Psychology*, 2nd edn, eds. J.G. Manis, & B.N. Meltzer, Allyn and Bacon Inc., Boston.

Psathas, G. (ed.) 1973, *Phenomenological Sociology: Issues and Applications*, John Wiley & Sons, New York.

Purkis, M.E. 1994, 'Entering the field: intrusions of the social and its exclusion from studies of nursing practice', *International Journal of Nursing Studies*, 31, 4, 315-336.

Putnam, H. 1981, 'Mind and body' in *Reason, Truth and History*, Cambridge University Press, Cambridge.

Raatikainen, R. 1994, 'Power of lack of it in nursing care', *Journal of Advanced Nursing*, *19*, 424-432.

Rabinow, P. (ed.) 1984, *The Foucault Reader, An Introduction to Foucault's Thought,* Penguin Books, London.

Rafferty, A.M. 1995, 'Art, science and social science in nursing: occupational origins and disciplinary identity', *Nursing Inquiry, 2,* 141-148.

Ray, M.A. 1990, 'Phenomenological method for nursing research', in Chaska, N.L. *The Nursing Profession: Turning Points,* The C.V. Mosby Co., St.Louis.

Reason, P & Rowan, J. (eds.) 1981, *Human Inquiry,* Wiley & Sons, London.

Reid, B. A. 1991, 'The effect of coding on the allocation of DRGs':Research Paper, School of Health Services Management, University of New South Wales.

Reinharz, S, 1979, *On Becoming a Social Scientist: From Survey Research and Participant Observation to Experiential Analysis,* Jossey-Bass Publishers, San Fransisco.

Reinharz, S. 1981, 'Implementing new paradigm research: a model for training and practice', in ed. P. Reason & J. Rowan, *Human Inquiry,* John Wiley and Sons, London.

Reinharz, S. 1983a, 'Phenomenology as a dynamic process', *Phenomenology and Pedagogy, 1,* 1, 77-79.

Reinharz, S. 1983b, 'Experiential analysis: a contribution to feminist research', in *Theories of Women's Studies,* ed. G. Bowles, & R.D.Klein, Routledge & Kegan Paul, London.

Retsas, A. 1994, 'Knowledge and practice development: toward an ontology of nursing', *The Australian Journal of Advanced Nursing, 12,* 2, (December- February), 20-25.

Reverby, S. 1987, 'A caring dilemma: Womanhood and nursing in historical perspective', *Nursing Research, 36,* 1, (January-February), 5-11.

Rew, L. & Barrow, E.M. 1987, 'Intuition: A neglected hallmark of nursing knowledge', *Advances in Nursing Science, 10,* 1, 49-62.

Rieman, D.J. 1986, 'Noncaring and caring in the clinical setting: patient's descriptions', *Topics in Clinical Nursing, 8,* 2, (July), 30-36.

Riley, W. & Schaefers, V. 1983, 'Costing nursing services', *Nursing Management, 14,* 12, 40-43.

Rittman, M., Northsea, C., Hausauer, N., Green, C. & Swanson, L. 1993, 'Living with renal failure', *ANNA Journal, 20,* 3, (June), 327-331.

Rizzuto, C. 1995, Documenting clinical nurse specialist role functions and outcomes', *Western Journal of Nursing Research,* 17, 4, (August), 448-450.

Roberts, S. J. 1983, 'Oppressed group behavior: implications for nursing', *Advances in Nursing Science,* (July), 21-30.

Robertson, S. 1994, 'CACCN national standards steering committee update', *Australian Critical Care, 7,* 2, 10-11.

Robinson, A. 1995, 'Transformative 'cultural shifts' in nursing: participatory action research and the "'projection of possibility"', *Nursing Inquiry, 2,* 65-74.

Rogers, M. 1970, *An Introduction to The Theoretical Basis of Nursing,* F.A. Davis Co., Philadelphia.

Rogers, M. E. 1987, 'Roger's Science of Unitary Human Beings', in *Nursing Science:Major Paradigms, Theories, and Critiques*, ed. R. R. Parse, W.B. Saunders Company, Philadelphia.

Rowan, J. & Reason, P. 1981, 'On making sense', in *Human Inquiry: A Sourcebook of New Paradigm Research*, eds. P. Reason & J. Rowan, John Wiley and Sons, Chichester.

Royal Australian Nursing Federation, Undated, 'Career Structure for Nurses' - Discussion Paper.

Rudge, T. 1992, 'Reflections on Benner: A critical perspective', *Contemporary Nurse, 1,* 2, (September), 84-88.

Russell, R. L. 1990, *From Nightingale to Now - Nurse Education in Australia,* W.B. Saunders/Bailliere Tindall, Sydney.

Salvage, J. 1985, *The Politics of Nursing*, Heinemann Nursing, Oxford.

Sampselle, C. M. 1990, 'The influence of feminist philosophy on nursing practice', *IMAGE:Journal of Nursing Scholarship, 22,* 4, 243-247.

Sandelowski, M. 1986, 'The problem of rigor in qualitative research', *Advances in Nursing Science, 8,* 3, 27-37.

Sandelowski, M. 1994, 'The use of quotes in qualitative research', *Research in Nursing and Health, 17,* 479-482.

Saylor, C.R. 1990, 'Reflection and professional education: Art, science, and competency', *Nurse Educator, 15,* 2, (March-April), 8-11.

Schon, D. 1983, *The Reflective Practitioner: How Professionals Think in Action,* Basic Books, New York.

Schultz, P.R. 1987, 'When client means more than one: Extending the foundational concept of person', *Advances in Nursing Science, 10,* 1, 71-86.

Schultz, P.R. & Meleis, A.I. 1988, 'Nursing epistemology: Traditions, insights, questions', *IMAGE: Journal of Nursing Scholarship, 20,* 4, (Winter), 217-221.

Schwertel Kyle, B.A. & Kinder, S. 1990, 'Costing out nursing: Combining PCSs, DRGs, and standards of care', *Health Care Supervisor, 8,* 2, 46-56.

Shadbolt, B. 1995, 'Two moths don't make an eagle', in *Proceedings of Research Day 27th April, 1995,* Faculty of Nursing, University of Sydney.

Short, S.D., Sharman, E. & Speedy, S. 1993, *Sociology for Nurses: An Australian Introduction,* Macmillan Education, Melbourne.

Shumway, D. R. 1989, *Michel Foucault,* University Press of Virginia, Charlottesville.

Siegloff, L.H. & Walker, M.C. 1992, 'Developing a new reality from strong foundations' in *Issues in Australian Nursing 3,* eds. G. Gray, & R, Pratt, Churchill Livingstone, Melbourne.

Silva, M. C., Sorrell, J. M. & Sorrell, C. D. 1995, From Carper's patterns of knowing to ways of being: An ontological philosophical shift in nursing', *Advances in Nursing Science, 18,* 1, 1-13.

Silver, M. 1986a, 'A vision becomes reality', *The Australian Nurses Journal, 16,* 2, (August), 44-47.

Silver, M. 1986b, 'From neophyte to expert', *The Australian Nurses Journal, 16,* 3, 38-41.

Silver, M. 1989, 'Career structure for nurses: The South Australian experience', in *Issues in Australian Nursing 2,* eds. G. Gray, & R. Pratt, Churchill Livingstone, Melbourne.

Skeet, M. 1980, *Notes on Nursing - The Science and the Art,* Churchill Livingstone, Edinburgh.

Smith, A. 1995, 'An analysis of altruism: a concept of caring', *Journal of Advanced Nursing, 22,* 785-790.

Smith, J. 1993, 'Quality, costs and nursing', *The Lamp,* (May), 17-18.

Smith, M. C. 1984, 'Research methodology: Epistemological considerations', *IMAGE:Journal of Nursing Scholarship, XVI,* 2, 42-46.

Smith, M.C. 1992, 'Is all knowing personal knowing?' *Nursing Science Quarterly,* 5, 1, (Spring), 2-3.

Sparacino, P. 1992, 'Advanced practice: the clinical nurse specialist', *Nursing Practice, 5,* 4, 2-4.

Speedy, S. 1987, 'Feminism and the professionalization of nursing', *The Australian Journal of Advanced Nursing, 4,* 2, (December - February), 20-28

Spicker, S. F. & Gadow, S. (eds.) 1980, *Nursing: Images and Ideals: opening dialogue with the humanities,* Springer Publishing Co., New York.

Spiegelberg, H. 1975, 'Part One' of *Doing Phenomenology: Essays On and In Phenomenology,* Martinus Nijhoff, The Hague

Staunton, P. 1986, NSW Nurses Association Briefing Notes on New Public Hospital Nurses (State) Award Operative, 27th June, 1986.

Steele, S. & Fenton, M.V. 1988, 'Expert practice of Clinical Nurse Specialists', *Clinical Nurse Specialist, 2*, 1, 45-52.

Stein, L. 1978, 'The doctor-nurse game', in *Readings in the Sociology of Nursing*, eds. R. Dingwell, & J. McIntosh, Churchill Livingstone, Edinburgh.

Stevens, B. J. 1976, 'Accountability of the clinical specialist': The administrator's view, *Journal of Nursing Administration*, (February), 30-32.

Streubert, H. J. & Carpenter, D. R. 1995, *Qualitative Research in Nursing: Advancing the Humanistic Imperative*, J.B. Lippincott Co., Philadelphia.

Stiles, M. 1989, *On Specialization: In Nursing: Toward a New Empowerment*, American Nurses' Foundation, Kansas.

Stiles, M. 1994, 'The shining stranger: Application of the phenomenological method in the investigation of the nurse-family spiritual relationship', *Cancer Nursing, 17*, 1, 18-26.

Storr, G. 1988, 'The clinical nurse specialist: from the outside looking in', *Journal of Advanced Nursing, 13*, 265-272.

Strauss, A. & Corbin, J. 1990, *Basics of Qualitative Research - Grounded Theory Procedures and Techniques*, Sage, Newbury Park.

Street, A. 1990, *'Nursing practice: High, hard ground, messy swamps and the pathways in between'*, A Monograph, Deakin University Press, Geelong.

Street, A. 1992a, *Inside Nursing: A Critical Ethnography of Clinical Nursing Practice*, State University of New York Press, New York.

Street, A. 1992b, *Cultural Practices in Nursing*, A Monograph, Deakin University Press, Geelong.

Sudano, L. 1987, 'Designated nurses', *The Australian Nurses Journal, 16*, 6, (January), 39-41.

Sudano, L. 1986, 'Nurses speak', *The Australian Nurses Journal, 16*, 5, (November), 36-37.

Tanner, C.A., Benner, P., Chesla, C. & Gordon, D.R. 1993, 'The phenomenology of knowing the patient', *IMAGE:Journal of Nursing Scholarship, 25*, 4, (Winter), 273-280.

Taristano, B.J., Brophy, E.B. & Snyder, D.J. 1986, 'A demystification of the Clinical Nurse Specialist role: Perceptions of Clinical Nurse Specialist and nurse administrators', *Journal of Nursing Education, 25*, 1, (January), 4-9.

Taylor, B. 1992, 'Relieving pain through ordinariness in nursing: A phenomenological account of a comforting nurse-patient encounter', *Advances in Nursing Science 15*, 1, 33-43.

Taylor, B. 1993, 'Phenomenology: one way to understand practice', *International Journal of Nursing Studies, 30*, 2, 171-179.

Taylor, B. 1994, *Being Human; Ordinariness in Nursing*, Churchill Livingstone, Melbourne.

Taylor, C. 1985, 'What is human agency?'; 'Self-interpreting animals' and 'The concept of a person' in *Human Agency and Language, Philosophical Papers 1*, Cambridge University Press, London.

Taylor, S. J. & Bogdan, R. 1975, *Introduction to Qualitative Research Methods: A Phenomenological Approach to the Social Sciences*, John Wiley & Sons, New York.

Tesch, R. 1990, *Qualitative Research - Analysis Types & Software Tools*, The Falmer Press, New York.

The Royal College of Nursing, 1992, *The Value of Nursing*, London.

Thompson, C.B., Ryan, S.A. & Kitzman, H. 1990, 'Expertise: The basis for expert system development', *Advances in Nursing Science, 13*, 2, 1-10.

Thompson, J. 1990, 'Hermeneutic inquiry' in *Advancing Nursing Science Through Research Vol 2*, ed. L.E. Moody, Sage Publications, Newbury Park.

Tong, R. 1989, *Feminist Thought - A Comprehensive Introduction*, Routledge, London.

Tracey, B. 1995, 'Response: Is holism an appropriate philosophy for nursing?' *Nursing Inquiry, 2*, 118.

Travelbee, J. 1971, *Interpersonal Aspects of Nursing*, 2nd edn., F.A. Davis, Philadelphia.

Turkoski, B. B. 1995, 'Professionalism as ideology: a socio-historical analysis of the discourse of professionalism in nursing', *Nursing Inquiry, 2*, 83-89.

Turner, R (ed.) 1987, *Thinkers of the Twentieth Century*, St. James Press, Chicago.

Urmson, J. O. (ed.) 1960, *The Concise Encyclopaedia of Western Philosophy and Philosophers*, Hutchinson, London.

Uys, L.R. & Smit, J.H. 1994, 'Writing a philosophy of nursing?' *Journal of Advanced Nursing, 20*, 239-244.

van den Berg, J.H. 1966, *The Psychology of the Sickbed*, Duquesne University Press, Pittsburgh.

van den Berg, J.H. 1972, *A Different Existence: Principles of Phenomenological Psychopathology*, Duquesne University Press, Pittsburgh.

van Lennep, D. J. 1969, 'The Hotel Room' - 'De Hotelkamer', in Persoon en wereld:Bijdragen tot de fenomenologische psychologie', translated by J. J. Kockelmans, 34-40.

van Manen, M. 1977, 'Linking ways of knowing with ways of being practical', *Curriculum Inquiry, 6*, 205-228.

van Manen, M. 1984, 'Practicing phenomenological writing', *Phenomenology and Pedagogy, 2,* 1, 36-69.

van Manen, M. 1990, *Researching Lived Experience:Human Science for an Action Sensitive Pedagogy,* The Althouse Press, Ontario.

van Manen, M. 1995, 'Phenomenological Research' Workshop, Monash University, E. Gippsland Campus. 23rd -25th January.

Van Morrison, 1984, Lyrics from the song 'I forgot that love existed' from the album, 'Poetic Champions Compose', Caledonia Productions.

Versluysen, M.C. 1980, 'Old wives tales? Women healers in English history', in *Rewriting Nursing History,* ed. C. Davies, Croom Helm, London.

Vesey, G. & Foulkes, P. 1990, *Collins Dictionary of Philosophy,* Harper Collins, Glasgow.

Vezeau, T. M. 1994, 'Narrative inquiry in nursing', in *Art and Aesthetics in Nursing,* eds. P.L. Chinn, & J. Watson, National League for Nursing Press, New York.

Walker, K. 1994, 'Research with/in nursing: "troubling" the field', *Contemporary Nurse, 3,* 4, (December), 162-168.

Walker, K. 1995, 'Courting competency: nursing and the politics of performance in practice', *Nursing Inquiry, 2,* 90-99.

Walker, E 1991, 'Pen and paper power for nursing's destiny', Paper presented at Controlling Nursing's Destiny Conference, Royal College of Nursing, Brisbane 30-31st May.

Walker, L.O. & Avant, K.C. 1995, *Strategies for Theory Construction in Nursing,* 3rd edn, Appleton and Lange, Norwalk.

Walsh, M & Ford, P. 1989, *Nursing Rituals, Research and Rational Actions,* Heinemann Nursing, Oxford.

Walters, A. J. 1994, 'A hermeneutic study of the concept of 'focusing' in critical care nursing practice', *Nursing Inquiry, 1,* 1, (November), 23-30.

Walters, A.J. 1994, 'An interpretive study of the clinical practice of critical care nurses', *Contemporary Nurse, 3,* 1, 21-25.

Walters, A.J. 1995, 'The phenomenological movement: implications for nursing research', *Journal of Advanced Nursing, 22,* 791-799.

Waterworth, S. 1995, 'Exploring the value of clinical nursing practice: the practitioner's perspective', *Journal of Advanced Nursing, 22,* 13-17.

Watson, J. 1981, 'Some issues related to a science of caring for nursing practice' in *Caring an Essential Human Need',* ed. M. Leininger, Charles, B. Slack, New Jersey.

Watson, J. 1985, *Nursing The Philosophy and Science of Caring*, Colorado Associated University Press, Colorado.

Watson, J. 1994, 'Poeticizing as truth through language', in *Art and Aesthetics in Nursing*, eds. P.L. Chinn & J. Watson, National League for Nursing Press, New York.

Watson, S. 1994, 'An exploratory study into a methodology for the examination of decision making by nurses in the clinical area', *Journal of Advanced Nursing, 20,* 351-360.

Webb, C. 1992, 'The use of the first person in academic writing: objectivity, language and gatekeeping', *Journal of Advanced Nursing, 17*, 747-752.

Weber, M. 1971, '"Objectivity" in social science' *in The Interpretation of Social Reality*, translated by J.E.T. Eldridge, Michael Joseph, London.

Weilitz, P.B. & Potter, P. A. 1993, 'A managed care system: Financial and clinical evaluation', *JONA*, 23, 11, (November), 51-57.

Wenger, A. 1985, 'Learning to do a mini ethnonursing research study: A doctoral student's experience', in *Qualitative Research Methods in Nursing*, ed. M.M. Leininger, Grune & Stratton, New York.

Werner, J. S., Bumann, R.M. & O'Brien, J.A. 1988, 'Clinical Nurse Specialization: An annotated bibliography roles and functions', *Clinical Nurse Specialist, 2,* 3, 127-130.

Werner, J.S. Bumann, R.M. and O'Brien, J.A. 1988, 'Clinical Nurse Specialization:An annotated bibliography educational preparation', *Clinical Nurse Specialist, 2,* 1, 27-29..

Wilkes, L. 1991, 'Phenomenology: a window to the nursing world', in *Towards a Discipline of Nursing*, eds. G. Gray, & R. Pratt, Churchill Livingstone, Melbourne.

Wilkes, L. & Wallis, M. 1993, 'The five Cs of caring: the lived experiences of student nurses', *The Australian Journal of Advanced Nursing, 11*, 1, (September - November), 19-25.

Wilson, S. 1977, 'The use of ethnographic techniques in educational research', *Review of Educational Research, 47,* 1, 245-265.

Wilson-Barnett, J. 1995, 'Specialism in nursing: Effectiveness and maximization of benefit', *Journal of Advanced Nursing, 21*, 1-2.

Wilson Row, C. 1994, 'CACCN national standards steering committee update', *Australian Critical Care,* 7, 1, p.8.

Wintz, L. 1987, Career paths of nurses: When is a nurse no longer a nurse? *JONA, 17,* 4, (April), 33-37.

Wolf, G.A. 1990, 'Clinical Nurse Specialists: The second generation', *Journal of Nursing Administration, 20,* 5, (May), 7-8.

Wolf, Z. R. 1986, 'The caring concept and nurse identified caring behaviours', *Topics in Clinical Nursing, 8,* 2, (July), 84-93.

Wolfer, J. 1993, 'Aspects of 'reality' and ways of knowing in nursing: In search of an integrating paradigm', *IMAGE: Journal of Nursing Scholarship, 25,* 2, (Summer), 141-146.

Woods, N.F. & Catanzaro, M. 1988, *Nursing Research: Theory and Practice,* The C.V. Mosby Co., St. Louis.

Wright, S. 1991, 'Facilitating therapeutic nursing and independent practice', in *Nursing as Therapy,* eds. R. McMahon & A. Pearson, Chapman Hall, London.

Wuest, J. 1994, 'Professionalism and the evolution of nursing as a discipline: A feminist perspective', *Journal of Professional Nursing, 10,* 6, (November-December), 357-367.

Yeaworth, R.C. 1978, 'Feminism and the nursing profession, in *The Nursing Profession - Views through the Mist,* ed. N. L.Chaska, McGraw-Hill, New York.

Young, I. M. 1990, 'The ideal of impartiality and civic public' in *Justice and the Politics of Difference,* Princeton University Press, Princeton.

Zimmerman, M.R. 1990, 'Quality improvement in health care', *Proceedings of the NSW Health Services Research Group Workshop,* 'Case-mix data - A management trial', (June) Dept. of Statistics, University of Newcastle.

OFFICIAL DOCUMENTS

KMPG Peat Marwick, 1995, 'Issues Relating to Specialty Nursing Vacancies', A Report prepared for the NSW Health Department.

'The National Review of Nurse Education in the Higher Education Sector - 1994 and Beyond. Issues Papers'. 1993. School of Nursing, The Flinders University of South Australia, Adelaide.

NSW Nurses Association 1992, 'Public Hospital Nurses' (State) Award'.

NSW Health Dept., 1992, Structural Efficiency Program - The Clinical Services Proposals for Allied Health Services, Medical Services, Nursing Services, Sydney.

Dept. of Health NSW, 1989, Circular No. 89/77 Public Hospital Nurses (State) Award - Clinical Nurse Specialist Classification.

Ministerial Implementation Committee, 1988, 'Report to the Minister for Health on Mental Health and Developmental Disability', Volume 1, (December), Govt. Printer, NSW.

Dept. of Health NSW, 1987, Circular No. 87/32 Public Hospital Nurses (State) Award - Guidelines for Clinical Nurse Specialist Classification.

Marsh, P. 1986, 'ACTU Factual Document Regarding Nurses' Wages and Career Structure', No. D113-86 Australian Government Printing Service, Canberra.

Report of the Working Party Established to Examine Nurses Clinical Career Structure in Public Hospitals, 27th November 1985a.

Parliament of NSW, 1985b, Interim Report of the Working Party Established to Examine Nurses Clinical Career Structure in Public Hospitals. Govt. printer. no.367, Canberra.

NEWSPAPER REPORTS

Jopson, D. 1994, 'Dear Mum. . .it was an angel who wrote Harry's letter from hell', *Sydney Morning Herald*, 26th October, p.3.

Connolly, A. 1994, 'Nurses lose on research front', *The Australian*, 20th July.

Davey, K. 1994, 'Diary of a hospital hit by crisis', *Sun Herald*, 6th November, p.14-15.

Dean, A. 1994, 'Woman alleges hospital neglect', *Sydney Morning Herald*, 27th August.

Delvecchio, J., Molitorisz, S. & Scott, M. 1995, 'Search for students to fill gaps', *Sydney Morning Herald*, 9th February, p.5.

Ferrari, J. 1994, 'Push to improve clinical skills of student nurses', *The Australian*, 14th December.

Lewis, J. 1994, 'Graduates job prospects return to high', *Sydney Morning Herald*, 19th September, p.5.

McCarthy, J. 1994, 'Nurses more than doctors' helpers', *Sydney Morning Herald*, 23rd July.

Papadopoulos, N. 1994, 'Overhaul hospital drug rules: Coroner', *Sydney Morning Herald*, 3rd September, p.1.

Patty, A. 1993, 'Nurses "deskilled"' *Sun Herald*, 12th September, p25.

Southward, J. & Crowe, S. 1995, 'Crisis for hospitals', *The Sun-Herald*, October, 29th, Front page.

NEWSPAPER REPORTS (AUTHOR UNKNOWN)

Sydney Morning Herald, CAMPUS '95 Supplement, 2nd January, 1995, p.34, ('Demand for nursing falls').

Sydney Morning Herald, Letter to Editor, 2nd September, 1994, p.6. ('Dedicated staff deserve better').

Saturday Telegraph, 31st July, 1994, ('Uni leading the way in nurse training').

Telegraph Mirror, 29th March, 1994, ('Nurses win in family ruling').

Sydney Morning Herald, 30th November,1993, ('Nurses feel overworked and undervalued').

Financial Review, 12th Sept., 1990, ('Prognosis looks good for nursing's entrepreneurs').

UNPUBLISHED PhD THESES

Madjar, I. 1991, Pain as Embodied Experience: A Phenomenological Study of Clinically Inflicted Pain in Adult Patients, Massey University. New Zealand.

Taylor, B. 1991, The Phenomenon of Ordinariness in Nursing, Deakin University, Geelong.

Walters, A. J. 1992, The Phenomenon of Caring in an Intensive Care Unit, Faculty of Nursing, Deakin University, Geelong.

APPENDICES

APPENDIX A: NSW Health Dept. Circular (1987:No. 87/32) - Guidelines for the Consideration of CNS Status.

The Nurse who does attain CNS status will excel in his/her chosen field as demonstrated by satisfying the following:

a) The CNS is systematically rostered as the 'senior' registered nurse on duty, apart from the NUM;
b) The CNS is likely to be the person nominated as the person in charge on the shift when the NUM is not rostered for duty;
c) The CNS is to be regarded as a 'core' person on the unit;
d) The CNS will be involved in the orientation of new staff members and will occupy the 'preceptor' role of new staff members;
e) The CNS would also be the person who would be an active, regular and a significant contributor in determining hospital policies, protocols and developing procedure manuals;
f) The formal active role in education of other staff either basic or ongoing will be another function of the CNS and requires the giving of formal lectures and or the preparation of notes and other educational devices;
g) The CNS will demonstrate a commitment to continuing education and a continuing professional development which will be evidenced by regular attendance at courses, (not only those courses conducted in the employer's time but where necessary in the employee's own time as well), and by membership of relevant professional and/or special interest groups and by subscription to relevant professional journals;
h) The function of the CNS is to guide and instruct other registered nurses as an integral part of their day to day duties and to generally act as resource for nurses and other staff.

In NSW, the CNS is explicitly required to assume a managerial role in the absence of the NUM while research is not defined as a function of the CNS role in the industrial award.

APPENDIX B: CNS Participant Information Sheet and Consent Form

PARTICIPANT INFORMATION STATEMENT

Title of Study: An Interpretation of Advanced Practice Through the Lived Experience of Clinical Nurse Specialists

Researcher: Sally Borbasi-Faculty of Nursing, The University of Sydney, 88 Mallett Street, Camperdown...2050.
Tel: 5170293(W) 4887063(H)

The aim of this study is to observe you, as one of a group of clinical nurse specialists (CNSs) in a medical/surgical area, in order to discover more about the nursing expertise of the group. The study will assist in uncovering the knowledge that you have with regard to nursing so that all of your expertise/competence can be uncovered and "brought to light" (illuminated). Through observing your practice and encouraging you to document and reflect upon and discuss your work it will become more visible and hence more valued.

Moreover, the study will enable you as an advanced clinician to become more aware of your expertise and what it is about your practice that makes a difference to patient care. The study is based on a belief of the value of nursing knowledge as a basis for practice, and by participating in this research you will be contributing to the body of knowledge that is unique to the practice of nursing. Through the study process you will get to share with me and with the other participants in the study some of your ideas and thoughts about your life as a clinical nurse specialist.

As a participant you will be asked to allow me to work alongside you and to observe your practice. As a registered nurse I will be interacting with you in the workplace as I "follow you" around. You might find this uncomfortable at first but after a while you will become accustomed to my being there. Everything that you say or do will be treated in the utmost confidentiality and no where in any of the reports of the research will your name be mentioned. If at any time you wish to withdraw from the study you are free to do so without prejudice.

In addition you will be asked to keep a journal of the events concerned with your role as a CNS that hold meaning or are significant for you. These and other aspects of your role as a CNS will be discussed in individual and small group audio-taped interviews run by myself (at times which are convenient to you). It is anticipated that these will be once a week.

Once the actual observation phase of the study is completed, I will be seeking to maintain contact with you so that you can substantiate any meanings as necessary arising from the analysis of the data. This means that you as a participant will be very much involved in checking that my interpretations of the data that I have collected about your nursing practice are in fact true interpretations.

If at any time during the study you wish to make a complaint about the conduct of the study you may contact the Chairman or Secretary of the Ethics Review Committee via the Research Development Office on

Once this study has been completed I would be happy to co-author any conference papers or journal articles with you about any aspect of the research because you will be an integral part of it. (Your anonymity as a participant will be maintained at all times).

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

I, ----------, hereby give my consent to participate in the above nursing research study, explained to me by Sally Borbasi.

I give my consent to participate in this study on the understanding that:-

1. The study has been explained to me and I understand the general purpose and methods to be used.

2. I have read and understood the Participant Information Sheet.

3. I am volunteering to be involved in the study without any pressure or cohersion and understand that I am free to withdraw at any time.

4. What I say will be treated privately and confidentially and that I will not be referred to by my name in any of the reports.

5. My involvement will mean that I shall be "followed around" by the researcher during my day to day nursing practice.

6. My involvement will mean continued contact with the researcher during the interpretation phase of the study (possibly up to 12 months), so that I can clarify any meanings as necessary.

Signed:_____

Date: _____

RESEARCH STUDY - "AN INTERPRETATION OF ADVANCED PRACTICE THROUGH THE LIVED EXPERIENCE OF CLINICAL NURSE SPECIALISTS".

PARTICIPANT CONSENT FORM

I, _____ [Name]

of _____ [Address]
have read and understood the Information for Participants on the abovenamed research study and have discussed the study with Sally Borbasi.

I am aware of the procedure involved in the study and am willing to answer questions regarding the practice of the clinical nurse specialists. I freely choose to participate in the study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

NAME: _____

SIGNATURE: ----------

DATE: ----------

NAME OF WITNESS: ----------

SIGNATURE OF WITNESS: ----------

APPENDIX C: Instructions for the Use of the Diary

Nurses have not been careful record keepers of their own clinical learning....the lag in description contributes to the lag in recognition and reward. Furthermore, adequate description of practical knowledge is essential to the development and extension of nursing theory. Nursing science has much to gain from nurses who compare their graded qualitative judgments and who describe and document their observations....paradigm cases... (Benner, 1984 pp 1, 11).

Dear

Thank you for participating in this study in which I want to uncover the knowledge that is embedded in your clinical practice and to explore what your lived experience/s is/are as a clinical nurse specialist. In essence what it is *really* like for you to be an advanced practice nurse and what is involved in your everyday life on the ward.

I am giving you this "diary" in the hope that you will begin to describe and document your lived experience/s as a CNS on the ward. I want you to describe patient care episodes in narrative form with as much detail as possible. Describe any events that "stand out" for you or have "stood out" for you in your everyday practice. For example, one in which you felt that your intervention made a difference to the patient's outcome, or one in which you felt you learnt something significant to your practice or one that illustrates your role as a CNS extremely well and so on. Anything you feel that had an impact on you and/or the patient and the way you nurse.

Please write a direct account of your personal experiences as you live through them during this research phase (and beyond if you wish!). Focus on particular incidents and describe these specific events, happenings or experiences. Your accounts can remain totally confidential if you wish or they can be a source for discussion and reflection at the group interviews with the other participants.

In writing your descriptions please try to:

. describe the experience as you lived through it
. describe your experience from the inside, the feelings, the mood, the emotions etc.
. focus on an example of the experience which stands out for its vividness
. attend to how the body feels, how things smelled, how they sounded etc.
(van Manen, 1990:64).

Thank you for doing this - your diary will become data for the study but it will be your diary and it will be returned to you as a keepsake for reflection in future years.

APPENDIX D: Patient Participation Information Sheet and Consent Form

"AN INTERPRETATION OF ADVANCED PRACTICE THROUGH THE LIVED EXPERIENCE OF CLINICAL NURSE SPECIALISTS"

INFORMATION FOR PARTICIPANTS - PATIENTS

You are invited to take part in this research study entitled "an interpretation of advanced practice through the lived experience of clinical nurse specialists". The objective of the study is to explore the professional lives of advanced practice nurses in order to discover what it is that they do, think and feel whilst they fulfill their roles caring for you the patient. As clinical nurse specialists the knowledge that they have as they carry out their everyday duties has not been sufficiently written about and this research will assist in filling that gap. As a patient you are an integral component of the working lives of these nurses and as such your thoughts and opinions are highly valued. This study is being conducted by Sally Borbasi who is a registered nurse now employed as a lecturer at the Faculty of Nursing, the University of Sydney.

If you agree to participate in this study it will mean that I the researcher will be asking you questions (at a time convenient to you) about the role and qualities of the clinical nurse specialists who are caring for you. All aspects of this study, including the results, will be strictly confidential and I alone will have access to the information. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Participation in this study is entirely voluntary:you are not obliged to participate and - if you do participate - you can withdraw at any time. Whatever your decision it will not affect the nursing care that you receive or your relationship with the nursing staff.

When you have read this information, I, (Sally Borbasi) will discuss it with you further and answer any questions you may have. If you would like to know any more at any stage, please feel free to contact me on the ward. This information sheet is for you to keep.

Please be advised that any person with concerns or complaints about the conduct of a research study can contact the Secretary of the Ethics Review Committee of the Central Sydney Area health Service on (02)

Thank you.

RESEARCH STUDY - "AN INTERPRETATION OF ADVANCED PRACTICE THROUGH THE LIVED EXPERIENCE OF CLINICAL NURSE SPECIALISTS".

PARTICIPANT CONSENT FORM

I, _____ [Name]

of _____ [Address]
have read and understood the Information for Participants on the abovenamed research study and have discussed the study with Sally Borbasi.

I am aware of the procedure involved in the study and am willing to answer questions regarding the practice of the clinical nurse specialists. I freely choose to participate in the study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

NAME: _____

SIGNATURE: ----------

DATE: ----------

NAME OF WITNESS: ----------

SIGNATURE OF WITNESS: ----------

APPENDIX E: SCENES OF CLINICAL LIFE (Anne, May 1994)

I should have been a scholar or an earnest diplomat.
I could have been a teacher, but I'd had enough of that.
The choices seemed so endless, their selection such a curse,
To save my brain from 'frying', I became a student Nurse.

My training passed so quickly, the future looked secure.
The job not too 'mind blowing', one I could endure.
I partied hard, I played the game, I fell into my slot,
Yet deep inside my heart I sensed I'd somewhere lost the plot.

Then quickly 'fore I knew it, I stood high upon the heap.
The path had now plateaued, it once appeared so steep.
They chose to call me expert, my opinion reigned supreme,
I felt like such a phoney, with my pampered self-esteem.

The glow has slowly tarnished, but the money's not too bad.
My career has reached its apex, and yet it sometimes makes me sad.
I work so hard at caring, my expectations somewhat high,
But the funds are slow at coming in as I watch my patients die.

If I'm so jolly clever, and a specialist in my sphere,
Why do I feel so useless, why is my heart so full of fear?
Is it because my brain is active, and is trained to want much more?
We should look into the future, not just what has come before.

Disregarding pessimism, I'm a CNS that's that.
I doubt I'd feel much better if I wore another hat.
I keep slogging at the coal-face, I'm prepared to start the change,
And although the target's far away, I'm closer to the range.

APPENDIX F: Nurses' Analogous Metaphors

Nursing is like a roller coaster: Scary at first, but you're bored by the end.

Nursing is like a bedpan: Full of s--- and paperwork.

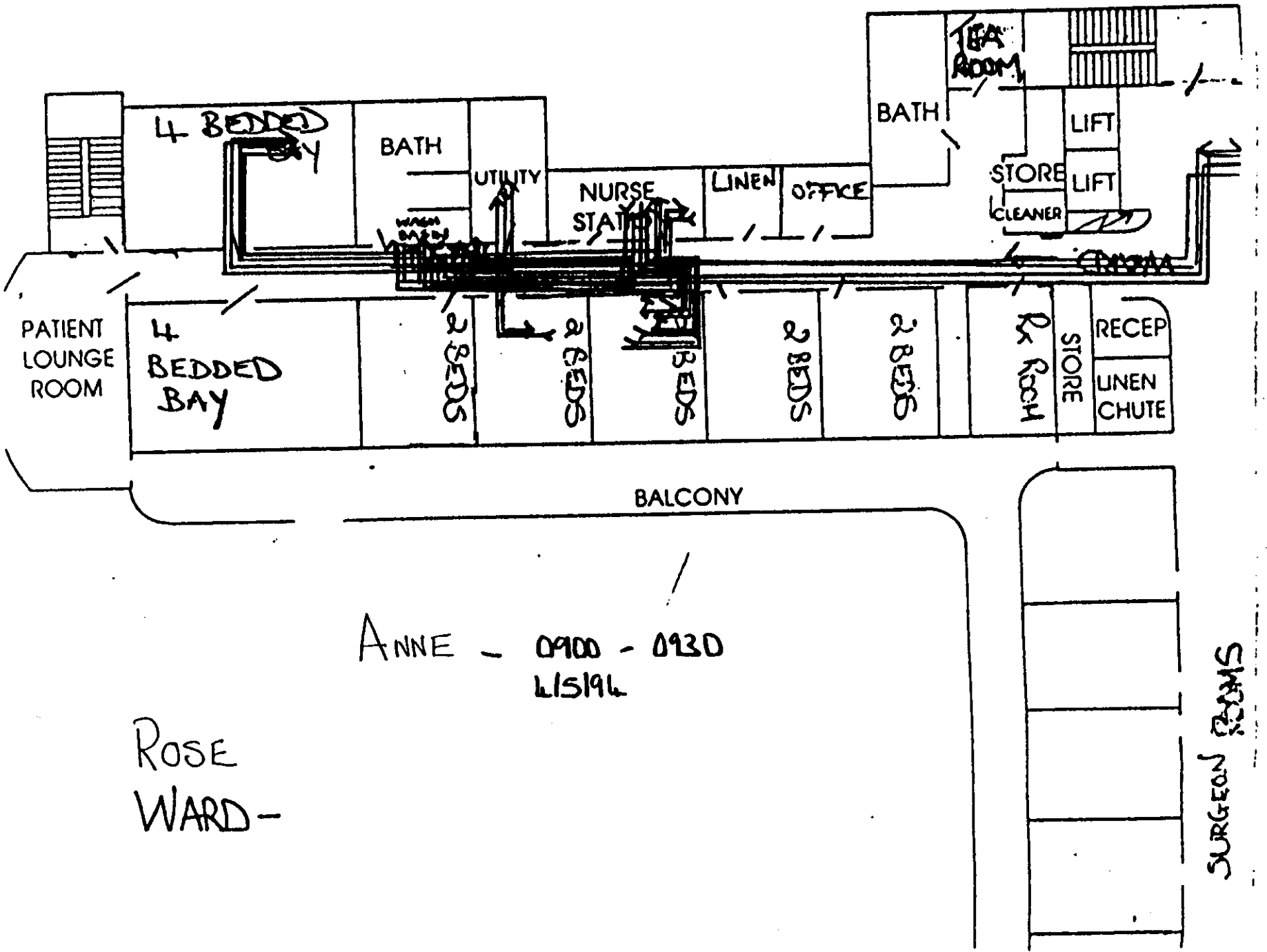
Nursing is like swimming the Channel: You put in lots of effort, it takes a long time, and the end is never in sight.

Nursing is like a tight pair of pants: Hard to get into, hard to get out of, and restricting while you're in them.

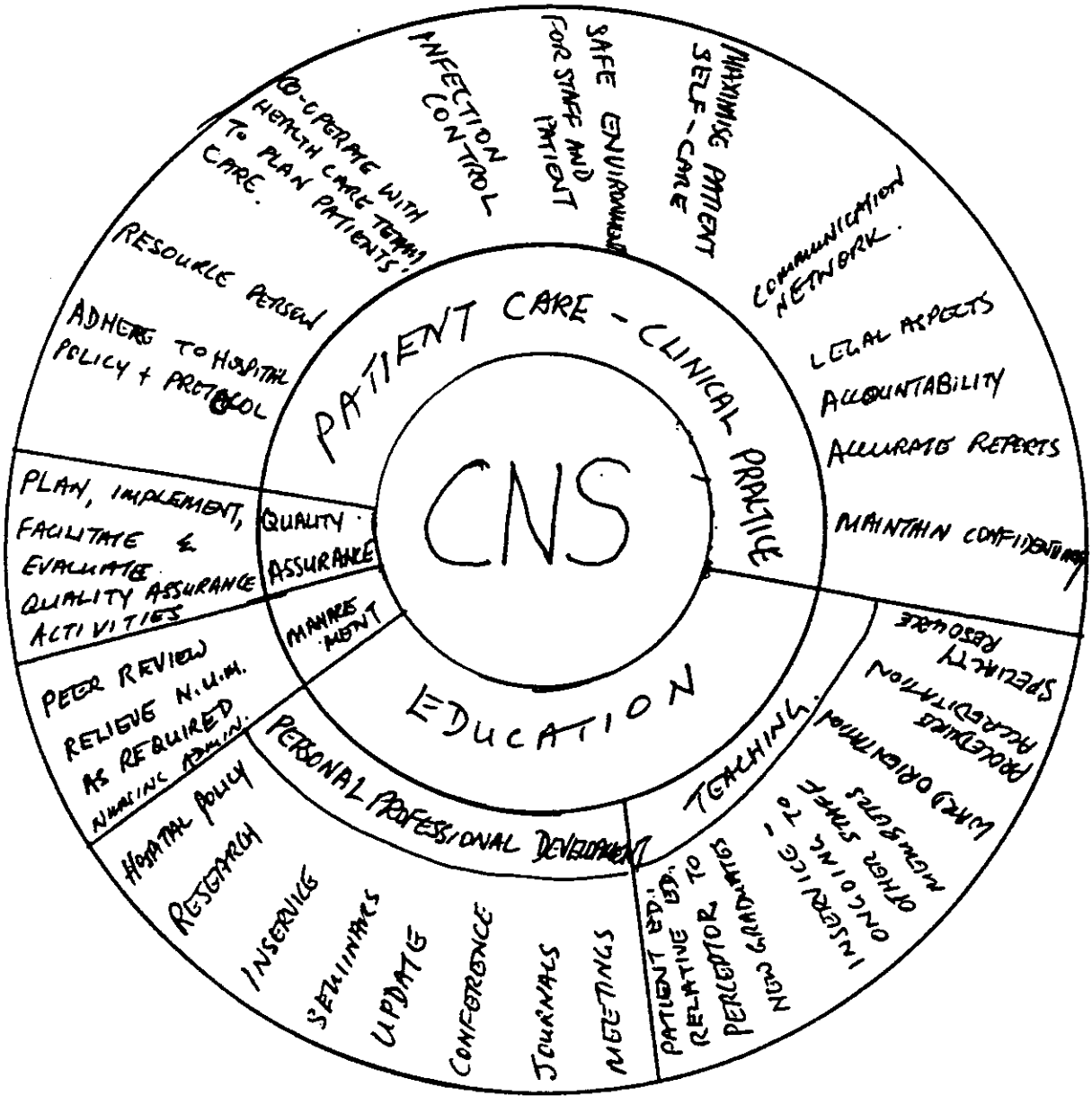
Nursing is like a black hole: You know there's something out there, but you never seem to find just what it is.

Nursing is like an analogous metaphor: When it's bad, it's *really* bad.

APPENDIX G: CNS Movement Map

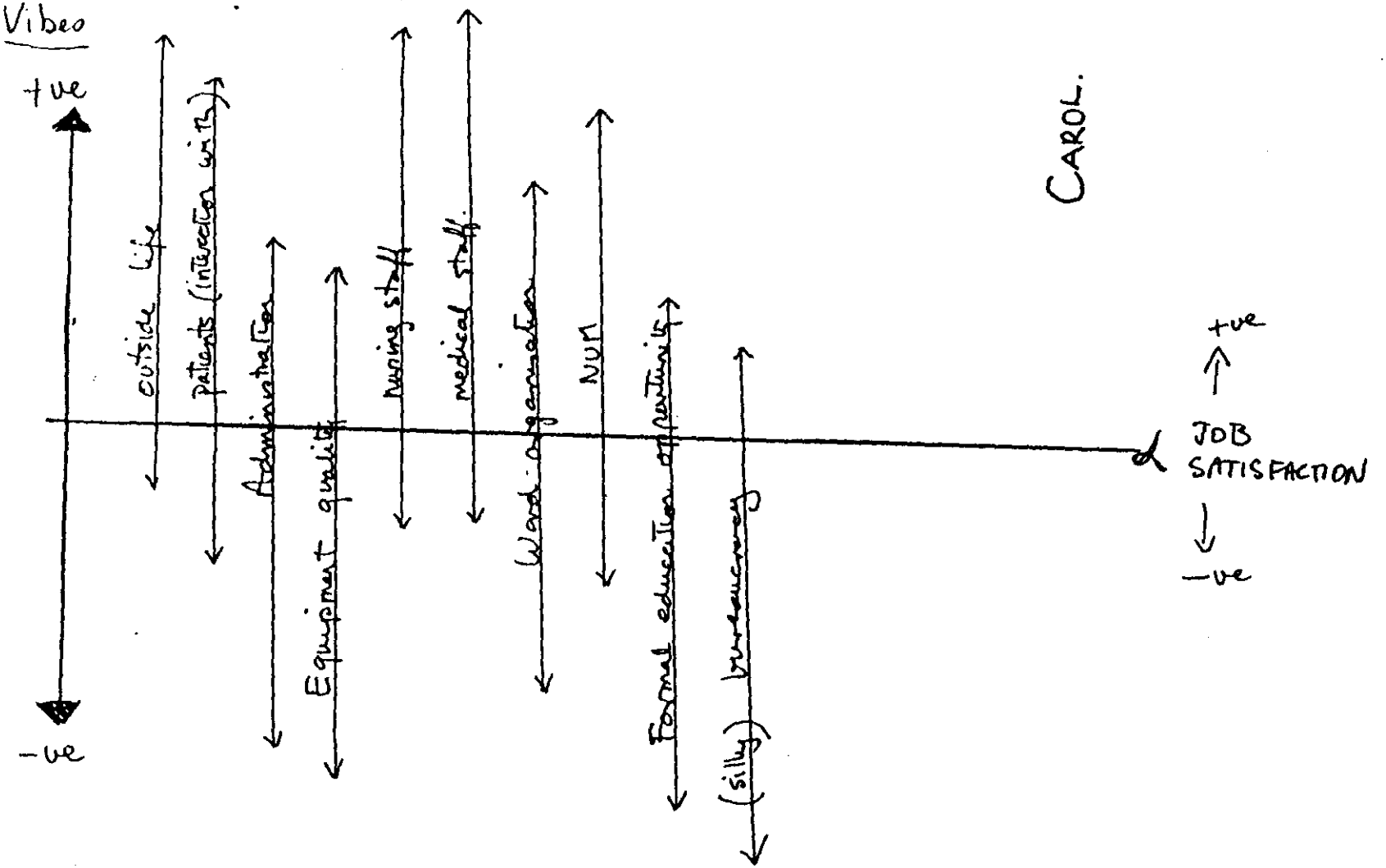


APPENDIX H: Annabelle's Conceptual Map of 'CNSing'



JUNE 1994

Carol's Conceptual Map of 'CNSing'



The proportion above & below the axis
Changes ~~the~~ constantly, but at any time
the sum is proportional to job satisfaction.
I hope it is not directly proportional to quality of care of patients.

APPENDIX I GLOSSARY OF TECHNICAL TERMS

Agency Staff	Relief staff supplied via a nursing agency rather than being permanently employed by the hospital
AMI	Acute myocardial infarction - 'heart attack'
AV shunt	Arterio-venous shunt - used as an access port for haemodialysis
BP	Blood pressure
Coning	Life threatening displacement of brain tissue
CSU	Catheter specimen of urine
CVP	Central venous pressure
Diathermy	The production of heat for therapeutic purposes
Elase	A trademark for a topical, fixed combination drug containing enzymes
Ensure	A tradename for a nutritional supplement commonly administered via a naso-gastric tube
FBC	Full blood count
FFP	Fresh frozen plasma
IMED -IVAC	Tradenames for intravenous infusion pumps
INR	International normalised ratio - prothrombin ratio - test to ascertain blood clotting ratio
IV	Intravenous
Milton	A proprietary antiseptic
MIMS	Drug reference system
MRI	Magnetic resonance imaging
MSU	Mid-stream urine
Nil by Mouth	A state of fasting

NRB	Nurses Registration Board
NS	Normal Saline
'Outliers'	Patients who are admitted to a ward which does not normally take patients with their medical condition
Oxygen 'sats'.	A measure of the degree to which oxygen is bound to haemoglobin, expressed as a percentage of the possible limit. Normal range 95%-100% Can be measured via an oxymeter.
Packed cells	A preparation of blood cells separated from liquid plasma
PCA	Patient Controlled Analgesia
Pneumothorax	An accumulation of air in the pleural cavity
'Specialling'	One patient to one nurse ratio
Steri-strips	Topical dressings in the form of 'strips' designed to assist in tissue repair by holding skin edges together
TED stockings	Stockings designed to deter the development of thrombophlebitis post-operatively (clots in veins)
The 'obs'	Observations of vital signs - Temp.; Pulse; Resps, and BP
TURP	Transurethral resection of the prostate gland
Vasovagal Syncope	A sudden loss of consciousness, resulting from cerebral ischaemia
WCC	White cell count

References Used in the Compilation of the Glossary

Anderson, K. N., Anderson, L.E. & Glanze, W. D. (eds.) 1994, *Mosby's Medical, Nursing and Allied Health Dictionary,* 4th edn. Mosby, St Louis.

Cape, B.F. & Dobson, P. 1974, *Bailliere's Nurses' Dictionary,* 18th edn. Bailliere Tindall, London.

Hope, R.A., Longmore, J. M., Moss, P.A.H. & Warrens, A.N. 1989, *Oxford Handbook of Clinical Medicine,* 2nd edn. Oxford University Press, Oxford.