Project

A Case Analysis of Nurse Voice in the Context of Paediatric Acute Illness

Prepared by:
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BSN, Charles Sturt University

A Project Submitted in Partial Fulfillment of the
Requirements for the Degree of
MASTER OF NURSING
In the
School of Nursing
University of Victoria
Faculty of Human and Social Development

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Supervisory Committee

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Abstract

Nurses who have cared for a hospitalized child suffering the rapid deterioration of an acute illness speak of challenges in having their voices heard in clinical care arenas. The case that is analyzed in this paper is a composite of stories told by bedside nurses working in a tertiary care hospital in a large Canadian city. Foucault's work on subject and power will ground a historic and social critique of the case. Questions for the analysis are drawn from the theoretical frameworks of Benner and Nightingale. Alternative solutions and possibilities for nurse action which will enhance the nursing voice are identified. This case analysis will contribute to a richer understanding of how the nursing voice is taken up in front line paediatric care. The reader may take the questions posed and possibilities generated in this case analysis to pursue a critique of the historical assumptions and power relationships which shape nursing practice in their particular setting.

Dedication

My belief is that any achievement results from the gifts of those who have gone before. For this reason I am humbled before many individuals who I acknowledge as responsible, in small and grand ways, for the completion of this project.

I am grateful for the support and challenges offered by my supervisor Dr. Young. Her investment of time and generosity of spirit have inspired an enduring affection for learning that will remain with me throughout my life.

Thank you to my committee members for their thoughtful critique, time, and enthusiasm for my ideas.

I gratefully acknowledge my colleagues who directed, listened, argued, pushed and invited me to strive for excellence.

I thank the children and their families whom I have had the great fortune to nurse. It is and will always remain my privilege to connect with you in the most difficult and joyous moments of your lives. There are no words which can capture the gratitude I feel for everything you have offered me.

I acknowledge my husband and children who have demonstrated tolerance and patience throughout this process. They have never let me forget, that no matter what my academic or professional failures and successes might bring, that I am loved. There is no gift greater then what they bring into my life.

Everything I know about nursing, every small good I may have contributed, has been the direct result of someone's willingness to share with me what I needed. I pledge to offer the same to others; to nurture without judgment, challenge without threat and contribute positively to our incredible discipline.

In memory of
Viola Alice Dryden, RN
Mother, teacher, mentor, friend

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Context of the Project

As a clinical nurse with over two decades of practice in the specialty of Pediatric Critical Care, I have cared for many critically ill children and their families. As a nurse educator, clinical practice leader and a member of an emergency response team, I have had the opportunity to observe, coach and mentor nurses in caring for these critically ill children. Over time, I have taken note of the vastly different manner in which the nurse's voice[1] is integrated into acute clinical events. In events where the nurse was engaged in all aspects of the health care team's actions, I observed that he or she contributed objective and subjective data about the child's condition and readily communicated clinical impressions regarding the child's status with the health care team. In these nurse-engaged situations, nursing knowledge[2] was actively sought out and the nurse was actively involved in the planning and evaluation of child's care. On other occasions, I have observed the nurse integrated differently. In these non nurse-engaged situations the nurse, although participating in the tasks associated with the event (documenting, monitoring, providing emotional support), had little input into the actions of the health care team, the urgency of the response to the child's changing condition or how resources for that response were utilized.

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[1]Voice is concerned with what nurses say, how they attempt to be heard and their perception of how their messages were taken up by the inter-professional team. In this case analysis I assume that when nurses exercise their voice they seek to influence the team's responses in order to prevent the critical illness deterioration of the child.

[2] Nurse knowledge is an understanding of patients which includes the physical, emotional and spiritual dimensions of patient's illness experience. Drawing from Benner's (1984) Novice to Expert model, nursing knowledge includes identification of patient need, selection of actions or responses to that need, accounting for contextual issues and the predicting the potential outcomes of chosen actions for patient, family and team. Nursing knowledge is more then intellectual reasoning and clinical judgment it also incorporates the sociopolitical and personal landscapes for care delivery.

Statement of the Issue

Colleagues who have experienced situations in which they recognize a child in their care is at risk of acute illness deterioration describe feeling separated from the team and the clinical event as a whole. These colleagues report feeling their concern for the child was not wholly embraced by the inter-professional [3] health care team. Some reported being minimized, trivialized, or ignored. Alavi and Cattoni, in their 1995 paper *Good Nurse Bad Nurse,* argue that the speaking opportunities available to nurses are limited. Nurses in this case analysis, all of whom are bedside nurses, share their stories which reflect on the limitation of nurse voice and the negative consequences of nurse silence for themselves, the child and family, and the profession. I have experienced dissatisfaction after being silenced during such salient clinical events and I feared that the team's capacities to connect with the patient-specific understandings my nurse's perspective offered were diminished. I felt my own capacity and my abilities to influence the situation were eroded.

Nurses stories in the literature illustrate that there can be a substantial cost when the nursing voice is not heard (Nelson, 2004). In a recent study, paediatric bedside nurses expressed frustration, profound dissatisfaction with their perceived lack of influence on the course of events in acute illness deterioration (Middaugh, Costello, Dryden-Palmer, Parshuram,, 2007). This frustration, if unexamined and

[3] Inter-professional refers to two or more professions working collaboratively to synergistically influence patient care (Canadian Inter-professional Health Collaborative, 2008). Much of the literature available on inter-professional relationships focuses on the nurse/physician dyad (DiPalma, 2004; Manias & Street, 2001b; Stein, 1967). This case analysis emphasizes the nurse/physician relationship as reflected in the case nurse's narratives. The term inter-professional is used to provide the reader opportunity to connect to the ideas expressed in the analysis as they may exist in their own practice context. The reader is encouraged to interpret this analysis of nurses and physicians as potentially representative of power influences between nurses and others, and to look beyond the more limited scope of individual disciplinary groups.

unquestioned, may lead to delayed responses to early condition changes which may negatively impact the child's health outcomes. In addition, this frustration may contribute to moral distress for nurses and ultimately nurse dissatisfaction (Ashcraft, 2004; Clarke, 2004; Moland, 2006).

The purpose of this project is to examine the experiences of one group of bedside nurses, as a representative case, to uncover the constraints, facilitators and unexplored influences on nurse voice in critical illness events in a paediatric acute care context.

Significance of the Issue

Nurses are recognized as the only health care professionals with constant connection and intimate ongoing knowledge of patients (Benner & Tanner, 1987; Carper, 1978). Nurses also experience significant inconsistency in how their voices are taken up in collaborative inter-professional responses to changing patient needs (Alavi & Cattoni, 1995; Middaugh et al., 2007).

Historically, a gap has existed between the discourses of nurses and physicians and how each discipline's perspective is integrated into the decisions, choices and actions of patient care (Keddy, Gillis, Jacobs, Burton & Rogers, 1986; Melchior, 2004). More recently, Storch and Kenny (2007) contend there is an enduring division between the moral work of physicians and nurses. They posit that there is an urgent need for nurses to identify constraining and facilitating factors which sustain disciplinary separation, and that nurses strive to develop processes which support enhanced inter-professional collaboration. The experiences of voice

which nurses describe in this case analysis underscore Storch and Kenny's assertions and illuminates real gaps in inter-professional functioning.

The 1994 paediatric cardiac surgical deaths at the Winnipeg Health Sciences Centre are a tragic example of the potential effects of silencing the voices of nurses. Ceci (2004) analyzed Justice Sinclair's report on these unexpected deaths and concluded that the cardiac program nurses experienced silencing that was born from gender based, socially constituted claims on the validity of nursing knowledge. Initially it may seem almost unfathomable that any health care professional could be silenced when the well being of a child is at stake, yet this situation existed with enough vitality to withstand direct challenge from nurses. Failure to recognize and hear the nurse's concerns in this situation allowed the deaths to continue for months. Knowledge gained from studying health care team communication and identifying what it is about inter-professional relationships that support or constrain the voices of nurses will open up opportunities to improve team function. Understanding how nurses' voices are taken up by the inter-professional team can reduce failure-to-rescue [4] events for children and improve nurse satisfaction (Moland, 2006; Storch & Kenny, 2007). Improving rapid response to physiologically deteriorating children will directly contribute to better physiological and emotional outcomes for acutely ill children and their families (Parshuram, Hutchinson & Duncan, 2006).

[4] Failure-to-rescue is a term used to identify preventable adverse events in hospital (Clarke, 2004).It indicates a death which occurs during hospitalization as the result of a complication that was not present on admission (Schmid, Hoffman & Happ, 2007). Failure-to-rescue is an approach to quality management which seeks modifiable factors for reducing in-patient mortality and morbidity.

The broad causality of failure-to-rescue is not the focus of this case analysis. Instead, I suggest that attention to the integration of the bedside nursing voice will improve inter-professional information sharing, support collaborative problem solving, identify constraints to transparent communication and unite multiple disciplinary perspectives. Close examination of nurses' experience of voice can inform early recognition of children at risk for complications. This case analysis illuminates how bedside nurses navigate through situations of patient deterioration, what these nurses have to say and how their voice is taken up.

Project Objectives

This case analysis is concerned with nurses who have experienced the sudden clinical deterioration of a child in their care. I will exam the historic and social influences on the voices of nurses in the context of caring for children who are vulnerable[5] to a critical illness event[6]. The underlying questions guiding this case analysis include the following: how is nurse voice constituted in these rapidly evolving and life endangering situations, and how do historical and social influences contribute to a discourse of power which ultimately shapes the possibilities for nurse action? Exploration of historical and socially embedded

[5] Vulnerability refers to the degree of risk for critical illness deterioration of the child as determined by the nurse. If a child is perceived as vulnerable the nurse's perception of how likely the child is to experience an undesirable clinical situation is heightened.

[6] A critical illness event is the dynamic physiological deterioration of a patient. This includes, but is not limited to, clinical emergencies such as stat response calls, cardiopulmonary arrest and respiratory failure. It also captures rapid clinical changes that are judged by the nurse to be threatening to the child's well being, for example, seizures or respiratory distress.

influences can create new discourses from which alternative realities of failure-to-rescue can be constructed (Ceci, 2004).

Origin of the Case

In the fall of 2006, I participated in a focus group held in my practice setting. The goal of this inquiry was to identify predictive cues of rapid clinical deterioration in children. The investigators were interested in discovering which cues nurses and other health care providers used when determining a child's risk for sudden clinical deterioration (Parshuram et al., 2006). I was asked to be a member of a group of expert bedside paediatric critical care nurses. These nurses were asked, 'What patient cues alert you to be concerned that a child in your care is at risk for a code blue[7]? Remarkably, these nurses identified a number of signals which traditionally had not been quantified in paediatric acute care situations. Nurse-derived cues were complex integrations of nursing experience and evidence specific to the child. These included the child's tolerance to handling, subtle changes in behavior and mood and level of parental anxiety. These cues were holistic impressions, and the foundation of the nurse's concern for the child's well being or vulnerability to deterioration.

Some weeks later I was invited to observe a physician group participating in the same exercise. Cues generated by the physician group focused on

[7] Code Blue is an emergency call for rapid assistance from a specialized hospital team. It activates an organizational process of rapid deployment of a rescue team in response to critical illness events. A code blue call represents the urgent up step of the current level of care to match the advancing level of acuity of the patient. Responders to these calls are nurses, physicians, respiratory therapists, administrators, and spiritual/emotional support professionals.

empirically measurable physiological data, for example, a heart rate elevation greater than 10 % from baseline. Reflecting on the physician discussion, I came to realize that the cues the physician's identified were significantly different then those developed in the expert nurse discussion. It was curious to me that that the factors weighted heavily by nurses were not evident in the physician's dialogue, nor the physician-derived cues valued as highly predictive by the nurses.

The Case: Bedside Nurse's Experience of Voice

This is a case of bedside nurses' experiences of 'voice' in failure- to- rescue situations. Unlike more commonly pursued cases, which illustrate a single specific situation, for example a case of H1N1 virus, this case is a composite of my own experiences as a bedside nurse and my experience of being part of the above focus group and the experiences of bedside nurses uncovered through my participation in a further study exploring the same phenomenon. That study examined bedside nurse's experiences caring for children during the 36 hours prior to an actual or near-code blue event (Middaugh et al., 2007). This study provided rich data regarding the events of paediatric clinical deterioration and unexpectedly uncovered common social experiences of nurses seeking acknowledgment of their concerns and integration of their nursing knowledge into the inter-professional team's actions.

Information from this study inspired me to question what conditions would inhibit the voices of bedside nurses in critical illness events. Why is it that a nurse's

holistic knowledge requires positive confirmation before that knowledge can be taken up by others? Why would the voice of the bedside nurse be quieted during acute, life threatening clinical situations? These are the questions which became the basis for this case analysis, as well as the focus of my professional interest in preparing our next generation of paediatric acute care nurses. The combined experiences of the aforementioned study nurses as well as my own exposure to this practice situation comprise this case. Not unlike a musical composition, with many instruments and notes delivering the melody, the joining of these experiences as a single case will bring a richness to this analysis which might otherwise be undiscovered. Taken together these experiences form a complex composition of voice for bedside nurses. The case for analysis therefore is the combined experiences of voice as told through bedside nurse's stories.

Descriptions of the nurse's experiences, taken from the Middaugh et. al (2007) study transcripts, will demonstrate key elements of how the voices of nurses are taken up in paediatric failure-to-rescue events. The inclusion of examples, as spoken by the nurses, provide an opportunity to connect the theoretical analysis to current nursing practice realities and offers a forum for the voices of nurses to be recognized.

Listening: The Case Analysis Approach

A case analysis approach provides a systematic method of evaluation while preserving the context of the issue. Interrelated elements of the human condition can be preserved when utilizing a case analysis approach to the study of nursing voice. Case analysis aligns with an empirical, interpretive and empathetic approach

to investigation (Heinz, 2007). Nurses' experiences from the literature, as well as my personal experience, ground this analysis in the practice realities of bedside nurses. The desire to critically evaluate and learn from complex social phenomena preserving the holistic characteristics of the situation is a legitimate application for case analysis (Heinz). In this case analysis the boundaries between the object of study (the voices of nurses), and the context for study (critical illness events), are difficult to delineate and cannot be easily reduced from the dynamic social and political influences within the case. By focusing the analysis on the gap between nurses' expectation of being heard and their experience of voice I can illuminate hidden conditions which constitute the realities of clinical practice. These conditions potentially influence the efficiency and accuracy of the team's response and the nurse's perception of influence and sense of moral integrity. Case analysis can enhance our understanding of inter-professional power dynamics and identify conditions which preserve the present situation for nurses.

I examined nurses' experience of voice in situations of critical illness deterioration as a single phenomenon. I limit my examination to the space and time of a single institution and social political reality of a North American, urban, paediatric acute care teaching hospital. Dunphy and Longo (2007) suggest that the search for new knowledge should echo the true experience of nurses and remain practically applicable to bedside practice. Examining the experience of bedside nurses through their own stories will ensure the authenticity of the interpretations and ground recommendations in the realities of current practice. Wertheim (2008) advises that analysis should focus on relevant cases. For this reason, this case

addresses only the comments of nurses who spoke about their experience of voice.

The critical platform for this critique is informed by Foucault's (1982) work of subjectivity and power. Foucault argues that the purpose of critique is to guard against excessive rationality and to understand how subjects are constituted through their history. The historic considerations and power dynamics within this case are made visible through Foucault's lens. Prevalent and potentially limiting sociopolitical discourses embedded in the nurses experiences of voice are then made available for examination and critique.

Theoretical Foundation of Analysis

The questions for this analysis are drawn from the simultaneity paradigm of nursing (Watson, 1985). The tensions described by the case nurses have been experienced in my practice as well as documented in the literature (Moland, 2006). The experience of voice is socially constituted and consists of power relationships experienced by, and between, subjects (Foucault, 1982; Nelson, 2006). Voice is both contextual and subjective, and therefore the theoretical foundation of this analysis embraces the premise that understanding is bound to the lived experience of the case nurses (Paley, 2005). The nurse experience of voice in the context of child critical illness has meaning for nurses.

I assume in this project that enhancing our understanding of how historical and social influences construct and sustain bedside nursing voice will empower

nurses and improve inter-professional team function. This aligns with Foucault's (1982) assertion that critical social analysis should be used for emancipatory purposes and the discovery of a 'new economy' of power relations (p. 780).

Questioning how the voices of bedside nurses are constituted, taken up by the team and shape possibilities for nurse action is an empowering exercise for nurses. In this project, I am not only concerned with understanding what nurses 'know to do' or ' how to do', but also what nurses feel is the 'right thing to do' for a given situation (Cash, 1995, p. 525). Benner (1984, 2000) contends that the central nursing ideal of holism is essential to balance scientific reason with the craft, judgment and virtues embedded in caring practice. Benner's framework allows for a discussion of how nursing knowledge is constructed however, her model does not address the lack of recognition and minimal influence the nurses experienced in this case analysis.

Florence Nightingale's (1860/1992), *Notes on Nursing*, speaks of the tension between scientific knowledge and caring knowledge. Nightingale directs nurses to be 'devoted and obedient' in their caring service (p. 172). She insists on obedience to physicians as necessary to the well being of the patient and is critical of nurses who act independently or in contradiction to medical direction. Nightingale calls these breaks from physician authority 'amateur physicking' and warns that such actions are 'reckless' actions of women (p.162). Nightingale maintains that nurses must also be thoughtful in their actions. Nurses should not follow the physician's instructions without believing in the correctness of those actions for the patient. Nightingale qualifies her directive for obedience warning that a nurse's duty demands more than thoughtless submission to doctors. She

advocates for the thoughtful application of the physician's recommendations calling this 'intelligent obedience' (p. 173). Nightingale acknowledges in her writing that nurses accumulate patient-specific knowledge essential to providing conscientious interventions for individual patients. Nightingale did identify potential barriers to intelligent obedience arguing that, 'Really good nurses are often distressed, because they can not impress the doctor with the real danger of their patient' (p. 152). She speaks of tensions for nurses that stem 'from the nurse not having the power of laying clearly and shortly before the doctor the facts from which she drives her opinion, or from the doctor being hasty and inexperienced, and not capable of eliciting them'. (p.152). When the expectation of obedience conflicts with the responsibility to act in the best interests of patients, tension is created for nurses. Nurses are positioned to ensure that care is matched to patient need. Hearing the voices of nurses is essential to achieve this synergy. The stories presented in this case analysis resonate with nurse's frustration at their inability to reconcile these two directives.

The theoretical lenses of Nightingale (1860/1992) and Benner (1984, 2000) have contributed to the recognition of the issues embedded by amplifying both content and process issues. Benner contributes an understanding of the complexity and contextual nature of nursing knowledge and its meaning in nursing practice. Nightingale's (1860/1992) work adds a historic perspective and explanation for the social influences which shape the voices of nurses today.

Becker, as quoted in Schwandt (2001), advised researchers to expand the simplistic question of 'what is this case?', and instead seek to answer 'what is this a case of?' (p.22).The multiple experiences of the case nurses viewed from two

platforms of analysis will provide a rich foundation to answer the later question. The struggles recounted by case nurses are founded in historically constituted silencing resulting in frustration and moral distress. Ultimately, this case analysis may underscore that things do not have to be the way they have always been for nurses.

Constituted Nurse Voice

Nurses are the inter-professional team members situated closest to the patient. This intimacy and proximity with patients requires nurses to take up a central role in communication about care. Benner, Tanner, and Chelsea (1992) state that one of the most important outcomes of the critical thinking process for nurses is the contextual understanding it generates about a patient. That contextual understanding, along with the dynamic connections nurses have with patients over time, supply unique knowledge to the interprofessional team (Carper, 1978). James as cited in Nelson (2004) asserts that to exercise one's voice we must accept that one's individual voice exists. Nurses must recognize that their voices are separate from others and provide unique perspectives in the clinical arena. Nursing scholars have continued to debate exactly the nature of what nursing has to contribute (Fawcett, 1984). Although a resolution to this debate has not been reached, it is clear that this unique nurse knowledge is not universally accepted as creditable truth by other disciplines (Ceci, 2004). As a result, tensions have developed for nurses related to the extent nursing science should and does influence patient care (Gordon & Nelson, 2006).

Paediatric illness care is highly dynamic. In this environment information about patients requires timely and insightful interpretation by skilled nurses (Curley & Maloney-Harmon, 2001). In children, most patient-specific knowledge must be determined through observation and interpretation. Children cannot always be counted on to self report symptoms or articulate, in detail, their own ideas, fears, and experiences of their health condition. This developmental reality of ill children increases the importance of the intimate interpretations bedside nurses construct about individual patients. In the context of the acutely ill child; the understanding constructed by the bedside nurse is paramount to early recognition of clinical vulnerability and essential to the ongoing determination of the best response to avoid the patient's deterioration (Curley & Maloney-Harmon). Bedside nurses ought then to play a key role in the team's clinical judgment about that particular child and his or her illness needs. In this case however it appears that the nurses closest to the child are not always heard or have their clinical concerns and opinions taken up by the inter-professional team (Middaugh et al., 2007).

A number of scholars have looked at communication between nurses and other health team members (Edwards & Donner, 2007; Coombs & Ersser, 2004; Harrison & Nixon, 2002; Manias & Street, 2001a, 2001b). Predominately these investigations have examined structured communication activities and processes. Harrison and Nixon observed shift handover practices of nurses. Manias and Street (2001a) observed ward round communication and medication documentation. Both of these studies illuminated multiple strategies which nurses utilize in presenting their clinical judgments to others on the team. These communication maneuvers have evolved in different contexts of practice to support nurses being heard in

clinical discourse. One strategy uncovered is the breakdown of the nurse's holistic impressions into discreet pieces of physiologic data prior to presenting the information to physicians (Harrison & Nixon). Bedside nurses predominately talked in terms of physiologic information and were rarely observed to speak holistic or care-based dialogues. In a study of interdisciplinary relationships in an intensive care setting, Coombs and Ersser observed nurses adapting how they spoke about patients when interacting with the medical team. Nurses in their study preferred medical language and illness focused dialogue when engaging in inter-professional patient discussion. Bedside nurses were often absent from essential patient communication activities. Coombs and Ersser found that nurses were not proactive participants in clinical discussion engaging primarily in response to questions posed by the medical team. They did observe that some nurses attempted to present more impression based holistic information about patients for discussion but were largely unsuccessful. Edwards and Donner's descriptive study of how critical care nurses pass on their nurse knowledge exposed strategies nurses use to influence clinical activities. In this study, nurses created threads of data which they linked together in order to build a case for their nurse-derived recommendations. Anthony and Preuss (2002) contend that language barriers exist for nurses trying to integrate their judgments into decisions made by the inter-professional team. Poor understandings of differing epistemological positions and minimal shared language can lead to misunderstandings amongst the team.

These aforementioned studies expose that the opportunities for bedside nurses to speak about patients are limited in time and space, the language of

nurses' knowledge is absent from clinical discourses and thus the scope of what nurses can contribute is restricted.

The aforementioned strategies nurses use to integrate nurse knowledge and amplify nurse voice might also risk altering the truth of nurses' clinical assessments. Limiting space for the voices of nurses and modifying the language of nurses can potentially marginalize or dilute nurses' insights. Nurse contributions might then become less valuable components of a complete patient picture.

These communication maneuvers arise from a climate where medical knowledge is accepted as a superior form of truth. Alternative ways of taking up the views of nurses must be established in order for nurses to be heard in the inter-professional clinical decision-making process (Litchfield & Jónsdóttir, 2008).

Nurses Knowledge

Sound clinical judgments made by nurses lead to effective clinical decision-making and, in turn, to interventions essential to the survival of patients. Benner et, al., (1992) argue that nursing knowledge about specific patients must be preserved and passed along to the health care team. Nursing has a long tradition of having unique understandings of patients that emerge in multiple ways of knowing (Benner & Tanner, 1987; Carper, 1978). Liaschenko (1997) identified three distinct ways of knowing in nursing: knowledge about care (pathophysiology and treatment options); case based knowledge (precognitive understandings based on previous patterns of patient response); and, understanding systems and contexts of care. Nurse scholars have studied how

nurses come to use their distinct knowledge, and how nurses then choose to respond to clinical situations (Benner, 1984; del Bueno, 1983; Tanner, 1993). However, these theoretical models do not provide an explanation for how nurse's clinical judgment is woven into the multiple inter-professional discourses of clinical decision making and care delivery.

Nightingale (1860/1992) addresses the importance of developing patient specific knowledge in her '*Notes on Nursing*':

> Nurses *ought* to understand in the same way every change of her patient's face, every change of his attitude, every change of his voice. And she ought to study them till she feels sure that no one else understands them so well (p.169).

Thus, Nightingale expresses the need for nurses to focus on patient-specific detail writing, 'Good nursing consists simply in observing the little things which are common to all sick, and those which are particular to each sick individual.' (p. 147).

Nightingale distinguishes the importance of nurse's intimate understanding of paediatric patients writing, "In the case of infants, *everything* must depend on the accurate observations of the nurse..." (p. 142).

In the case, nurses recalled similar intimate understandings of their patients. One nurse described her patient before the child deteriorated stating: "The patient was very lethargic, complaint with care, unusual for him. Mom was edgy. Mom kept asking if he was okay. I wanted the doctors to assess". This nurse was very familiar with patient specific responses as Nightingale suggests (1860-1992). Bedside nurses in this case demonstrate this enduring method of

building patient understanding though individual details and contextual awareness. Holistic impressions were derived from data acquired during nurse-to-nurse report, individual patient assessments, and assessment of parents, including their impressions of the child. Empirically measured changes in physiological status as well as behavior, mood, or anxiety of the child and parent contributed significantly to the nurse's understanding of the patient's clinical condition. Benner (1984) defines this interpretation of multiple and diverse patient indicators as expert clinical judgment that is essential to patient care. Similar to the above expression of concern, the majority of case nurses first provided a holistic interpretation about the child's condition. Nurses then immediately began reducing their skillfully formed impressions into lists of discreet objective clinical signs (heart rate, oxygen requirements) and subjective concerns (changes in child's behavior). Once constructed, the nurse's impression of the child must be made available to others on the health care team in order for to influence actions. As Coombs and Ersser (2004) found, deconstruction of nursing knowledge is necessary for nurses to connect to the medical discourse in order to be heard. Having to break down these complex understandings renders the unique nursing impressions invisible and the entirety of the nurse's understanding is lost to the team. This reduces nurse contributions to simple data reporting, and the carefully crafted nurse impressions are not taken up as a legitimate component of a complete clinical picture (Manias & Street, 2001a).

Historical Construct of Nurse Voice

Historical examination of the relationships between practitioners of different health care disciplines expose which voices are taken up in clinical discourses (Ceci, 2004). Influence in health care is generally held by those who control education, the work environment, or reward productivity (Reverby, 1987). Historically, nurses have been trained rather then educated, and restricted through that training in how and when they could exercise their nursing knowledge (Keddy et al, 1986). Early nurses lacked formal educational opportunities as institutional and educational standards for nursing have emerged only in the past 100 years. When education systems were first established, and into the middle of the 20th century, instruction for nurses was delivered by physicians who thus controlled what knowledge nurses were exposed to. The privileged social positioning of physicians was exercised as a superior authority of knowledge (Keddy et al). Nurses lacked the patronage of higher learning institutions and suffered gender and class prejudice as a predominately female group from less politically influential classes (Reverby). Nursing education, until about the 1970's was primarily approached as vocational training rather than an academic pursuit, resulting in challenges to the legitimacy of nursing as a scientific profession (Bunting & Campbell, 1990).

Nightingale did not foresee a need for the certification of nurses (Reverby, 1987). She viewed nursing as more aligned with the arts and resisted scientific structuring of the discipline (Reverby). This contributed to early doubts about nursing as a credible science and knowledge authority. Lay women practiced under the banner of nurse. Uneven educational preparation created unpredictable skills sets between nurse practitioners. This provided evidence to

those outside of the discipline of the inferior positioning of nurse knowledge. This public impression continued on even after establishing education and practice standards and still shadows the profession today (Ceci, 2004; Gordon, 2006).

Nightingale (1860/1992) insists that quality training and a virtuous character is all that is required to develop nurses capable of self regulation, power sharing, and influential professional status. Critics point out that Nightingale did not take into account the class and gender barriers early nurses faced, or the limitations forced by social conditions of the time (Reverby, 1987). The knowledge held by nurses was subjugated as the result of socially founded inequities experienced by nurses (Keddy et al 1986).

Florence Nightingale (1860/1992) advocated for practice which preserved a service model and maintained medical authority. Her writings direct nurses to refrain from questioning, disturbing, or overtly influencing physician directives in the care of patients. Nightingale wrote;

"[pointing out that you are more aware of the patient's state] is not the way to impress with the truth a doctor, more capable of forming a judgment from the facts, if he did but know them, then you are. What he wants is not your opinion, however respectfully given, but your facts' (p.151)

Nurses of the time labored under the supposed superior knowledge of physician's and were expected to heed medical direction. Nightingale's suggestion that nurses be attentive to change and advocate for patients while insisting on subservient positioning has prevented the voices of nurses being known.

Nursing has been shaped through historic associations with medicine, the military, and the church (Alavi & Cattoni, 1995; Bunting & Campbell, 1990). All have played major roles in developing the knowledge, skill, and practice traditions of nurses. These institutions place a strong emphasis on structured leadership and the giving and receiving of orders. Early notions of what constitutes good nursing called for strict adherence to medical direction (Alavi & Cattoni). These ideals of good in nursing were further solidified by the social constructs of women which emphasized the virtues of obedience and service (Alavi & Cattoni; Bunting & Campbell). This selfless characterization of nurses laid the foundation for the subservient positioning of the discipline and limited the opportunities for nurses to give voice to their knowledge.

Nightingale saw nursing as a divine calling realized through the training of womanly virtues (Reverby, 1987). Nurse knowledge was not characterized as scientific but an internally motivated call to service. Nightingale posited that a nurse must feel a calling for her occupation She wrote that a nurse 'will, for her own satisfaction and interest in her patient, inform herself as to the state of his pulse…'(p.171). Nightingale asserted that nurses who do not embrace this calling are not good nurses. She wrote, 'no telling will make her capable of doing so' (p.171). This blurring of the distinctions between nursing skill and the ideal of selflessness left little room to recognize the technical and scientific expertise of nurses. Good nursing was the product of good character and the complex knowledge required to care well for patients was obscured from views outside of the discipline.

Earliest modern nursing practice was concerned mainly with the domain of 'doing' care. Nurses carried out the directives of physicians with little input into designing the care. The gender biases historically forged and reinforced by the virtue ethic of nursing inhibited the development and recognition of the scientific expertise of nurses (Reverby, 1987). This perception of nurses as duty bound medical workers rather than scientific, skilled professionals has continued to impact nurses today. Nurses who informed this case have hundreds of years of gender- and service-driven discourse to overcome when attempting to be heard.

Nurses are linked, through gender association, with the emotionality and virtues of the caring discourse. This creates a paradox for the expression of nursing voice (Reverby, 1987).

Gordon (2006) describes language-based difficulties with regard to articulating the work and the science of nursing. Gordon contends that in response to the continued dominance of positivistic science, nurses have retreated into a 'new Cartesian' discourse which privileges caring knowledge and skill over technical and scientific expertise (p. 104). Gordon asserts that separating caring and technical expertise in nurse's dialogue is problematic. When nurses speak about nursing only in terms of its caring epistemology there is an incomplete understanding of the wholeness of what nurses contribute to the care of patients. She characterizes this new dialogue as a denial of nurses' technical expertise and accuses nurses of retreating from their scientific domain. She argues that this retreat entrenches dated and limited understandings about the true nature and value of nursing care. Nurses are not recognizable as contributing sound scientific expertise or possessing complex technical skills. Much of the work of nursing then

becomes invisible, nurses are not viewed as influential and nurse's voices are then diminished.

Weinberg (2006) identifies similar difficulties for nurses in articulating the unique nature of their work. In her observations of nurses during restructuring at the Beth Israel Deaconess Medical Center, she found that when nurses preferenced their caring discourses, salient issues affecting the quality of patient care were reframed as personal to the nurses. Defining nursing care through only the relational and holistic elements ultimately isolated the nurse's voices and significant practice issues were not addressed. In her view, privileging the caring discourse of nursing overshadows the richness of knowledge and skill that nurses bring to the care. In this case analysis effects of this privileging of caring language may detract from the power and credibility of bedside nurses' voices.

The caring connection claimed by nurses is the vehicle through which we understand patients, yet that patient- specific knowledge can be rejected by others as emotionally and relationally biased (Benner, 1984). Nurses' foundational world view of holistic caring is not embraced or acknowledged outside of the nursing discourse (Reverby, 1987). This constitutes one of the greatest challenges to achieving external awareness of nurse voice. Potentially, inter-professional practitioners do not embrace the world view of nurses, and may conclude that nursing knowledge is not credible and therefore does not need to be acknowledged (Benner 2000; Nelson, 2006).

Nurses have sought to strengthen the credibility of their science however this has sent mixed messages to some nurses in practice (Wilson-Thomas, 1995). To solidify the discipline's scientific status some nurses advocated for an

epistemological stance aligned with a medical worldview (Reverby, 1987). This argument created tensions between those who embrace nurses' holistic and intuitive characteristics and those who sought a closer alliance with the medical model (Bunting & Campbell, 1990). The resulting divide within the discipline forged a separation between nursing knowledge and nursing practice. This philosophical impasse is experienced by nurses as disconnection between practice and academia, nurse scholars and practitioners and between front line nurses and nursing leadership. This is a point of strain in the discipline which continues today (Cash1995; Litchfield & Jónsdóttir, 2008).

Kitson (1997) contends that the most perilous method the discipline of nursing could choose to gain scientific status would be to reject that caring position for the positivistic world view. She argues that nurses are not equipped to compete for power with physicians in positivistic arenas and would risk losing what is unique about the craft of nursing in the process. She urges nurses to embrace their caring discourse and build their scientific status through respecting and celebrating their epistemological positioning.

Conversely, Gordon (2006) argues that the service and virtue-based ethic of nursing continues to erode nurses' influence, and to the value attributed to the voices of nurses. She writes that emphasizing nursing as a caring science has de-valued perceptions of the skill and scientific expertise of nurses. She asserts that embracing a positivistic scientific world view is essential for nurses to gain influence and power in health care delivery. Gordon, citing evidence from nurse's descriptions of their work, argues that care-based nurse discourses are not accessible to those outside of nursing. She urges nurses to refrain from using

their caring voice and instead offer their scientific knowledge in their discourses. Gordon contends that this is the only way in which nursing will become a visible contributor and gain credibility amongst the broader health care community.

This repression of the connected knowledge of nurses and privileging of objective truth is amplified in the case when nurses assert their awareness of a child's changing condition. To successfully communicate with the medical team nurses must often abandon their disciplinary epistemological positions or, at best, suppress the expression of them. The nurse experience below demonstrates this conflict as her nursing awareness of a child's vulnerability was rejected by the physician with tragic results:

> I had this patient the day before, he was tolerating feeding and was very interactive and smiley. We turned off his [drug infusions] during the day. During night shift he started to not tolerate feeding. When I saw him that morning he was retching and gagging. He was cold and clammy-looking and very cranky, not interactive like before. He cried for 40 minutes straight and was inconsolable. I paged the resident to come and assess him. I told the resident about changes in the patient's behavior and feeding. The resident said "What do you want me to do with a crying baby", and did not order anything. I had a feeling that the patient would code and an hour later he did.

This nurse's concern about the patient's behavior change was interpreted by the resident as emotional worry for the child's mood state and thus, the nurse's voice was disregarded. The outcome for the patient was devastating to all those

involved. This nurse reported feeling frustration and moral distress at the deterioration of the child and her inability to catalyze preventative action.

When speaking of patients, some nurses in our case story intentionally withheld their nursing knowledge and selectively forwarded information that aligned with the dominate scientific discourse. These nurses chose to silence their caring voice perhaps because they learned over time that sharing holistic impressions would frustrate their attempts to be heard. One nurse's story described how she waited over nine hours to speak of her concern for a child because she felt compelled to remain silent until confirmatory physiological findings were available. This nurse may have anticipated rejection of her impression of the child's increasing vulnerability. This further marginalizes the expert clinical judgment brought forth by nurses and contributes to significant delays in action to prevent clinical crisis. Sharing the knowledge embedded in nursing with other health professionals is historically laden with perceptions of scientific legitimacy.

Power- Knowledge and Relationships

Foucault asserts that power relations are evident in multiple ways and in the many discourses of everyday life (Manias & Street, 1999). He posits that power in and of itself is neither good nor bad, however the effects of enacted power create possibilities for individuals. Power is enacted between subjects and is observable through examining the effects of that action (Foucault1982). Foucault views knowledge as the technique/method for sustaining power. To Foucault, the power-knowledge relationship leads to the prioritization of particular forms of knowledge as better truths (Manias & Street, 1999). Therefore, the

concepts of power and knowledge are linked and not reducible from one another. An imbalanced power-knowledge relationship between subjects can restrict reason and limit possibilities for the subordinate subjects. Realities for subjects are forged, maintained, and contested through the application of power (Foucault, 1982).

Foucault (1982) proposes that what one understands about self and others is constituted through history. In his view, subjectivity is ‘made’ and the sociological and historical contexts determine how and why different forms of knowledge dominate. He argues that power creates realities and sustains beliefs about truth. Foucault posits that power governs the individual and also controls productivity (Ceci, 2003). Ceci suggests that understanding how we have become subjects of a certain sort is necessary to understand how we are in the present.

Foucault states that to understand the nature of power one must look closely at how power is exercised within relationships (Manias & Street, 1999). In this analysis, power is discernible as the capacity for nurses to choose action or to influence responses to their perception of risk for the child. Many nurses in the case had little influence and experienced power-over realities which rendered their preferred nurse actions unavailable or unattractive (Chinn, 2004). Power dominance in health care is nurtured through institutionalized preferencing of medical knowledge as more valid (Ceci, 2004). This dominance of the medical truth is woven into the fabric of the past and, if unchallenged, will continue to influence the future.

Power positioning in the form of hospital leadership hierarchies has always been inclusive of nurses. Those nurse leaders who achieved influence however were those situated in closest proximity to the physicians (Reverby, 1987). This left the front line nurse at a disadvantage to build relationships with the physicians. Time honored servitude, lack of public credibility, and the dominance of the scientific patriarchal medical profession left most nurses unable to gain influential status within the team. Nurses have been historically burdened with the continued necessity to advocate for the credibility of their knowledge and have continued to occupy a less influential professional standing (Gordon, 2006; Weinberg, 2006). This has had the effect of inhibiting nurse engagement in connected, collaborative relationships particularly between bedside nurses and physicians. Foucault (1982) would recognize this laying of influence as a dominated power relationship because it limits the subordinate subject's possibilities for action. The relationships between nurses, nurses in differing positions, and physicians, and how each communicate about their clinical realities reveal inequitable power relations thriving in current practice.

Case nurses spoke of the challenges of maintaining inter-professional relationships that would support their voice. Some nurses told of situations where they were not only silenced but were unable to access information about the patient from others. Bedside nurses were the least influential in the nursing hierarchy and needed to align themselves with more influential partners to be heard. The ability to be heard had no correlation with experience or depth of knowledge, but instead seemed closely linked with the position of the nurse in the hierarchy of power. Although senior bedside nurses did not receive more

influence related to their clinical experience they did benefit from more fully developed skills with regard to finding alternative ways in which to be heard (Benner, 1984). A senior nurse told of her strategy to have her concerns heard;

> I was not happy with her breathing pattern. The [doctor] did not want to do anything. I called the nurse practitioner back to assess child. The nurse practitioner then called MD to have second opinion and the doctor ordered blood work. As blood work was done I noticed her heart rate drop and called the nurse practitioner and doctor back.

Although the clinical Nurse Practitioner (NP) represents a nursing voice, her positioning on the team is unique. The advanced practice model at this site aligns closely with the medical team in daily practice activities. In the above exemplar, a pre-existing practice relationship improved the nurse practitioner's ability to be heard. The NP was more credible to the physicians related to her advanced practice status. NP's participate in a day-to-day reporting structure with physicians and therefore are well versed in culture of medical communication. All these elements combined to make the voice of the NP stronger than the bedside nurse's voice in the situation. The need for the bedside nurse to have her concerns interpreted by others minimized her contributions and isolated the nurse with the most intimate patient knowledge from decision making. This in turn delayed responses to the child's distress.

Stein (1967) wrote about the nurse-physician relationship characterizing it as a game. The object of the game, as Stein views it, is to avoid open disagreement between nurse and physician. The more important the content of

the interaction the more subtly and skillfully communication must be handled between the players. Social and moral consequences exist for poor play. Nurses who do not play well risk developing reputations as poor nurses or troublesome team members. Physicians who do not play skillfully risk alienating themselves from the nurses resulting in dysfunctional working relationships and reduced productivity. Stein describes that the goal of the game is to subvert nurse voice and sustain physician power. In Foucault's view this game could be interpreted as at once an example of the multi-directionality of power (nurse indirectly influencing physician whilst physician overtly directs care) or may constitute a form of resistance to disciplinary power[8].

Stein (1967) questions why such an inefficient communication pattern exists? He points out that 'players are not fully aware' of the strength of this pattern' to see beyond their established role in the game (p. 703). The imposed structures of the game result in restrictive organizational processes, preservation of physician authority, and limitation of opportunities for nurses to be heard. This supports Foucault's (1982) assertion that power is consciously and unconsciously applied to systematically stabilize the existing balance.

Considering the narrative example above, both Stein's and Nightingale's perspectives are evident in modern clinical practice. From Stein's (1967) view this bedside nurse was successful in the game as she achieved action without the risk of challenging existing power relationships. Through the lens of Nightingale, the boundaries of respect for physician authority were maintained

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[8] Disciplinary power is power-in-action which maximizes the conformity of individual subjects with pervasive socio-political norms (Udod, 2008). These norms are born from dominant discourses in practice which determine what is relevant and credible knowledge (Manias & Street, 1999).

the ‘facts that the nurse alone can observe’ were reported and the patient eventually received care (Nightingale 1860/1992, p.151). Unfortunately Nightingale did not account for the conflict between the responsibility to act and the limitations of her prescribed subservient positioning of nurses in the medical hierarchy.

Limitations on Nurse Voice

In the case under consideration, nurses were limited in their possibilities for independent action for their patients. As mentioned previously, nurses perceived little control in the failure-to-rescue situations. The power to act in the way that the nurse determined best appeared tightly linked to the positioning of the nurse and the credibility attributed to the nurse’s knowledge. Nurses in positions of authority, for example nurse practitioners had more influence than bedside nurses. Bedside nurses focused on maintaining smooth team functioning, preserving what they felt to be the standard of care while seeking a way to have their concerns taken notice of. In keeping with Nightingale’s service directive, staff nurses told of being cautious about threatening the authority of the physicians (1860/1992). Bedside nurses preferred consulting with influential nurses rather than the medical hierarchy. This case is ripe with examples of nurses resisting actions which would disrupt existing hierarchies of power. This nurse described feeling little control over her actions with a deteriorating child;

> I had to page the doctor multiple times… He [the boy] was screaming in pain. [In the end], the clinical support nurse is the one who had to go and get the doctor, not me.

This nurse faced barriers when trying to convey the urgency of the situation for the child. Ultimately this nurse turned to the clinical support nurse for help in having her concerns about the patient heard.

. Nurses who were able to maneuver outside of established power boundaries perceived success in having their voice heard. These nurses report that they had previously established relationships with colleagues who held power. These connected nurses were more likely to be listened to, and were given more control to act in the way they determined best for the child. This reinforces the notions of position as well as power discourses are a play in these clinical situations.

Nurses are socialized to attend to the direction and authority of physician and also nurse leadership (Keddy et al, 1986). Hierarchical authority within nursing was experienced in the case as prohibitive, or alternately as a means for bedside nurses' voices to be heard. A novice nurse described a situation in which the nursing hierarchy constrained her actions;

> 'I was worried but the resident was not concerned. My clinical support nurse did not feel it was a problem so there was not much else I could do'.

True to the discipline's historical valuing of obedience, this bedside nurse did not feel empowered to move beyond her direct supervisor to voice her concern for the child. The result for the patient was delayed recognition of vulnerability and clinical deterioration continued.

Another nurse expressed a positive experience in utilizing her connections to a clinical support nurse to expedite responses for a child's low blood count. The hierarchical positioning of the clinical support nurse allowed for immediate action

by the physician care team. This bedside nurse perceived more control as she advantaged her voice within that more influential clinical support nurse-physician dynamic. Although the outcome was perceived as positive by the bedside nurse, it also serves to reinforce that hearing the voice of the bedside nurse is not a priority for the inter-professional team. Linear paths of communication and the addition of new participants in situations of clinical urgency is time consuming, inefficient, and isolating to nurses who are positioned closest to patients.

Limitations to being heard were also seen in the distribution of work. There are many competing responsibilities in clinical care which can distract nurses from efforts to integrate their voice. Many of the stories within the case include references to competing demands and service responsibilities, such as securing equipment and supplies, which took time and resources away from the nurse's attempts to communicate during the clinical crisis. Nurses find it difficult to articulate what they experience as competing tensions embedded in these demands. When they do speak up about their dilemmas, nurses are often not heard (Weinberg, 2006). The lack of clarity about what nurses do and the historic characterization of nursing as selfless service create real problems for nurses with regards to how to advocate for their time and position in the hierarchy of power (Weinberg, 2006). Nurses are often required to focus their skill and attention on activities other then what they define as nursing care, for example answering the ward phones or stocking paper supplies for the charts when clerical staff are not available. Similarly, resources and time to engage in, what would be defined by nurses as nursing activities becomes limited (Weinberg; Heartfield, 2006).

Good in nursing is often defined by those external to its practice using measures which do not resonate within the paradigm of the discipline (Nelson, 2006). For example, physicians value the efficient delivery of medical care and professional relationships which maintain their authority to control the team (Alvai & Cattoni, 1995; Foucault, 1982). Successful nurses achieve efficiency and proficiency regardless of their caring ethic. Reverby (1987) writes that because the original work forces in hospital were women, often unpaid student laborers; altruism, sacrifice, and submission were expected. Nurses who did not work to these expectations were issued consequences. Bunting and Campbell (1990) identified this as exploitative apprenticeship. One nurse in the case acknowledges;

> The charge nurse told me to just get ready [for the spinal tap]. I could not refuse to do the tap, which is what I would have liked to do. I prepared for the worst and had all members of the team in the room prior to code...I even mentioned to the doctor that eventually she would tire out and we'd have a very serious problem - still nothing was done. I felt very helpless in this situation.
>
> *Note: this child could not be resuscitated and died during the procedure.*

In this situation the bedside nurse was encouraged to be efficient and prepared, however her unique understanding of the patient's vulnerability remained silenced.

The historical foundations of nursing service ideals have laid the foundation for this dichotomy between the responsibility for care and minimal influence over what is actually carried out. Present day authors have documented

the difficulties nurses have with speaking up about working conditions and excessive demands placed on their practice (Gordon, 2006).The preferencing of the caring discourse has somehow inhibited nurses from excising their voices when speaking of their own needs. When the nurses can not speak for themselves they, as the above narrative illustrates, will not be heard when speaking for their patients. This dynamic played out in front line practice marginalizes the specialty knowledge of nurses, inhibits nurses from delivering best care and can result in moral regret for nurses (Moland, 2006).

Whispered voices: Effects of Silencing

Foucault (1982) suggests that to examine power relations one must look to evidence of resistance. He conceptualizes power as a web, moving in many directions with multiple points of resistance (Manais & Street, 1999). Foucault (1982) asserts that power relations only occur when subjects are free to resist. It is through resistance that power is adapted and perpetuated. In the case there is persistent tone of discontent in the case nurses' narratives. The frustration expressed by the bedside nurses represents opposition to existing power structures (Ceci & McIntyre, 2001; Foucault, 1982). Interestingly, nurses who informed this case were overwhelmingly willing to participate and tell their stories (Middaugh et al., 2007). Nurses have something to say about their experience of voice and welcomed the opportunity to talk about their practice with acutely ill children. This tension articulated by the nurses indicates that the nurses recognize that there is an alternative to their current condition.

Foucault (1982) determined that when subjects participate in power struggles it is difficult for them to determine what is at the root of the issue. Often subjects look close to home for explanation, perhaps blaming individual team members or local resources. Nurses in the case were disadvantaged enough that system problems were not always visible; therefore generating ways to enhance their voices were unobtainable. Foucault posits that subjects in dominated power relations do not expect change; instead they become fixed in repeating the same pattern. Most nurses articulated a vision of having their voices heard, however expressed little expectation that their concerns would be taken up by the care team. Their desire to be heard did not translate into overt challenge of the situation, but instead was expressed as resignation and frustration. Florence Nightingale (1860/1997) stressed the passivity and decorum of nurse and the need to never engage in conflict or evoke a passionate voice. The case nurses stayed true to her course. Case nurses acknowledged that physicians had the most authority in deciding action however, expressed regret that those decisions were often made with partial information. Further, the information informing decisions lacked the richness of the bedside nurse’s insights and thus limited the potential for action. Case nurses did not speak out or overtly challenge the broader issues of their silencing perhaps because they did not realize large scale change is possible.

Nursing is a moral activity and, as such, the way in which nurses experience their silencing has moral implications (Storch, Rodney, Pauly, Brown, Starzomski, 2002). Reverby (1987) discusses tensions between duty of care and the autonomy to care (or to provide caring actions) as a great dilemma for nurses.

Nurses experience tension when their obligation to preserve health for the child is in opposition with their duty to be non-confrontational within the team. That dichotomy comprises the root of the difficulty these nurses experience in asserting their right to be heard and to act from their own scientific positions. Nurses' sense of moral responsibility to act to preserve the child's health led to nurses experiencing distress. Moland (2006) states that nurses often describe these conflicts as moral dilemmas and that they feel powerless to resolve them in an ethically satisfying way.

Storch et al. (2002) identify similar ethically unsatisfying situations for nurses. They found that nurses were very limited in exercising their moral agency and had restricted opportunities to talk to one another about their practice outside of structured patient communication. Storch et al. found that nurses where inhibited from naming and sharing their struggles because of limited opportunities to talk together about these matters. They found that this lack of communication between nurses negatively impacted nurse's moral voice.

Gordon (2006) identifies that historically nursing has had difficulty separating its moral obligations from its scientific responsibilities. Nurses safeguard patients and advocate for the team and the organization. These obligations can often be attached to practice recommendations that conflict with what nurses determine is best to do. These challenges are difficult to resolve for any professional however, to do so without giving voice to the struggle is paralyzing. Unable to reconcile the realities and restrictions of nurse voice and action, nurses are faced with a greater moral burden (Moland, 2006). Recurrent exposure to the situations described in the case can lead to an erosion of nurses'

ethical selves and threaten their moral integrity (Bergum, 2004; Moland, 2006). Nurses respond to these threats by leaving the profession, moving their practice away from the bedside, distancing themselves from nursing's caring foundations, or they continue to shoulder the ongoing lingering regret that has become an increasingly familiar companion to nurses (Nelson, 2006).

Fortunately, as Shannon (1997) points out, these professional conflicts need not be inevitable. Shared understandings between disciplines can be richer and actions more informed if avenues of collaboration can be built. In contrast the cost of a poorly sustained practice community for nurses can be high for nurses, patients, families, and the organization.

The future: To Be Heard

This case reflects the local experience of a small group of nurses in a specific practice environment; however, the picture drawn from this case has resonance with international nurse audiences (Middaugh et al., 2007). Numerous nurses have approached me after presenting this case to share similar experiences of frustration and disempowerment. This experience of voice is replicated broadly within the discipline and the challenges nurses face in being heard are 'transversal'[9] (Foucault, 1982). This makes asking theoretical questions of the case all the more salient for nurses today and in the future.

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[9] Transversal describes anti-authoritarians struggles which are experienced across varied government, political, and economic environments (Foucault, 1982).

This case analysis reveals that nurses and others must acknowledge nurses' legitimate voices in order to remove beliefs that may disallow nurse influence. Because nursing is uniquely positioned in the domain of human care, their experience of voice resound in the daily individual choices nurses must make (Uustal, 2002). The environment in which nurses seek to have their voices heard remains affected by the long, long reach of history. This has inspired some nurse scholars to question if nurses can achieve their vision of good practice (Bergum, 2004; Grace, 2001; Laschinger & Finegan, 2005). The nurses in this case did not receive sufficient support from their organization and teams to meet their own expectations of good practice. The silent nurse voice and absence of opportunity to pursue more inclusive team dialogue generates real difficulties for nurses. Bedside nurses are inhibited from fully exercising their expertise in paediatric failure-to-rescue events. Nurses then have difficulty connecting their own perspectives to the larger situation or even realistically measuring how effectively their obligations to self, patient, organization, and profession have been realized (Bergum, 2004). In other words, nurses are constrained in achieving practice that is morally and professionally fulfilling. Discourses of efficiency, institutional hierarchies, and ideas of legitimacy of knowledge are active in the bedside nurse's practice. All of these elements serve to quiet the voices of nurses.

Sensitizing nurses to the influences of history and power can lead to productive nursing action which can empower their voice (Dunphy & Longo, 2007). Cultivation of a climate where nurse voice is valued as more then vehicle

for efficient delivery of medical care is necessary for nurses to achieve practice that is consistent with their professional values (Rodney & Street, 2004).

A social worker colleague of mine is fond of offering this suggestion to nurses. He encourages nurses to ‘put the issues on the table’ and ‘call’ the behaviors which they find problematic. When nurses feel silenced they should articulate that feeling if only to mark the experiences for themselves. Nightingale (1860/1992) argued that providing opportunities for nurses to succeed is not enough; barriers to being heard must be recognized and broken down. We must teach nurses how to be heard, how to listen, how to choose alternative actions, and how to dispel any notions that nurses are not worthy to speak.

Nurses must be educated on the historic and political foundations of their current place in health care. Simple exposure to the events of the past will not be enough to catalyze change. Nurses must understand the origins of their epistemological position and also be given the tools to critique these beliefs as they effect everyday practice. For example, nurses must first understand how the caring discourse evolved before, as Weinberg (2006) suggests, nurses can differentiate their scientific care from interpersonal caring in dialogue with inter-professional colleagues, administrators, and policy makers (p. 37). Nurses can no longer afford to allow theoretical concerns to stand isolated from the realities of practice. Weinberg (2006) insists that nurses can not wait for others to “figure out what is going on’ and must take action to ensure that the discipline is fully exposed” (p.42).

Nurses must actively market their worldview and speak in a language that is accessible to others. When a language is developed that is explicit about the nature of nursing knowledge, its application to practice arenas will facilitate a richer understanding of the contribution of nurses. Then new understandings of the science of nurses can be woven into the practice preparation of other health care disciplines. Shared understandings are the beginning of mutual respect between disciplines and the foundation of more power-neutral practice environments (Chinn, 2004). Potential spaces to reexamine dominate medical discourses and identification of whose voices have been silenced must be sought. It is my hope that transparent inter-professional critique will inspire interest in understanding how silencing and voice are experienced in therapeutic relationships as well. Respiratory therapists, allied health professionals, families, and patients would all benefit from this new dialogue.

Once a shared language is developed, space for a collaborative dialogue between health care professionals must be forged. I would suggested mandatory case debriefing after code or near code events. Debriefings are common learning tools however; these sessions often focus on the medical management of the patient. Utilizing skilled and unbiased facilitators, debriefing sessions which reach back to capture team dynamics early in the child's deterioration can make visible how voices were taken up and expose the inter-professional dynamics at play. For this exercise to be helpful all team members must participate and all must feel safe to speak. Establishing this safety will require effort and commitment from all inter-professional team members. The traditional mortality and morbidity presentation style of debriefing clinical situations must be abandoned for

transparent dialogues responsive to the needs of all participants. Collaborative conversations must be the goal and competitive critiques minimized. The language of ethics should be introduced into these inter-professional conversations being careful to avoid dominance by any single discourse of authority.

As we move into the next chapter of our future, nurses must be thoughtful leaders of inter-professional practice and interprofessional education. Nurses can champion broad acceptance of multiple disciplinary cultures and lead the mutual respect between professional groups (McCallin, 2001). Nurses must seek to identify subverted voices (their own and others) and work to ensure all are heard.

Conclusion

Much of the experience of nurse voice is unexplored by those in practice contexts. This case analysis has exposed, through a composite case of over 300 nurse experiences that historically-derived and socially-contexted influences on nurse voice endure in modern inter-professional practice. Nursing theory has not yet adequately addressed the division between nurse's caring responsibilities and its dominated practice reality. Practitioners have not yet found a way to articulate the whole of knowledge embedded in nursing. Nursing scholars have not yet resolved the gap between the caring and the scientific terrains of nursing. These living dilemmas, steeped in our own history, impact how the bedside nursing voice is taken up today. These issues marginalize nurses' contributions to care and silence the voices of nurses in the early identification of vulnerable, at risk children.

Well intentioned individuals and teams are then inhibited from achieving their goals of best care to ill children. Nurses will continue to bear the burden of frustration and discontent working in a reality that discourages their full and meaningful contribution to the team.

Communication between nurses and other professionals can be complex and dynamic. Nurses are subjected to historically- bound and socially-driven ideas which influence how the voices of nurses are taken up in modern patient care (Gordon & Nelson, 2006; Peter, 2002). This case analysis provides a powerful illustration of the limitations of our current understanding of the value of bedside nurses' voices in the prevention of childhood critical illness events.

It is my hope that the reader will take the questions posed and possibilities generated in this analysis and critically evaluate their conditions of practice. Nurses must examine, through their own lens, the historic assumptions and power relationships which have shaped the present conditions of nursing in order to lay the foundation for the future.

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