

Nurses Making Caring Work: A Closet Drama

by

Joan Lee Boyce
B.N., University of Manitoba, 1972
M.Ed., University of Manitoba, 1992

A Dissertation Submitted in Partial Fulfillment of the
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ABSTRACT

NURSES MAKING CARING WORK: A CLOSET DRAMA

The study reveals how nurses operationalize their daily caring practices in a hospital oncology unit that is described by nursing students as having a “culture of caring”. Despite ample evidence that changes to nursing practices in hospitals are occurring, there exists a dearth of work, theoretical or otherwise, that clearly addresses what appears to be emerging as a major trend. This ethnographic study directs attention to issues and concerns related to the changes by exploring the question of how nurses sustain their daily caring practices in light of the contextual influences that support or impinge upon their daily nursing activities. The study spans over a three month period (2-3 days a week) and involves 19 registered nurses who volunteered to be participants. Participant observation and journaling are the methods used to generate data. This field study is strengthened by participants’ corroboration with the researcher. Data collection, analysis, and interpretation were conflated into a single simultaneous process.

The findings are presented in the form of an artistic portrayal: termed a closet drama”. Analysis revealed nine themes of caring practices that framed a collective story

of ‘caring comes first’: making connections, creating form, making do, tolerating ambiguity, committing to diversity and dealing with difference; facing the possibility of death and facing dying, thinking outside the box of strategic moves, caring for self and others, and staying the course. They are the titles for the nine acts. A discussion of the findings is included as part of the drama in a series of passages called ‘After Wards’.

Practices of caring are identified as a third mode of thinking that is situational and immediate and located between the two worldviews of modernity and postmodern; certain and uncertainty. Nurses’ intentionality is aimed at building bridges of understanding between the predetermined strategies of imposed order, developed to direct patient care, and uncertainty stemming from patients’ personal understandings of health and unique responses to their current health event. The characteristics of caring practices are identified as thoughtful conversations and generative tensions as a consequence of the dialogical encounters that result in reflective understandings. Caring practices create a space for the centrality of the social in intellectual thinking where assumptions are questions, contextual influences are taken into account, and capacity building occurs at an individual and system level.

Of note is that one of the themes, “making do”, resulted in nurses directing their attention in two different directions: towards their patient and towards system issues. Thus, “making-do” is seen to serve two different functions. One is that it resists the loss of different possibilities for care. The second is that it serves to maintain hegemonic norms. In the discussion related to the significance of the research, making do is identified as a fault line for the limiting of caring practices.

The researcher concludes that there is a need for lens that would better enable nurses to examine the effects of contextual influences on nursing and nurses; to recognize the effects and opportunities related to changing worldviews.

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DEDICATION

In loving memory of Dad
Mac (Clarence Earl) McFadyen,
A man of great integrity who cared deeply for his family and the quality of life.

CHAPTER ONE

RECOGNIZING A PROBLEM

“There is a crack in everything. That’s how the light gets in It’s here ... the heart has got to open in a fundamental way” (Leonard Cohen, *Anthem*).

Introduction

For the past two decades, nurses across Canada have been grappling with government restructuring of health care and the many problems embedded in health care delivery. They have been struggling to solve recurring problems and the resulting dissatisfaction with their work (McDonald, McIntyre, & Thomlinson, 2006). “Themes throughout the literature on the changing nature of nurses’ work include confusion about what constitutes nurses’ work, the increasing demands of nurses’ work, the lack of control that nurses have over the work they do, and the incongruity between what nurses are prepared as professionals to do and what they are expected to do in practice” (McDonald & McIntyre, 2006, p. 286). The incongruence between nurses’ understandings of nursing as a profession and norms for nursing practice in local areas has resulted in increasing accounts of moral distress by nurses in the work place (Ceci, 2001). Hardingham (2006) defines moral distress as an inconsistency between one’s beliefs and the actions one takes. In a review of several studies related to moral conflicts of nurses, Redman and Fry (2000) found that one third of the subjects experienced moral distress (cite in Hardingham, 2006) . One of the confounding factors was that nurses believed that moral conflicts involving physicians were irresolvable owing to an organizational disinclination to deal with physicians. In recognition of the increasing

moral distress experienced by nurses, nursing scholars such as McDonald (2006) are challenging nurses to look beyond traditional assumptions regarding their work and seek a better understanding of how the devaluing of such work, along with knowledge about caring, stems from cultural power arrangements. The genesis of this inquiry was spurred by moral distress over changes to caring that I observed in local practice settings in hospitals.

During the mid-1990s, two nursing-related events occurred that I could not understand. One was the inquest into the death of twelve children receiving treatment in the Pediatric Coronary Care Program (PCCP) at the Health Science Centre (HSC) in Winnipeg. Profoundly disturbing for me was the thwarting of efforts on the part of nurses to ensure adequate care for children having surgery in the PCCP. “The nurses try to get someone’s attention. They go to their superiors and up the chain. Few seem to listen. At one point one of the nurses is as much as told her opinion doesn’t matter, that she is a nurse, not a surgeon” (Haines, 1997). Ironically, Judge Thomas Sinclair (2000), who presided over the subsequent hearing, concluded in the final report that the subjugation of nursing knowledge was a contributing factor in the deaths of the twelve children.

The second event was the admittance of my 80 year-old father into intensive care. Although practices of valuing individuals and their potential are talked about in the literature as part of nursing activities (Watson, 1985, 1988; Cheek, O’Brien, & Burt, 1997; & Halldorsdottir, 2006), they were notably absent in my father’s care. He was subjected to a form of high tech care that obscured him as a person, lost amidst a battery of machines, monitors, tubes, cords, and lines. This event triggered intense reflection on my part which culminated in three questions. How was it that the relational caring that I

have taken for granted as a universal identity for nursing was not a visible part of my father's care? How was it that what he desired in the way of care was ignored? Why were key psychosocial aspects of his care not addressed?

In an effort to make sense of the above events, I began to write. Cixous (1993) posits that writing is "the attempt to unerase, to unearth, to find the primitive picture again" (p. 9). First, I wrote about the experience of my father's hospitalization treatment in intensive care. Then I reviewed the literature pertaining to the inquest into the deaths of the children in the PCCP receiving treatment at HSC and documented my feelings and observations. I also began to journal about the various experiences I recalled at the time that pertained to nursing practices related to providing care in hospitals.

When later reviewing what I had written regarding children's care in the PCCP, I came to realize that my focus had been the distress experienced by the nurses, the source of which was the thwarting of their efforts to have addressed problems related to surgical practices. In contrast, in reviewing what I had written about my father's experience, I discovered that the focus was my own distress at caring practices being limited. I concluded that this deficiency was a result of a knowledge deficit on the part of those nurses assigned to care for him. What triggered a reevaluation of my interpretations was an observation by Watson (1999) that "my pain is in witnessing mainstream institutional nursing trying so hard and yet being so defeated by institutional oppression, no matter how optimistic, confident and self-enlightened the person or the institution"(p. xx). This reevaluation raised more questions: How was it that the PCCP nurses weren't listened to? What factors obstructed their being heard and their concerns being addressed? Was the

lack of caring for my father the result of a knowledge deficit on the part of individual nurses or some other factors?

While analyzing the literature related to PCCP, I became interested in a dissertation by Ceci (2003) that draws upon the work of Michel Foucault. Ceci made visible how nursing, as a construction based on gender ideology, works to maintain nurses in a subordinate position. She concludes that the HSC nurses, as women, were perceived as possessing knowledge less valid than that of physicians. Ceci cites a claim by Youngson (1999), one of the PCCP nurses, that all the nurses were “experienced, capable nurses, accustomed to dealing with life threatening situations” (p.133). Yet, their concerns were not taken seriously. They seemed to be viewed as over emotional, hysterical and too subjective.

In reflecting upon Ceci’s insights, I questioned whether there were other factors that prevented nurses from being listened to. I had worked at HSC for over 12 years and so was aware that PCCP nurses saw themselves as possessing advanced nursing knowledge; they were also recognized by other nurses and physicians as experts in their field. This view was evinced by the previous cardiac surgeon, who had worked with Youngson prior to Dr. Odim’s appointment. When asked what he thought about the situation in the PCCP, he stated that when someone like Carol Youngson speaks up, she needs to be listened to (Karp, 1998). What I began to question was whether there existed irreconcilable differences in perspectives between Dr. Odim and the PCCP nurses bearing on one another’s professional privileges. Did Dr. Odim assume his orders would be executed and his practices accepted without question owing to his status as a cardiac surgeon? As a man of color working amongst whites, was he predisposed to feel that any

questioning of his authority reflected racial bias? His comment that racial discrimination was a motivating factor in Youngson's treatment of him (Karp, 1988) gives credence to For their part, as white educated specialists in their fields, did PCCP nurses assume they would be listened to and have their concerns addressed. McIntosh (1988) notes that there are everyday privileges associated with being white that play an important role in shaping everyday life within the larger social context yet go unrecognized and remain invisible with respect to how they affect others.

While examining my journal entries related to the PCCP, I became increasingly aware of the impact of hierarchical ordering. I questioned whether the difference between Dr. Odim's perspective of what constituted appropriate care and that of the PCCP nurses might have been resolved but for the fact that the hospital had voted in favor of Dr. Odim. There is wide spread recognition that the subordination of nursing to medicine and administration within the context of hospital bureaucracies represents a major factor that works to subjugate nursing knowledge of caring. Karp (1998), Robertson (1998), Youngson (1999), and Armstrong (2001) link the subjugation of nursing knowledge to such strategies as the directing of belittling comments at nurses and the withdrawing of hospital legal support for nurses during the inquest. These strategies were part of an effort to silence nurses, to prevent their raising concerns related to the care children received in the PCCP. Shakey (1999) asserts that the hierarchical structuring of relations results in the higher authority always having the final say. Thus, it wasn't until PCCP anesthetists walked off the job and parents, alerted by news reports in the media regarding problems with the PCCP, began to ask questions that a space was created for concerns on the part of nurses to be heard.

The above events directed my attention toward two conflicting realities confronting hospital nurses. The first is that nurses are positioned as autonomous practitioners who are expected to care for patients and their families and who are held accountable for their caring practices. The second is that nurses are employees within a hierarchically ordered bureaucratic system. They are positioned to follow directives issued by physicians and administration. Bevis and Watson (1989) concur that nursing is an oppressed profession owing to how it is positioned in healthcare institutions. Another compounding factor identified by McDonald, McIntyre, and Thomlinson (2006) is the dearth of nursing leaders who are prepared to pursue aggressively the changes that are required within both nursing and society. This is exacerbated by the fact that nurses in positions of leadership have been increasingly co-opted through promotion to administrative or managerial positions that place them in an adversarial relationship vis-à-vis practicing nurses. In their new roles they are expected to carry out administrative or government expectations that do not benefit nursing.

One consequence of my ongoing reflections was the realization that I had failed to pay attention to the reality of contextual influences when examining my father's hospitalization. I had limited my analyses to an examination of individual behaviors on the part of nurses without taking into account how the playing out of systemic issues within the local context had constricted nursing practices of caring. Foucault (1972) contends that cracks, contradictions, and ruptures only make sense with respect to specific contexts. It is in remaining attentive to and skeptical of the contextual forces at work in local areas that perspectives that structure practices can be identified and the reasons for different practices better understood (Foucault, 1988).

In reinterpreting my father's care, I was able to comprehend deeper patterns of meaning that lay beneath the event itself. I recalled the nurse who had looked at me with such regret in her eyes and then turned away to busy herself with the medical technology surrounding him. I reviewed nursing literature that focused on the effects of context on intensive care nursing. I pondered what Henderson (1994) and Heartfield (1996) identify as an erasure of the patient as a person within the context of intensive care settings. I recalled Heartfield's (1996) observation that the importance of physiological data collected from constant observations of monitors attached to the body can create a fabricated view of the patient. What is problematic here is the danger of this view taking precedence over a patient's personal meaning of illness. Henderson (1994) identifies incompatibilities between theoretical perspectives framing nursing and the operationalization of nursing within intensive care settings. She argues that whereas in the nursing literature, nursing is promoted as a collaborative interaction between individuals who are ill, their families, and nurses, what occurs in practice is often very different. In the context of intensive care, Henderson notes the privileging of physiological data over emotional and sensory data. This raises the concern that living bodies constantly being subjected to invasive procedures may come to be treated little differently than cadavers.

As a result of re-examining my writings, I concurred that although the erasure of my father as a person may have been, at least in part, the result of the above developments, it may also have been, once again, at least in part, the result of contextual influences, i.e., political and economic agendas impacting the local unit. His admission to

intensive care had coincided with major healthcare restructuring. Nurses whom I knew and who still worked in the hospital revealed to me that downsizing had resulted in a loss of experienced intensive care nurses in the unit to which my father was admitted. A considerable number of nurses with advanced knowledge of intensive care nursing had been replaced by nurses with more seniority. The consequence was that the few experienced nurses remaining had been assigned the responsibility of educating and monitoring the practices of the new nurses, in addition to carrying out their regular duties. The result was that the experienced nurses had less time to spend with patients. They were simply too busy looking out for the nurses newly hired to the unit, too busy helping them acquire the high tech skills unique to the unit.

My conclusions were supported by the literature. Fuller (1999), Gordon (2001) and Buerhaus & Staiger (2001) concur that for many hospital nurses, the consequence of healthcare reforms are dramatic. The elimination of hospital beds has resulted in the loss of large numbers of full-time nursing positions everywhere. The principle of seniority, mandated by nursing unions as a guarantor of secure employment, has resulted in experienced nurses being replaced by nurses with little to no knowledge of a particular area but with seniority. Pepin (1999) notes that in Canada, beginning in 1992, more than 20,000 full-time nursing positions were converted to part-time or casual positions. Thousands of nursing positions have been eliminated altogether. At the same time there has been a dramatic increase in the acuity level of hospital patients, a trend that has led to significant changes in nursing. This impact was acknowledged by federal Minister of Health Allan Rock in a 1998 address to the Canadian Nurses Association. He admitted that no group had borne the brunt of health care restructuring more than Canadian nurses

(Canadian Nurses Association, 1998). Former federal Health Minister Monique Begin corroborated Rock's statement, acknowledging that nurses were overworked, stressed and burnt out as a result of the restructuring of the health care system in the provinces.

Although my re-interpretations failed to provide answers to all my questions, I came to recognize what it was I was concerned about and why. I recognized that for some time I had been cognizant of the discontinuities in caring practices between different nursing units. I had been concerned about the deficit in caring, but in assuming this to be an individual trait, I had failed to examine critically the discontinuities. It wasn't until my father was hospitalized and until nurses' concerns regarding inadequacies in care in the PCCP at HSC in Winnipeg went unheard that a new light was shed on the meaning of health care restructuring for nursing practices. This new understanding led me to reflect more deeply upon contextual influences on nursing practices. I was encouraged in this effort by insights gained from the nursing literature regarding the negative effects on patients of nursing practices which came up short in the area of caring attitudes. Corley (1998) examines how the absence of caring reduces the quality of patient care and interferes with good patient outcomes. Halldorsdottir (1999) cites the experience of former cancer patients whose anger and frustration turned to despair, helplessness, and hopelessness after experiencing uncaring acts.

One consequence of all these insights was that a point was reached where the need to articulate the deeper patterns of meaning that I was coming to understand in relation to nursing as a practice of relational caring could no longer be resisted. I decided to return to graduate studies.

Developing a Focus for a Study

The work of Michel Foucault (1972, 1979, & 1980) offers a new lens through which to examine power relations and enables the examination of contextual factors influencing nursing practices of caring. Foucault (1980) challenges the notion of a gap existing between theory and practice, arguing that such a concept is a construct that originates within modernity, one that serves to maintain the hierarchical ordering of knowledge and the binary oppositional relation of theory to practice. He posits instead that theory and practice are in relation with one another, not separate from one another. Expressive ideas structure practices: the systematic use of language statements forms certain practices. He argues, moreover, for a type of inquiry that examines practices for the purpose of revealing their functions. This requires that the focus of inquiry be directed away from individual behavior and toward the level of practice. Foucault (1972, 1979, & 1980) contends that when the functions of actions are examined, reasons for different practices can be recognized and better understood. This approach enables knowledge embedded within practices to be identified. It makes possible the tracking of how broader systems issues such as political and economic agendas at the macro level of society are embedded in practices at the micro level of everyday life and vice versa.

My interest in exploring how contextual factors were influencing nursing in local contexts led to my drawing upon Foucault to interpret what I saw happening in hospital units where I was working with students. I began reviewing teaching records that I had created as part of my everyday professional practice with a view to helping inform me about nursing in hospitals. As a nursing faculty member, I had been assigned to teach nursing students in the final year of their BSN program, who were enrolled in practice

courses in the following areas: maternity, pediatrics, medicine, surgery, oncology, mental health, intensive care, and palliative nursing. These records were created while working with students at different hospitals; their purpose was to track how nursing was talked about by students and put into practice in different local settings.

In reviewing my teaching records, I noted the high level of distress students experienced within a number of nursing practice areas. In noting the experiences they reported as stressful, I came to recognize distress as the outcome of contradictions between their understanding of relational caring and how caring was actually operationalized within particular hospital settings. As these students struggled to make sense of caring, their distress was manifested in severe abdominal pain, trembling hands, an overall feeling of physical tension, inability to sleep the night before attending the unit, sadness, a feeling of loss, inability to think clearly, and feelings of not fitting in the unit. Ceci and McIntyre (2001) define dissonance as a disjunction “between what one believes one is called on to be and do, and what the world, and one’s relationship to it, allows” (p.123). They maintain that nurses’ distress needs to be listened to and that research needs to be directed toward examining disjunction in local contexts that are the cause. These insights support my view of distress as a disconnect between understandings of what is and what ought to be rather than an individual deficit.

With a view to understanding how nursing practices are changing, I designed a study to examine how caring practices were influenced by different hospital contexts. Upon obtaining ethical approval for my study, I invited the student nurses who had been enrolled in courses for which I had kept teaching records to sign a participant consent

form (Appendix A). Although this study was never completed, the preliminary findings provided a foundation for my dissertation research.

In reviewing my teaching records, I became aware of the disjunction between students' understanding of what nursing is and what they experienced nursing to be within certain practice settings.

This awareness would inform my interpretation of statements from students regarding what was happening. These statements functioned like spotlights, denoting the disjunctions. They allowed me to recognize differences between how nursing is structured in the nursing literature, i.e., as relational practices of caring, and how it is enacted in local practice settings in hospitals. Students were positioned between caring practices promoted in the literature and caring as it played out in practice, and as such they were sensitive to the contradictions arising between the two. Hills' (1998) discovery that student nurses "recogni[ze] ... the primacy of people and their experiences as central to nurses' work" (p. 164) while at the same time, in certain practice areas, struggle to keep the client at the center of care serves to validate my interpretations.

In reviewing my teaching records, I soon came to recognize that I had an abundance of data regarding norms for nursing practice in certain nursing units. In contrast, for other local units, I had very little data describing nursing practices. I had collected considerable data for those areas in which nursing students had exhibited distress related to discontinuities in caring practices. I had collected only limited data for those areas wherein students had exhibited little to no evidence of distress. What I concluded was that there were some local contexts, such as certain medical and surgical practice areas, where nursing practices of caring are being marginalized or eclipsed.

There are other areas – oncology, palliative care, community, maternity, pediatrics – where caring practices are sustained and reproduced. This inquiry is limited to local units where discontinuities in caring practices were experienced by nursing students. The following is a discussion of some of my findings.

Within the context of one medical nursing unit, the principal theme students identified was ‘no time to care’. Their statements affirmed that nursing was limited to brief physical assessments, complex technical treatments, monitoring intravenous therapy, and administering medications. Students observed that nurses had little or no time to spend with patients, listen to their concerns, or offer support to those who were dying. There was simply too much work: as many as eleven patients were assigned to one nurse. As a strategy for survival, nurses had developed regular routines that delimited what they could and could not do. They had had taken it upon themselves to define the role that students were expected to follow. For their part, the students conjectured that the nurses’ refrain ‘you’ll get used to it’ was intended to reassure them that in time they would adapt to the norms for caring within the unit. Yet, upon reflection, this kind of reassurance could be interpreted as preempting questions and critical reflection on the part of students regarding the disjunction between what nursing was and what they understood it to be. There was an acceptance by nurses of what I would term ‘perfunctory caring’.

The oft-repeated use of statement’s like ‘you’ll get used to it’ is a focus of Arendt’s work. Arendt (1995) insists that clichés and conventional sentiments function as armor, blocking consciousness at those portals where painful intrusions of reality threaten to enter. They function to prevent reflective thought and the recognition of the startling

contradictions within daily practices. Arendt's insights give me pause to wonder whether the standard use of the phrase 'you'll get used to it' helps these students and nurses avoid feelings of inadequacy and guilt stemming from the marginalization of relational caring within the unit.

In another medical unit, the theme that students used to describe nursing was 'coordination of care'. In their case nursing was organized as a type of team activity, described by nursing students as requiring prioritizing and delegating, in addition to organizational skills. Students observed that nurses assumed responsibility for those patients who were the most acutely ill and whose nursing treatments were the most complex. Licensed practical nurse or nursing assistants were assigned to care for the remaining patients. An additional responsibility shouldered by nurses was the coordination of care and services for patients being discharged; most often, these patients **were** had been delegated to other team members. This additional responsibility was noted by students to have increased in scope in the wake of health care restructuring. Early discharge had become part of the political agenda aimed at cutting costs. Thus, nurses received a mandate to discharge patients as quickly as possible; to obtain physician orders so that they could do so. Although early discharge was perceived by nurses as a positive intervention for patients, the coordination this required had the effect of increasing nursing workloads; yet, at the same time, the additional work of coordination was never recognized by management. Thus a new role for nurses as information analysts had insidiously developed as evinced by the effort devoted to collecting and analyzing the pertinent patient information needed to coordinate the human resources and services required to enable patients to be discharged home. Nurses had to discuss each patient's

condition with other professionals involved in his/her care as well as collaborate with professionals in the community responsible for care upon discharge. One consequence was that nurses had less time to spend with those patients assigned them. Increasingly, it was families and significant others who were looked to by patients for psychosocial support and comfort. Distress on the part of nursing students stemmed from the fact that patients needed more than nurses had time to give.

Bishop and Scudder (1999) identify caring as comprised of both holistic and wholistic care – two very different types of caring. Holistic care is defined as the fostering of a person's well being in ways that acknowledge all aspects of his/her experience. Wholistic caring is defined as the co-ordination of care through the involvement of all the caregivers. In an effort to help students achieve a balanced integration, the nurses cautioned them not to 'spoil' patients by letting them become too demanding and take up too much time. This caveat about 'spoiling' patients stemmed from the two-fold concern that students would not get their work done and when these same students were not on the unit, the patients would expect too much from the regular staff.

In one of the surgical units, nursing students identified the theme of 'skills, skills, and more skills'. Students described nursing in terms of overwhelming workloads, a frustrating reality wherein so much is lost, nurses always busy with technical skills; teaching limited to patients only having an awareness of community resources and comfort measures not being a regular part of patient care. Nursing was viewed by nurses and students as an assembly line of high tech skills.

The emergence of assembly line nursing was perceived by nurses to be a result of healthcare restructuring. New processes and programs had been developed to provide outpatient services for less complex procedures. Although this was thought to be a good thing for patients, the acuity on the unit had increased because admission had been restricted to patients requiring only complex surgical procedures. At the same time, there had been no increase in nursing staff to cope with the increase in patient acuity. This resulted in nurses having less time to spend with patients. In addition, patients ceased to be admitted to the unit prior to surgery. This further raised patient acuity levels and prevented nurses from getting to know patients prior to their arrival on the unit following surgery. Meeting patients for the first time only after surgery had the insidious effect of increasing the nursing focus on the physical body of the patient. Following surgery, nursing focus was largely limited to monitoring for abrupt physiological changes, observing the status of the surgical sites, and performing essential technical procedures related to follow up care for specific surgeries. With advances in medical technology, moreover, the number and complexity of procedural skills expected of nurse had increased. Nurses were expected to do more in less time.

Changes to nursing stemming from restructuring are substantiated in the nursing literature. The latter also takes note of how advances in medical technology and testing have resulted in even less attention paid the individual patient's personal history as well as the elimination of holistic examinations (Gordon, 1997, 2001; Schoenhofer & Boykin, 1998). It has been argued that a fixation on monitors and laboratory data tends to direct attention away from the lived experience of the patient. The concern is that the accompanying loss of listening and touching could result in a loss of the relational bond

between nurses and their patients. Sandelowski (1999) describes nurses as the soft technology that supports high tech medical practices, arguing that nurses have become the monitors for physicians, interfacing between machines and patients, physician and patients, tying sympathy to science. Thus, an ongoing challenge for nursing is to prevent the biomedical discourse of diseased organs and curing from combining with the technological discourse within nursing to prioritize technology over nurses and patients.

Critical pathways were viewed by students as a survival strategy for nurses on the unit. Critical pathways are intended to reduce risk and enhance patient care. They achieve this aim by providing direction to nursing students and nurses newly hired to the unit who are unfamiliar with the many different surgeries. They consist of evidence-based practices that serve to provide consistency with respect to norms for particular types of care. Disch (1994), however, sounds a cautionary note regarding text based tools such as critical pathways, citing them as an example of how text mediated coordination of knowledge and action allows for the intersection of professional discourse with the economic and management discourse within hospitals. In essence they represent a prescriptive strategy for identifying the basic norms of care for persons with specific health problems. Therefore, although they can be helpful, they also promote replacing nurses' discretionary judgment with predetermined actions. The danger in using such tools is that shifting nursing attention away from the patient and towards tasks outlined in the pathways may result in a decline in discretionary judgments. Thus, text based tools can become mere checklists. In light of this threat, it is critical that nurses ensure that their holistic assessments identify the particularities of patients' responses to surgical

procedures and treatments. Nurses need to ensure that formal strategies serve to enhance care rather than hamper its delivery (Campbell, 2001).

Most significant is the realization derived from the analyses of my teaching records of how contextual influences shape practices in different ways in different local contexts. Context matters; it influences how practices of caring are enacted. The findings in the preliminary study underscore the importance of including the effects of context in an examination of nursing practices. Indeed, they support Benner's (1984) argument that nursing cannot be adequately understood if the context and the particular functions occurring at the time care is given are ignored or excluded from nurses' reported accounts regarding practices of caring.

In one important respect the preliminary study proved insufficient. Although the data I had collected when compiling my teaching records captured some of the ruptures and discontinuities in caring practices in hospitals, it was inadequate to answering the question of how caring practices emerge. The need to address this question was key to the decision to persevere with my PhD; it also dictated a shift in focus with regard to my research. My concern was that failure to explore the question would preclude any possibility of my contributing to the ability of nurses to recognize the eclipse of caring practices and to understand the factors responsible. Foucault (1972) underscores this concern by stating that there is no guarantee that a particular perspective within practice will continue. Practices are always under reconstruction. With some economists – e.g., Evans, Barer, and Marmor (1994) –disparaging caring of the kind performed by nurses as standing on very shaky ethical ground, there is valid reason for my concern that caring could be eclipsed within nursing. Evans, Barer, and Marmor challenge the notion of

caring as a valid component within the politico-economic agenda for public healthcare. They argue that Medicare is a social contract made between the users of healthcare services and providers and is not intended to extend beyond medical boundaries. They contend that caring results in an extension of healthcare services beyond which the public healthcare system should have to pay. In their view, caring within a nursing context should be limited to only those practices that promote cure or prevent deterioration. In essence, theirs is an argument for allocating public funds for only services earmarked for those who will recover. A question that presented was: Is the implication that those with health problems such as degenerative diseases or AIDS and those requiring palliative care or hospice care should be ineligible for Medicare?

The Purpose of this Study

The purpose of this study is to explore how nursing practices of caring emerge “within a local nursing practice settings”. Its focus is the function that caring practices serve. My aim is to contribute to the growing dialogue concerning the impact of contextual influences on nursing practices. My hope is that by seeing what is normally invisible to them, nurses may be able to reproduce caring practices or at least challenge contextual influences that work to limit them. It is further hoped that nursing faculty may come to envision new possibilities for assisting students in operationalizing caring practices.

Organization of my Dissertation

Having provided a detailed introduction to this study in Chapter One, in Chapter Two I conduct a review of the nursing literature promoting nursing as practices of caring. I also identify the research question and examine complimentary intersections between the works of various authorities who view the emergence of relational caring as a hallmark of contemporary nursing. In Chapter Three I discuss the methodology used in this study, along with certain ethical considerations. The study's findings are presented and discussed in Chapter Four. In the final Chapter I present conclusions and discuss the significance of this study for nursing practice, education, and research.

CHAPTER TWO

LITERATURE REVIEW OF NURSING AS PRACTICES OF RELATIONAL CARING

From a nursing and anthropological viewpoint, the idea of care of self and others is one of the oldest forms of human expression. Since the beginning of mankind, care appears to be the critical factor in bringing newborns into existence, in stimulating individual growth, and in helping people to survive a variety of stressful situations.

Leininger, 1985, p. xi

Introduction

The proliferation of nursing literature related to caring since the early 1980s has made selecting material for this literature review a difficult task. I begin with an overview of the state of knowledge with respect to caring. I continue with an analysis of theoretical perspectives and an overview of the role of nursing education in disseminating caring theory. I have limited this portion of the review to primary sources by nursing theorists who have developed theoretical frameworks for nursing as practices of relational caring. I have chosen to cite only a select group of secondary sources by authorities who have elaborated upon theories of caring conceptualized in the primary sources. Next I examine the influence on caring of cultural contexts, sociopolitical agendas, and hospital medical and bureaucratic systems. This will be followed by a discussion of current nursing research. The final section identifies gaps in the nursing literature related to caring.

Review of the State of Knowledge of Caring in Nursing

Caring has always been viewed as an essential part of nursing. Nursing emerged from the historical role women have played caring for those most vulnerable in society (Reverby, 1997). It gained legitimacy as a woman's profession during the Crimean war

(1853 to 1856) when nurses' caring practices significantly reduced mortality rates for wounded soldiers in military hospitals (Dossey, 2000). British physicians acknowledged the benefits of nursing activities during the war, and the medical establishment supported the introduction of a formal nursing education program under the direction of Florence Nightingale in 1860 (Dossey, 2000). Two things became evident in my review of the nursing literature. One is that over the years there have been changes in how caring is perceived in the nursing profession. The second is that nursing theorists have moved away from the grand theories and meta concepts to more mid range theories.

Rafael (1996) contends that, for women, caring has always been a societal expectation, but there have been shifts over time in the meaning of caring. Initially, caring was viewed as a duty for women in general and later as a duty to be performed by a paid nursing workforce. Nurses' duty to care was exemplified by what Rafael describes as "ordered care". Nurses were expected to operationalize, without question, daily caring practices prescribed by each patient's physician. Rafael argues that nurses' understandings of caring shifted to a type of "assimilated caring" when they registered their resistance to "ordered caring" by grounding nursing in science as the preferred way of knowing. This shift in understandings of caring was influenced by liberal feminist thought and nurses' resistance to what Rafael calls "the physician-nurse game" played out in the context of "ordered caring" (p. 10). The "physician-nurse game" was predicated on the assumption by medical authorities that nursing was devoid of knowledge. The game played out over time with nurses acquiring medical knowledge but pretending not to know what physicians knew. The chief rule was to follow the doctor's

orders uncritically. The rules of the game shifted when nursing began to be thought of as a science; hence, redefined as “assimilated caring”.

Ross-Kerr and Wood (2001) contend that the shift to thinking about nursing as a science, along with the thrust to developing nursing theory, was the result of more sophisticated and scientifically based medical discoveries and interventions that were effecting changes to the healthcare system. In an effort to define what constituted nursing knowledge, moreover, nursing scholars developed theories comprised of meta-concepts such as “person”, “environment”, “health”, and “healing”. This was an attempt on the part of nurses to define “the major bodies of knowledge that a nurse needed to have in order to understand clinical situations” (p. 89). Nursing models, such as nursing process and nursing diagnosis, evolved along with the meta-concepts.

Rafael (1996) contends that a third shift in the meaning of care occurred when the “assimilated caring” model of thinking about care gave way to a model predicated on “empowered caring”; likely due to challenges directed towards traditional scientific thought. Ross-Kerr and Wood (2001) cite Kuhn (1962) as a key influence in changes to the philosophy of science because of his challenging the traditional notion of science as a logical progression of discoveries. He argues that new scientific discoveries are characterized by radically different and new ways of thinking about problems, resulting in a different worldview or paradigm shift. Such was the case with the third shift described by Rafael (1996) wherein the impetus for change was the recognition that nurses needed to know what it was that they did in order not to be limited in their authority. Thus, nursing researchers, such as Leininger (1978), Watson (1985, 1988, 1999, 2005), Benner (1984), Roach (1987), Reverby (1987), Hartrick (1997), Cheung

(1998), Liaschenko and Fisher¹ (1999), Gallagher (1999), and Gadow (1999) directed their attention towards exploring the meaning and nature of caring in the context of nursing. Broader feminist perspectives underpinned by tenets of empowerment contributed to a reconstruction of a different worldview for nursing; nursing identity changed from one of caring for patients to one wherein the professional nurse possessed specific knowledge practices deemed to be caring.

DeKeyser and Medoff-Cooper (2004) assert that nursing theorists moved away from the grand theories and meta-concepts to more mid range theories because researchers recognized that the latter could be more easily applied to the kind of work performed by nurses on a day-to-day basis, more realistically reflecting practice environments. DeKeyser and Medoff-Cooper (2004) cite Brunk (1995) in identifying three stages in theory development. Stage one is defined as the “domain of nursing” wherein grand theories and meta-concepts are formulated. At stage two mechanical or technical theories and models are delineated; nursing process and nursing diagnosis are exemplars of this stage. Stage three involves the shift in thinking from nursing theories to nursing philosophy. The move to philosophy, it is argued, more effectively reveals the nature of nursing. In this writer’s view it is in stage three that caring gained a foothold in nursing, as a ‘caring science’. Nursing affinity for ‘caring science’ was based on a recognized need by nurses to accommodate the relational basis of nursing, to recognize persons not things (Brown, Rodney, Pauly, Varcoe, & Smye (2004).

Watson (1995) and Gadow (1999) identify ‘caring science’ as a postmodern turn in nursing theory. Watson (1995) draws upon the work of Lather (1991) in defining postmodernism as a response across disciplines to the crisis of uncertainty brought about

by the failure of modernity to resolve in a rational way the dilemmas that characterize the human condition. Watson (1995) argues that caring science recognizes that the meta-concepts of nursing, health, environment, and person as one of many truth games. She also asserts that a hallmark of the postmodern movement is the recognition of the need to raise to the level of awareness the knowledge that has been systematically excluded from human consciousness. Watson (1995) cites Roger's (1989) 'science of unitary human beings', Newman's (1986) 'health as expanding consciousness', and Parse's (1981) 'theory of human learning', along with his own (1988) 'theory of transpersonal human caring', as exemplifying the development of post modern knowledge in the field of nursing.

Gadow (1999) posits that 'care ethics' parallels the post modern response across disciplines; a reaction to the restrictive biases of positivism that functions to destabilize hierarchies of meaning by creating a space for envisioning alternative possibilities. Though acknowledging the value in modernist frameworks, Gadow argues that the appeal to rational principles in the context of healthcare provides less certainty than it promises. Nurses rarely indulge in the modern certainty that there exists no gap in meanings. In their relations with patients, nurses constantly face the abyss: a place where certainties fail. Meanings are contingent because they are human creations; moreover, in the context of patient care, new situations often arise that need to be reflected upon and invested with new meanings. Thus, any interpretation of an experience can be changed because other meanings are always available.

Gadow (1999) argues that universal principles work only if all cases are alike, and this does not happen as patients and their conditions are never identical. In addition,

clinical situations often give rise to conflicting interpretations of principles. One example of such a principle cited by Gadow is the requirement to protect life. This can be interpreted to mean the need either to maintain physiologic functioning or to alleviate suffering. Thus, the certainty promised by universal principles and standardized frameworks of rational objectivity is not possible, because depending on whether the patient is in an intensive care or a palliative unit each interpretation encompasses very different meanings and requires different practices. For this reason, there exists a need to move beyond the framework of rational objectivity with a view to connecting with patients at an ethical level, one characterized by uncertainty and engagement. The concept of “care ethics” allows for this; its privileging of particularities involves a personal responsiveness that is grounded in the ambiguities of difference. Care ethics involves attentive discernment and the valuing of individuals for their uniqueness. Thus, caring ethics parallels post modern thought because it not only resists the imperative for certainty, unity, and order, but embraces contingency: events that are likely to happen but not certain to happen.

What Watson (1995) and Gadow (1999) reinforced for me was that ‘caring science’ acknowledges and recognizes that nursing knowledge constitutes a practice of discriminatory judgments that are unique to each caring event. ‘Caring science’ not only allows for challenging traditional assumptions and practices in healthcare; it also creates space for questioning the usefulness of particular nursing practices. An ethics of care challenges the Kantian split between reason and emotion and opens up space to question the previously unquestioned effects of current nursing practices on both nursing and nurses.

Whall and Hicks (2002) contend that although positivism and postmodern thought have contributed to the development of nursing science, there is a lingering influential push towards positivism that is apparent in the ongoing influence of the medical model in curriculum design. Sandelowski (1998) expresses a similar concern, noting that several scholars have documented nurses' uncritical acceptance of medical technology and have questioned whether this is the result of nurses being deceived by technology, seduced into believing that technology will empower nursing. What I would argue is that nurses' uncritical acceptance of medical technology stems from the lack of an appropriate lens or perspective that enables nurses to examine the effects of such discourses on nursing.

Gastaldo and Holmes (1999) argue that nurses become compliant in reproducing hegemonic norms because nursing is embedded in modernist thought. In their review of 27 international nursing publications issued during the period 1988 –1998, they concluded that nurses are constructed as autonomous, self-directed professionals because of how nursing is promoted. "The history of nursing theory", the authors claim, "points to the construction of the nurse as a humanist subject – a patient centered practitioner, a neutral scientific observer, and an advocate scholar of nursing discipline" (p. 238). If such be the case, then nursing is delimited as a neutral, apolitical arena wherein the contextual factors that influence the construction of nursing go unacknowledged. If contextual factors remain hidden, nurses are unable to examine their response to contextual issues and their effect on the construction of nursing and nurses. Thus, embedding nursing exclusively in modernist perspectives functions to maintain the hegemony of modern individualism, along with expectations that the individual nurse is able to invest caring in all nursing activities. The political question of what one is doing

by doing what they are doing goes unasked. There exists no lens through which nurses might recognize whether their nursing actions are serving nursing or other than nursing.

Of note is the ongoing critic of “caring science”, the semantics of caring and the implications of nursing use of the term. Barker, Reynolds, and Ward (1995) question whether the use of the term “caring” is counter-productive for nursing, owing to its universal use. Yet, they also acknowledge that it is only through the careful examination of what people need nurses for that the requisite practices will emerge. They pose that questions that need to be asked are: What difference does caring make to patients? What makes a difference to the course of the patient’s outcome? Thus, while Barker, Reynolds, and Ward question the usefulness of the concept of ‘caring science’ for nursing, they also recognize that if nursing is ever to adequately explain the complex activity of nursing, nurses need to continue to promote the development of a coherent philosophy of the person and the social practice of caring. The authors also support the need to continue the ongoing examination of current nursing practices of caring: “There is an urgent need to extend our understanding of the forms of human interaction which represent the “stuff” of helping” (p. 395).

Crigger (1997) reviews eight major arguments against ‘caring science’, relating to partiality, virtue, ethics, relativism, subjectivism, and the practical problems stemming from high intensity caring, paternalism, and human limitations. Critics, in Crigger’s view, are divided into three camps: one holding that caring as an ethical basis for nursing should be discarded; a second proposing that concepts such as empathy or therapeutic reciprocity be adopted to replace the concept of caring, and a third advocating that caring be viewed as an adjunct to rather than an alternative for existing ethical theories. From

this writer's perspective, these arguments serve to underscore how caring ethics differ from traditional ethics owing to its postmodern turn. What are viewed as some of the weaknesses of 'caring science' are, in fact, components of postmodernism.

At the present time the major challenge I see for nursing scholars investigating 'caring science' lies in making the field more visible, not just in terms of a unique identity for nursing but as a postmodern approach that enables nurses in clinical practice to better critique the influences of local contextual factors on their practices and identify responses to them that best serve nursing.

The Influence of Cultural Context on Understandings of Caring

Interest in the concept of caring that has been growing and developing in North America over the past three decades owes a debt to Noddings (1984). Noddings challenged the concept of a single universal type of caring. Noddings argues that although everyone has the ability to care, there are two distinct types of caring. One is the traditional universal type—objective, rule bound and influenced by Kantian thought. Based on rational and unemotional impartiality, the latter has as its *raison d'être* logical consistency. Hence, universal caring requires a type of detached thinking that obliges the caregiver to distance him/herself emotionally from the recipient of care.

Noddings (1984) identifies a second type of caring with a feminist approach to ethics. Its chief distinguishing feature is that it involves the actuality of caring for others. In common with the feminist approach, the emphasis is on forming a relationship wherein one moves closer to the one needing care. This requires a language of subjective thinking and reflection, one that allows time for seeing and feeling. This second type of caring

functions to counter detachment, abstraction, and objectivity by shifting discussion away from universal principles that fail to take into consideration individual choice. Reasons for actions are based on feelings, needs, impressions, and an awareness of personal ideals. Noddings believes this second type of caring requires the courage to take risks. It necessitates one moving into close proximity to the one needing care; activating a complex structure of memories, feelings, and capacities that can only occur in proximity. Proximity becomes the enabling factor for actualizing caring because it becomes a way of staying connected to the person. This connectedness is marked by a shift in focus on the part of the caregiver from his/her reality to that of the other person. This displacement results in an increased sense of vulnerability in that it necessitates reflecting on one's own ideals so that in meeting the needs of another the caregiver does not violate his/her own ethics. Thus a feminist ethics of caring necessitates the acceptance of responsibility for the part one plays in whatever happens. It takes double the courage to face the guilt that naturally arises when things go wrong and to keep on caring. Commitment to sustaining caring is at the heart of this second type of caring.

Nodding (1984) contends that viewing caring as a universal results in the different types of caring remaining unacknowledged and unrecognized. As a result, everyone believes they know what it means to care. The second type of caring thus tends to be ignored; it becomes invisible. The taken-for-granted familiarity with caring, moreover, results in a difficulty seeing and articulating what caring is. Therefore, with caring at a level below the threshold of visibility, caring practices are not reflected upon and examined. Not only do others fail to recognize caring; caregivers fail to recognize what it is they do.

Feminist scholars have argued that historically women have been positioned as caregivers within families and societies (Leghorn & Parker, 1981; Gilligan, 1982; Ferguson, 1984;; Reverby, 1997; Waring, 1988, 1996, & 1999). There exists an underlying societal belief that women possess a limitless ability to care. Thus, women are expected to care owing to the assumption that caring is a part of a woman's identity. A consequence is that not only caring practices but also women go undervalued in our society. Caring gets moved to the margins of society, unrecognized and unacknowledged as work.

Roach (1987) articulates how with nursing perceived as a woman's profession women and caring come to be viewed as synonymous with nursing. Thus it is that nurses have been caught in the tyranny of caring being equated with nurses' duties. With caring going unaccounted for in women's work, it follows that caring practices go unaccounted for in the organization of nurses' work. Such understandings have served society well in that caring as a duty generates no costs since the work of caring goes unaccounted for in the structuring and costing out of nurses' professional activities.

Waring (1996) examines the discounting of women's work of caring from an economic perspective. Gross domestic product (GDP) does not measure 'nonproductive' economic activity, such as the traditional nurturing and care giving activities performed by women in the home. Proceeding along the same line as Waring, Leghorn & Parker (1981) contend that since no exchange value has been given to women's traditional work, caring has been seen as women's 'natural' duty.

Rafael (1996) holds that the denigration of women and all that is female has become entrenched in all major institutions. The 'masculine' has become associated with

power, the 'feminine' with care, the latter being conceptualized as a virtue that possesses little esteem. Such insights made me realize that with caring going unrecognized and unvalued in society, nurses, in addition to others, fail to recognize its hidden qualities and the true value of their own caring practices. This is made abundantly clear by Menzies (2005) who notes that nursing practices such as engaged empathy fail even to be listed on patient-care charts. These are practices that are embedded in relationships and as such take time to enact. They are practices that require individual judgments as to what actions are most appropriate under different circumstances. Yet, they do not easily fit within hospital frameworks of leveling rationality, such as critical pathways. What is particularly problematic for nursing at present is that grid-works, such as critical pathways, have become more compatible with integrated health-care information systems than discretionary judgments on the part of nursing professionals.

Smith (1995) postulates that ideology is a kind of practice, a way of thinking about society. The result is that hegemonic discourse disadvantages women owing to a gender-based subtext that includes assumptions about roles for women that exclude the nurturing and caring components. McDonald (2006) concurs with this view, noting that the devaluing of nurses' work and knowledge stems from such cultural power arrangements. The way we think about gender will, he asserts, anchor us in the world of social realities where nursing is practiced and where the concepts of gender practices are formed. McDonald cites Butler (1990) in asserting that gender is not an expression of some intrinsic identity but rather a performance in which the individual acts out a script that is written in and through social practices. Individuals choose gender practices that make sense to them; practices that already exist and are deemed appropriate within the

local culture in which they are situated. To counter the devaluing of caring, McDonald (2006) cites Condon who suggests considering “the feminist understanding of Fisher and Tronto that appreciates caring as a positive dimension of our lives that has been socially devalued by a patriarchal and capitalistic order’ (Condon, 1992, p. 73)” (p. 341). In this way caring continues to be valued because efforts are directed at interrupting the discourses in healthcare that devalue it.

Theoretical Perspectives Framing Nursing as Caring Practices

Epistemology of caring

Watson (1985)¹ transforms the phenomenon of caring into a material reality for nursing. In her view caring is a relational and communicative practice that promotes healing; as such it constitutes the philosophical foundation of nursing. Nurses envisioned as always adopting a caring stance with regard to other human beings. The linguistic construct Watson uses to create a physical space for nurses to initiate caring practices is the “caring event”. The term “carative factors” is used to describe what it is that comprises a caring practice. “Carative factors aim at the caring process that helps the person attain (or maintain) health or die a peaceful death” (p. 7). They form the boundaries that distinguish caring from uncaring behaviors. In identifying them, Watson draws upon understandings from human sciences and communication theory.

Watson (1985) purports that carative factors differ from the curative factors associated with medicine. The former all work together to construct a nursing practice of relational caring that gives nursing its identity. What follows are exemplars of carative factors.

¹ The first edition published in 1979 is out of date and unavailable

“Interpersonal communication skills” are viewed to be essential to the development of an effective nurse – patient relationship, the quality of the relationship being the most significant factor in determining helping effectiveness. Communication practices are said to include attentive listening, understanding the personal meaning of behaviors, and the effective use of different modes of communication. “Sensitivity to self and others” and “acceptance of positive and negative feelings” are identified as the foundations for primary prevention and healing. They allow an understanding of the patient’s view of the world, thus making for nursing practices that are acceptable to the patient.

In her discussion of carative factors, Watson (1985) makes visible how nursing functions as a health promotion practice. Of significance here is that the carative factors of “attention to problem solving” and the “promotion of personal teaching and learning” are cited as practices for primary prevention and healing. Teaching and learning are acknowledged as a strategy for imparting information. Their function is to reduce the fear and anxiety related to the uncertainty and the seriousness of health conditions and medical interventions. Watson cites “faith-hope” as an empirically documented factor that helps patients accept information and engage in health seeking behaviors and activities aimed at bringing about change that positively effect healing. “Assistance with the gratification of patient needs” is affirmed by Watson as being one of the most important carative factors for healing.

In citing problem solving as a carative factor comprising both the nursing process and the scientific methodology of phenomenology, Watson (1985) provides nursing with a method of analytical inquiry that is distinctly different from the traditional classificatory

approach that informs medicine's deficit model of illness. Watson expands nursing analysis beyond the traditional reductionist process of problem solving found in the nursing process and in so doing provides nursing with a new identity, one that differs distinctly from medicine. For its part, phenomenology opens up a space wherein nurses can listen to the experiences of patients. Phenomenology is the study of human experience as it is lived; it thus enables nurses to gain a greater understanding of the meaning of experience. This is a result of phenomenology's attempt to bracket foreknowledge in order to best understand a phenomenon as it is experienced by the individual (Creswell, 1998). Phenomenology allows for the recognition that problem solving is a scientific method that does not accommodate any knowledge that cannot be seen. Hence, phenomenology necessitates the use of different ways of knowing that includes, but is not limited to, rational thought. There is, moreover, an expanded notion of what is to count as rational vis-à-vis the reductionist-analytical view that medicine often accepts as 'scientific'. Phenomenology focuses attention on what is experienced as a phenomenon, describing the latter in detail before subjecting it to a reconstructive scientific analysis. For Belenky, Clinchy, Goldberger, and Tarule (1984), going beyond rational knowing involves an integrated way of knowing that speaks to valuing all ways of knowing; it takes into account, moreover, that culture, power relations, and different experiences affect individual strategies for knowing. Thus, phenomenology offers nurses a philosophical rationale for paying attention to patterns embedded in the 'whole' lives of patients, not just in what is 'medically' wrong with them. Phenomenology better enables the nurse to see the patient as a unique person who has different needs and desires related to healthcare. The benefit for patients is that they gain a greater voice in determining the

care they want. Thus, the contradictions and peculiarities characterizing the patient's lived experience in relation to a particular phenomenon are revealed.

Watson's identification of phenomenology as a part of problem solving was a defining moment for the nursing profession. Phenomenology provides nurses with an approach to inquiry that leads a particular type of nursing analysis. The latter is holistic in nature, involving the patient's lived experiences related to his/her own understandings of health and illness. Thus, the phenomenological approach makes for the generation of a very different kind of information vis-à-vis that produced by its classificatory medical counterpart. Differences between medicine and nursing become more visible: whereas medicine focuses on treating disorders, nursing is more concerned with the patient's response to a disorder and its treatments and with what the patient wants in relation to care. Thus, nurses owe a debt to Watson (1985) for providing nursing with its own distinct type of inquiry. Nursing knowledge gained its own place in relation to medicine rather than being seen as an extension of medical knowledge. As a result, nurses gained increased legitimacy for their actions.

Another positive impact of Watson's (1984) conceptualization of problem solving as both nursing process and phenomenology is the complementary link that was made with Noddings' (1984) construction of caring as a feminist approach to ethics—a combination of deductive and inductive thought. Noddings (1984) argues that when caring for someone, inductive thinking should precede the deductive thinking used in problem solving, wherein conclusions are derived from universal premises. Noddings (1984) defines inductive thinking as an exploration of the unknown and a search for new understandings and particularities that are unique to the person, thus creating a

complementary link with Watson's definition of relational caring as an inquiry of discovery. This constitutes a phenomenological approach to nursing. The benefit lies in creating a space for dialogue and examination as evinced by Reverby (1987), Growe (1991), Bamford (1991), Rafael (1996), Kuhse (1997), and Gordon (1997, 1999, 2001) with regard to everything that follows the gendered nature of caring, i.e., the influence on nursing practices of gendered understandings of nursing and the power inequities that exist within traditional healthcare structures

In her second publication, Watson (1988) strengthens the complementary link she establishes between nursing and health promotion in her first work. Her efforts had a positive influence on nursing in so far as opening up a space for quality of life issues to be recognized. Watson draws upon Rogers' (1989) science of unitary human beings to redefine caring from an interpersonal relation to an inter-subjective one between nurse and patient. Inter-subjective relation is defined as a transpersonal practice of caring that goes beyond, across, and through what is commonly understood as interpersonal caring. Thus, nursing inquiry is expanded to an exploration of individual capacities rather than an exploration of deficits or needs vis-à-vis the nursing process. Patients come to be viewed differently: not as individuals with problems, but as persons capable of envisioning possibilities for their own care. Caring becomes a pursuit of meaning hidden in the mystery that is life: epistemology as a search for the grounds of knowledge comes to be linked with ontology as a concern for life and the nature and relations of being. The nursing goal for patients' achievement of self-actualization becomes, instead, patients gaining harmony in body, mind and spirit. Thus, nursing moves towards a more constructivist worldview of caring, a participatory project between the nurse and the

patient, wherein possibilities for health and healing are envisioned. This expanded view of caring resonates with constructivist understandings. Notes Vance Peavy (1997): “a well-lived life is a work of art, more like a poem or a dance than a machine or collection of disparate traits and parts” (p. 8).

One consequence of Watson’s (1988) expanded concept of caring is that the patient is engaged in a project of becoming an active participant in the healing process. Patients are expected to participate in and assume increased responsibility for their own healing. The nurse is repositioned from “author of” to “participant in” care. The intent is for patients and nurses to be partners in a process framed as a journey of discovery aimed at enhancing the patient’s well-being. The chief intended benefit is that patients will have increased authority with respect to decision-making related to their own care. One limitation is that in assuming increased responsibility for their own health, patients are held more accountable for life style choices. Indeed, in this new approach to healthcare the burden of responsibility for maintaining health is shifted from the collective to the individual. Two consequences of the patient-as-active-participant model can be seen currently played out in healthcare restructuring in the shift from hospital to out patient services and in the increased financial burden that can be placed on patients as a result.

Watson (1999) expands transpersonal caring into a transpersonal caring-healing model—an ontological archetypal model of feminine communication. Through the awakening of the feminine unconscious and the balancing of feminine energy at the archetypal core, caring wisdom is said to emerge. Wisdom is the repressed healing capacity of feminine energy, drawn upon across time by nurses, both female and male. Meditation, yoga, art, storytelling, dance, architecture, and theatre are processes aimed at

liberating both the nurse and the patient so that alternative ways of caring can be envisioned with a view to promoting healing. Dreaming, a strategy used in Jungian psychology to access the unconscious, is a communication practice used to awaken one's sacred feminine archetype of caring wisdom. The concepts of Yin and Yang, moreover, describe feminine and masculine systems that work together to create equilibrium and harmony in the person.

The positive aspect of Watson's (1999) model lies in making the differences between nursing and medical knowledge practices more visible. Drawing upon understandings from quantum physics and Eastern practices, moreover, has served to enhance the legitimacy of caring practices in nursing. A space has been created for nurses to envision healing practices that represent alternatives to allopathic medicine. The Holistic Nursing Association stands as testimony to the vigor of the new approaches sweeping through the nursing profession.

For Watson, over 25 years of research in the area of caring, has culminated in a view of caring science as a sacred science (2005). At the heart of this concept lies the assumption that all of us are interconnected with all of life. With the primary foci for caring science being the 'ethics of face', we face our own and other's humanity and the ethical demand of understanding that the basic expression of life is both giving and receiving. Thus, caring is viewed to involve a shift towards honoring a heart centered evolution. The human tasks are forgiveness, offering gratitude. They play out in practices of and surrendering; a healing relationship that involves individuals, intersubjective relationships, and trust informing all communication. It involved laying oneself open and becoming vulnerable.

Watson's (2005) construction of caring science as a sacred science is an invitation to nurses to incorporate a reverence for the sacredness of life and death and a perspective of heart centered evolution within knowledge practices. Watson asserts that notwithstanding two or three decades of criticism of caring in nursing, the focus on developing caring and caring knowledge, if anything, has intensified. She outlines a number of recommendations for nursing researchers to consider in this regard, including using research methods that reflect the nature of healing relationships; developing criteria related to the caring-healing relationship; and formulating quality guidelines for developing a research proposal aimed at assessing the impact of caring-healing relationships.

In summary, Watson's (1985, 1988, 1999, 2005) construction of nursing as a practice of caring and her dedicated commitment to deepening understandings related to caring work has been widely accepted by nurses. Watson raises the phenomenon of caring to a level of visibility within nursing that enables nurses to see what is unique in what they do. Thus, nurses can come to recognize caring as an essential component of their daily activities and better understand the nature and meaning of the caregiver's work. Watson offers a common language that has enabled nurses to talk about and examine the meaning of caring.

Ontology of Caring

In her examination of the kinds of expertise nursing practices require, Benner (1984) developed a system of classification or grids of specification called "competencies". Competencies have become the scientific constructs used to

linguistically represent nursing practices. To delineate her concept of caring, Benner draws upon Heideggerian (1962) thought, wherein caring is viewed as an ontological way of being in the world: put more specifically, everyone cares and if one ceases to care one ceases to be. Thus, in embracing Heidegger, caring as a nursing concept has expanded: it has come to mean a type of ‘presencing’. The benefit is that listening to the stories of patients and their families has gained legitimacy, and this, in turn, has led to greater recognition of the importance of **nurses** spending time with patients.

Tanner (1993) defines presencing as a phenomenology of “knowing the patient”. This is a recurring theme that Benner (1984) identifies in nurses’ conversations about caring practices. For Tanner, “knowing the patient” means knowing him/her as a person as well as his/her pattern of response to illness and treatment. This kind of knowledge is considered critical to making skilled clinical judgments. Tanner’s insights ring true: **because** nurses know that caring for patients is much easier following the first few shifts because by then they have come to know them and can thus better address their needs.

In her model of human relating, Hartrick (1997) identifies five relational capacities that enable “presencing” to take place: “initiative, authenticity, and responsiveness; mutuality and synchrony; honoring complexity and ambiguity; intentionality in relating; and re-imagining” (p. 523). These practices are viewed as an alternative to mechanistic models of therapeutic communication techniques traditionally used in nursing. It is posited that they make for more discerning observations where the patient is concerned and improved nursing judgments. They direct the nurse’s attention toward forming a relationship with and becoming involved with the patient rather than using prescribed communication tools and strategies. What Hartrick fails to note is that

the five relational capacities come to be viewed as characteristics of the individual nurse. Rather than communication skills constituting tools used by the nurse, the nurse becomes a tool of communication. The implicit assumption is that in constituting the relational capacities of the nurse, “presencing” is possible for all nurses in all nursing activities and thus constitutes an expected part of all caring events. “Knowing the patient” is no longer seen as essential. A problem with the new model, one that goes unacknowledged, is that with caring framed as “presencing” and “presencing” redefined in terms of characteristics of the individual nurse, caring becomes a hidden part of nursing activities. “Presencing” goes unaccounted for in nurses’ work because there is no need to set aside time for nurses to get to know their patients. It is their relational capacities, rather than “knowing the patient”, that enable nurses to identify each patient’s pattern of response to illness and treatment. Therefore, nurses do not need to care for the same patient. In addition, because relational capacities take the place of communication skills, there is no longer a set of skills to measure. Caring is transformed from an active form of communication to the passive activity of listening; it is reduced to the neutral process of being in connection with the patient, a part of a helping relationship, rather than a distinct nursing practice. Thus, caring practices can be moved to the margins of nursing where they become invisible, an unacknowledged and unexamined part of nursing practice.

A consequence of Benner’s (1984) transforming caring from an epistemological to an ontological practice is that theory is no longer viewed as a prerequisite for caring. This is exemplified in Benner, Tanner, & Chesla (1996) where caring is defined as ‘engaged reasoning’. The authors contend that engaged reasoning constitutes a connection between nurse and patient, one that results in their inhabiting a shared world.

This requires involvement for which there is no theory. The justification is that the nurse enters into the situation along with the patient and family, guided by intuition. [B]eing the perfect model of a craft... caring practices of nursing provide a paradigm case of skills that have no theoretical component at all” (p. 47). This kind of thinking leads inevitably to the assumption that nursing lacks a theoretical foundation which, in turn, functions to maintain power differentials between physicians and nurses and reproduce medicine’s hegemony in healthcare, with physicians as “knowers” and nurses as “doers”.

Benner, Hooper-Kyriakidis & Stannard (1999) expand the definition of ‘engaged reasoning’ to include clinical forethought. This new definition represents a type of “thinking in action” and “reasoning in transition”. This type of thinking, it is argued, allows for clearer reasoning within the context of changing situations. ‘Thinking-in-action’ is described as ‘engaged reasoning’ combined with perceptual acuity. ‘It includes an ongoing interpretation of the present clinical situation in terms of the patient’s immediate past condition. Patterns and habits of thought and action are viewed as directly tied to responding to patients and their families and the demands of a changing situation.

In their construction of competencies, Benner et al. draw upon Schon’s (1987) “notion of artistry in practice” (p. 9). However, they see fit to replace “reflection”, the term Schon uses, with “thinking”, arguing that the latter conveys the innovative and productive nature of what clinicians do in ongoing situations. “Reflection” is thought to connote a stepping back from or being outside the situation. Thus, thinking in action is justified as a more engaging process, one that enables the nurse to identify false assumptions and unexpected responses. It is thought to engage narrative understandings of the situation rather than rule-governed thinking.

Upon initial reflection, I concluded that ‘thinking in action’ connotes a phenomenological approach to nursing inquiry. Benner et al.’s (1999) description of ‘thinking in action’ as a narrative understanding seems to reflect the unique power of a phenomenological approach to access the immediate lived experience that precedes explanation. Kvale (1996) asserts that phenomenology allows for a privileged access to a person’s most basic experiences by attempting to go beyond the immediately experienced meanings to the pre-reflective level of lived experience, making visible what matters most to the person. Yet, in so far as explanations related to ‘thinking in action’ make sense, what is confounding is that it is “expert” physicians, not “expert” nurses, who are identified as invaluable in “assisting nurses to develop essential clinical knowledge that allows for expert clinical judgment and skill interventions” (Benner et al, 1999, p. 36). Because context is ignored in this study, it is difficult to ascertain precisely what influences may have resulted in physicians being so invaluable. Why expert physicians and not expert nurses are looked to for educating nurses is unclear. Questions that are raised are: Did the local context allow time for nurses to collect the requisite information and identify the relevant variables required for a phenomenological analysis? Did patients feel as though they were being understood? Or, with nurses being mentored by expert physicians did ‘thinking in action’ become a highly personalized type of physical care that limited the focus of the caregiver to the medical disease rather than the person? What percentage of nurses’ time was spent ‘thinking in action’? Was there time for reflection on the part of nurses to examine the effects of local nursing practice norms on nursing identity? A personal concern for me is whether ‘thinking in action’ functions to enhance

the unique identity of nursing or does it maintain medical hegemony in acute care hospital settings?

In my view there is a growing need for local context to be part of the analysis in studies of clinical nursing practice norms. Lather (1991) posits that individuals or groups that perceive themselves as having less power have two choices: one is to move toward the power base, i.e., toward an acceptance of hegemonic norms; the other involves examining the effects of power relations and identifying options. The latter is only possible if one possess an appropriate analytical framework. Smith (1995) argues that the unexamined and unquestioned acceptance of ideologies and practices result in complicity in one's own oppression. Subjects are drawn into participating in their own oppression by not examining the effects of their practices on their own identity. An example of nurses falling under the sway of dominant medical norms is provided in a study by Zussman who observed doctors and nurses in two American intensive care units (cited in Kuhse, 1997). Zussman concludes that nurses are not gentle caregivers, not patient advocates, and not angels of mercy. They are drawn into medical practices directed towards survival and cure; they are mere technicians who function like interns. A question raised for me was: How did nurses succeeded in resisting this fate in the acute care units cited in the aforementioned work of Benner et al (1999). What was unique about the local contexts that enabled those nurses to maintain their distinct nursing practices?

Although competencies existed as a concept in nursing long before Benner (1984) coined the term, they were not formalized processes. When Benner (1984) and Benner, Hooper-Kyriakidis, and Stannard (1999) normalized nursing practices within grids of specification they called competencies, nursing actions became more visible to nurses

and nurses were better able to understand what it is that they do in nursing. Yet, an unintended result was that competencies came to represent the first step in the universalization of caring. Competencies are the written texts that connect nursing knowledge and action, thereby enabling what it is that nurses do to become visible to others. Thus have nursing associations standardized nursing competencies in an effort to increase the legitimacy of nursing practices. As early as 1990, minimum competencies for graduate nurses were established (McMillan & Andrew, 1996). Standardized competencies enabled comparative analyses to be made regarding the practice of individual nurses. The latter, for their part, came to be viewed as changeable, transferable, and replaceable objects, in other words, abstractions. Competencies made possible the development, by non-nurses, of strategies aimed at influencing nursing practices. Rather than each nurse constituting the authority for his or her own practice, competencies become the authority for defining what practices might be deemed appropriate for nurses.

Of significance here is Purkis and Nelson's (2006) concern that competency models carry the implication that "nurses will practice their competence within everyday circumstances that render invisible the responsibilities of the wider sociopolitical system for offering financial and material resources necessary to support competent practice" (p. 233). A consequence of the decontextualization of competency criteria is the implicit assumption that the responsibility for appropriate care lies exclusively with the individual nurse. Individual accountability becomes divorced from context. The consequence of the decontextualization of competency criteria is that the individual nurse can be held fully responsible for care regardless of the local situation. Thus, nurses are forced to participate

in the construction of themselves as competent actors even in a failing system. They are compelled to collude in pretending that good nursing care is possible, even when they know this to be untrue.

Dissemination of Caring Practices

Bevis and Watson (1989) developed a “caring curriculum” that had the effect of revolutionizing nursing education. In so doing, they challenged the use of formalized curriculum model development, e.g., the Tylerian behaviorist model that they viewed as “entrenching nursing practice in a training modality” (p. 11). Formalized models, it was argued, dehumanized nursing by privileging reductionist, abstract knowing over intuitive, individualized knowledge of patients. The authors contended that non-logical, more difficult to articulate, and inexplicable knowledge of caring was not being captured by such models. In their work caring is posited as the foundational concept for an emancipatory curriculum: one that facilitates “the release from the inhibitions of asking the unasked, an escape from the easy acceptance of the ready answer, a confronting of the injustice of the oppressive classroom and a discontentment with passivity” (p. 162). The notion of curriculum draws upon Noddings’ (1984) concept of caring ethics and her (1988) later conceptualization of moral education for caring requiring modeling, dialogue, practice, and confirmation as essential for the learning of caring practices.

The “caring curriculum” gave cause for optimism in calling into question accepted norms within not only education but also nursing and society. In particular, it created a space for nurses to reflect upon and critically examine norms for nursing practice within local practice settings. The model challenges the consequences stemming from how

nurses are positioned within society. Feminism is a key concept used here to frame the education process as an emancipatory dialogue used to challenge the subordination of nursing knowledge, a consequence of nursing constituting a largely, woman's profession under the hegemony of what Bevis and Watson (1989) label "bureaucratic technocure medical institutions".

The "caring curriculum" structures nursing as practices of caring, primary prevention, and healing. Humanistic existentialism places the emphasis for learning on human interactions that encompass an intentionality for learning. The focus is on the teacher's ability to create a climate that is: egalitarian; fraternal in a common search for enlightenment, skills, and truth; and caring and compassionate. Students' lived experience is the basis for the various teaching approaches. The intent of the program is to enable nursing graduates to be "more responsive to societal needs, more successful in humanizing the highly technological milieu of health care, more caring and compassionate, more insightful about ethical and moral issues, more creative, more capable of critical thinking, and better able to bring scholarly approaches to client problems and issues and to advocate ethical positions on behalf of clients" (Bevis & Watson, 1989, p. 1). Social critical theory is the language used to structure communication as a practice of co-operation, empathy and dialogue. The latter is structured as open and mutual and marked by signs of reciprocity, such as listening and silence. Such practices draw upon Habermas's communicative action theory as discussed in Fraser (1987). The underlying assumption of communicative action theory is that underlying universal truths work to dominate and direct individual behaviors. The premise is that through communicative dialogue the reasoning mind can uncover

universal truths regarding domination. Enlightenment, responsible choice, and means of problem solving are assumed to be the result of dialogue. Enlightened knowledge is gained through critical exploration and self-reflection.

In British Columbia, several schools of nursing adopted Bevis and Watson's (1989) model and implemented *A Caring Curriculum*. The latter underscores the divide between what students understand caring to be – such understanding being the result of how nursing is promoted as practices of caring in nursing literature – and the realities they encounter in nursing practice.

The Influence of Context on the Construction of Nursing as Caring Practices Sociopolitical Agendas

Within Canada, a highlight of Watson's (1985) "caring science" was that it equated carative factors with health promotion practices and established a complementary link between nursing and the federal government agenda for health promotion; a government agenda seeking to shift thinking about health away from the deficit model of disease entrenched within medicine towards a health promotion model. The latter was a response to government concerns during the 1970s regarding the projected rise in the incidence of chronic disease. Facing escalating health care costs, Ottawa and the provinces turned their attention toward addressing the interplay between behavioral risk factors and disease. In 1974, federal Health Minister Lalonde commissioned a government report that underscored this shift. The report placed major emphasis on prevention, with treatment identified as only part of what is needed to ensure a healthy population. Thinking about healthcare underwent a crucial shift away from medical

intervention and toward behavior and lifestyle factors. Health was redefined in terms of behavioral risk factors that shifted the focus of intervention towards the promotion of physical well-being. The goal was to create an expanded vision of healthcare, one involving individuals in addressing life style issues affecting health. The implicit message was one of health promotion, wherein individuals were viewed as capable of determining their own needs and finding their own solutions to health issues. With the government model of health promotion and nursing as practices of caring both informed by theories of individualism, both focused on the unique differences in individuals. Watson's (1985) construction of caring as health promotion and healing practices positioned nursing as the profession best able to operationalize the health promotion model.

In the late 1980s, thinking about health and health care expanded once again. The *Epp Report* (1986) emerged as a landmark document for the federal government, one that signaled a major shift in societal thinking about health and health care. "One reason for the shift was the awareness that most lifestyle improvements occurred principally among better educated, more privileged members of society (Registered Nurses Association of British Columbia, 1992). Another was a growing realization that socio-environmental risk factors were themselves important health determinants. Thus, empowerment, defined as the capacity on the part of the individual to define, analyze and act upon life problems and living conditions, joined treatment and prevention as a goal within healthcare. A positive consequence for nursing was that nurses gained increased authority with respect to their caring actions. Caring constructed as a practice of caring positioned nurses as participants with patients in the planning of care (Watson, 1988). Strategies for empowerment were embraced as central practices of caring.

In the 1990s there occurred a shift in political thinking toward primary health care that would dramatically influence nurses' authority in relation to caring practices. The unintended outcome was a result of initiatives for restructuring healthcare that had begun with nurses in the 1970s. Primary health care as a framework for health care was first proposed by nurses in 1972 in a report titled *The Bordeaux Report of the Committee on Nurse Practitioners* (Du Gas, Esson, & Ronaldson, 1999); the first level of service in a comprehensive health care system. The aim was for professionals, other than just physicians, to be the first contact for individual and families needing care within the health care system. All professionals would be responsible for providing access to other parts of the health care system. This initial point of contact for individuals and families was viewed as the first stage in a continuous healthcare process. At a 1978 international conference sponsored by the World Health Organization (WHO), primary health care was recognized as a legitimate approach for making health care universally accessible to individuals and families. At this conference, Dr. Halfdan Mahler, Director-General of WHO, stated that because they work so closely with people, nurses are "the key to acceptance and expansion of primary health care" (p. 56).

Primary Health Care: A Discussion Paper, a 1990 report issued by the Registered Nurses Association of British Columbia affirmed nurses' commitment to the international goal of 'achiev[ing] health for all' and to primary health care as the optimum strategy for achieving it. A model for primary health care was proposed, one informed by six principles: publicly funded essential health care that includes promotive, preventive, curative, rehabilitative, and supportive services; socially acceptable and affordable methods and technology; accessibility; full participation of individuals and communities;

first level of a continuing health process; and inter-sectoral collaboration. This model was based on a definition of primary health care included in the 1978 WHO *Alma Ata Declaration*: “essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (p. 2).

In 1995, Ottawa ordered a five-year freeze on transfer payments that would ultimately drive provincial governments to restructure health care. Primary health care was viewed as a major component in this restructuring process. With the goal that of repositioning health professionals within the health care system, a key premise of primary health care became the right care, at the right time, by the right person through a variety of primary-contact professionals providing different entry points to the healthcare system. The intent was to increase the legitimacy and authority of professionals other than physicians with respect to decision making.

In 1997, Ottawa provided resources to support primary health care through better use of technology, new strategies to manage chronic diseases, and improved access to care in aboriginal communities. In 2003, initiatives in several areas, including primary health care, home care, catastrophic drug coverage, diagnostic and medical equipment, and information technology received federal funding (First Ministers’ Accord on Health Care, www.hc-sc.gc.ca).

An unexpected consequence for nursing was that the operationalization of the concept of primary health care resulted in the five essential services – promotive,

preventive, curative, rehabilitative, and supportive –being allocated to different facilities. Hospitals, for example, were designated essential acute care services, with the focus on cure. Restricting curative services to hospitals effected changes in nursing activities. Increased acuity, a consequence of less complex care being designated to outpatient services, resulted in increased workloads for nurses. Bauman, O’Brien-Pallas, and Armstrong-Strassen (2001) concluded that owing to increased patient acuity and the complexity of care in hospitals, the discrepancy between the work demanded of nurses and what nurses can reasonably give creates an imbalance that threatens the health of nurses and puts patients throughout Canada at risk (cited in McDonald and McIntyre, 2006).

Medicine and Hospital Bureaucracies

In hospitals, nurses have always occupied a niche within the parallel universes of nursing and medicine: the former a nursing holistic model of caring, the latter a medical deficit model of disease. This duality has positioned the patient as subject/ object and whole /part. Positioned as employees and subordinated to physicians in hospital bureaucracies, nurses’ have struggled to accommodate the incompatible expectations of the different players.

Foucault (1980) posits that hierarchical ordering has a paralyzing effect owing to the belief, one taken for granted, in its necessity. Ferguson (1984) argues that power structures within bureaucracies are a primary source of oppression for both women and men. When the major goal of bureaucracy is to eliminate uncertainty through the control of knowledge, bureaucratic policies and procedures are designed to replace the need to

develop relationships. The underlying premise is that by predicting individual responses to similar situations and prescribing universal strategies for addressing them, certainty can be achieved. This is a kind of Archimedean thinking that is predicated on a pre-articulated normative framework (Disch, 1994). It functions to resolve or settle debate not to initiate or inspire critical thinking. Organizations become comfortable in this mode because it allows them to fall back on the firm ground of traditional values, which are often accepted without questioning. Cheek (1996) sees nursing being drawn into such thinking through the growing proliferation of policies and procedures, referred to as “frameworks of leveling rationality”, prescribing what nursing actions are deemed appropriate. The result is less emphasis on structures and processes that facilitate face-to-face interactions.

Campbell (1994) offers an insightful example of a framework of leveling rationality in a study aimed at examining the impact of a nursing management system introduced in the early 1970s. The intent was to better coordinate and manage the scheduling of nurses work. Hence, nurses had participated in tracking time spend implementing care to patients with particular needs. What was created was a workload measurement and staffing formula based on classifying patents needs. By measuring and enforcing productivity expectations, the new system made possible the objective management of productivity. Major expenditures on computers and information management personnel were allocated. This approach has become widely accepted as a means of exerting financial control over nursing staff. An unintended consequence for nurses has been that the average length of time for the implementation of particular nursing activities was used to calculate the formula. Any additional nursing time required

for unpredicted, more complicated patient care or care that doesn't fit into the workload measurement goes unaccounted for in the staffing formula, nurses are expected to time manage with the staff allotted

Foucault (1990) contends that the greatest challenge of our time will arise from the increasing organization of society through the proliferation of frameworks of leveling rationality. I agree with Foucault that this increasing organization makes questioning the appropriateness of practices more difficult. Rationalizing frameworks make it almost impossible to identify the source of decisions and resist their implementation.

Janet Rankin (1998) identifies a major change to healthcare in the form of business practices that have permeated the healthcare system. She argues that this is inevitable given the goal of managing all facets of patient care in a way that promotes cost effectiveness and efficiency. "Cross-training" is one example of the kind of business strategies developed to meet this goal. What has gone largely unaddressed in nursing is that implicit within the model of 'cross-training' is a fundamental transformation in the character of nursing: nurses with specialized knowledge about persons with specific health problems have become generalists who can deal with multi-dimensional issues involving a wide range of health problems. Rankin notes the paradox of other health professions moving toward increasing specialization while nursing moves in the opposite direction. What are the consequences to nursing and nurses?

In light of the transformation that healthcare is currently undergoing, Spitzer (1998) questions whether nursing in its current form will cease to exist in the postmodern healthcare system. For her as well as others, the postmodern period is "a time of discontinuous changes, paradoxes, complexity, and a mismatch of paradigms (Derrida

1978, Lyotard 1984, Handy 1990, Boyne 1992, Fox 1993, Guerevitz 1997, Sarup 1988)” (p. 164). The post-technology crossroad is characterized by the increasing power of computerized communication systems. New, unprecedented situations are emerging as a consequence of advances in computers, telecommunications and other technologies. These are producing dramatic changes in professional practices. At the same time healthcare is confronted with paradoxes: e.g., organizations are required to be global and local, centralized and decentralized; workers are expected to be autonomous yet function as a team. Hence the changing expectations and unclear boundaries create an impetus for professionals wanting management to create clearer direction and increased order in such a chaotic world. Yet, at the same time professionals are being targeted for increasing accountability. Therefore, in this new environment it would seem that control of data bases, accessibility to knowledge, and management of information systems must fall under the purview of professionals; they must be integrated into their work. Several questions emerge in this regard: How will such changes impact nursing activities? Will nurses be expected merely to incorporate these tasks into their existing practices without the requisite work accounted for in the costing out of these activities? Will certain nursing activities such as caring practices be restricted or eliminated altogether as new activities are structured by new communications systems?

Recent Research on Caring

Recent as well as current research has contributed to our understandings of the nature and meaning of caring. Kirby and Slevin (1992) identify authenticity of being, commitment, compassion, empathy, conscience, and empowerment as but a few of the

elements essential to ensuring that caring practices are beneficial. Morgan (1996) expands understandings of caring through her analyses of nurses' experiences with compassion. Painter (1999) constructs a new model of therapeutic intimacy based on the tenets of connectedness. Yet, to date there is a dearth of nursing researchers who employ post modern or neo-modernist approaches in their research. The following section highlights a few of the studies I found to be most interesting in their use of the latter approaches.

What the following studies have in common is a post modern approach that draws upon the work of Foucault (1970, 1972, 1979, 1980). Foucault's perspectives create a link between history and experience thus making possible the exploration of the historicity of different forms of experience. In doing so, they create a space for the examination of the effects of power relations on practices in local contexts.

Holmes (1992) argues that a "critical theory ethics" provides the most complementary fit with nursing as a relational practice of caring and the humanistic values that are embedded in nursing. Holmes posits that a critical theory ethics creates a space for communicative action between different disciplines and is thought to meet the needs of contemporary reflective nursing practitioners. The problematic identified by Holmes (1992) is that critical theory is firmly lodged within modernist thought and does not allow for an examination of how context and the positioning of nurses affect nursing ethics. There is the notion here of an ideal speech situation as the medium for emancipatory action. The idea of there being such a thing as an ideal speech situation is, however, problematic. Such a notion can insidiously work to reinforce domination given the likelihood that nurses who are more skilled in dialectics as well as academics and

managers will gain more say in decisions about nursing practice than nurses working in practice areas. In addition, domination can be reproduced in communication between nurses and patients. It is nurses who are often more skilled in dialectics than patients and their families. Thus, Holmes draws attention to how communication becomes reconstructed from an interpersonal practice into one of linguistic competence by using a critical theory ethics.

Purkis (1994) challenges the use of existing nursing research that legitimates knowledge outside the context in which it is constituted. She argues that nursing lacks a conceptualization of power and social action as a complex inter-relational effect located within local nursing contexts wherein “reality is understood as constituted within social relations occurring amongst members in specifiable contexts” (p. 98). Purkis reveals how a structure, e.g., screening within public health, when used by knowledgeable nurses, shifts understandings of practice. Encounters are viewed as indicative of disciplinary mechanisms used in particular ways by members engaged in interactions within a particular context. Nurses are shown to participate in their own self-construction as a nurse subject of health promotion.

Powers (1994, 1996) made visible the effects on nursing and nurses of formalized models such as the nursing process and nursing diagnosis. Powers reveals how the language of needs and nursing diagnosis changes the way nurses view patients. Powers argues that nursing practice, as the link between the individual and his/her disease, is weakened as a result of the patient being reified as part of an aggregate rather than viewed as a unique human being. The unpredictable nature of individual responses to both disease and treatment remains hidden. The problem for nursing is that nursing

practices come to more closely mirror the medical model of disease. Rather than nursing process and nursing diagnosis contributing to a stronger identity for nursing, they function to strengthen medical norms by reproducing the hegemony of allopathic medicine. Thus, Powers' insights have increased the credibility of the caring curriculum by articulating how, for nursing, the use of formalized models is problematic – problematic because they change nursing practices in ways that do not serve nursing.

McCormick (1997) reveals how nurses discipline patients to comply with medical norms within local contexts. Nurses' power exists, according to McCormick, by virtue of their extensive knowledge of patients and through their disciplining of patients to comply, using various strategies, e.g., offering advice, issuing directives and giving orders. Strategies used to control the care of hospital patients gains legitimacy through nurses' use of knowledge practices drawn from understandings of chronic illness, adolescence, growth and development, and advocacy issues. Macro-processes extant in the larger society, e.g., family-centered care and cost restraints, are unconsciously incorporated at the site of micro-processes within everyday interactions between nurses and patients. What is made visible is how disciplines, through a network of systematic processes, link in insidious ways with broader systems issues. These processes go unrecognized by those being controlled.

Clarke (1999) examines the origin of evidence-based medicine and its connection to the concept of evidence based practice that has entered nursing. She challenges nurses' uncritical adoption of the concept of evidence-based practice and the relevance of knowledge classification stemming from it. In addition, she identifies the need for

balance, suggesting that in pursuing the latter, nurses use emerging evidence related to the values of caring.

The above passage demonstrates the value and relevance of postmodern research. The latter offers insights that can not be gleaned from modernist sources. Chief among these is the knowledge that nursing concepts and practices are subject to multiple interpretations and that an awareness of this contributes to explicating the differences in nurses' responses to identical situations. One of the benefits seen is that the function of a particular concept can be made visible. The question of who the concept best serves can be revealed. The way that nurses operationalize meta concepts in local practice areas can be made more transparent. The effect of the historical meanings of a concept on nursing and the influences of local contexts on nursing activities can be revealed.

A major consequence of the foregoing studies is that nursing can be seen as a political phenomenon. Nurses are revealed as agents who respond to influences in local practice areas. They are participants in the construction of nursing practices, supported and restricted in their efforts by the local context in which they work.

In introducing postmodern considerations with respect to qualitative approaches to nursing research, Crow's (1997) work has proved beneficial to nursing. She makes the point that postmodern thought allows for the challenging of privileged meanings that are often uncritically accepted as part of the common sense world of healthcare. Crow makes visible an implicit assumption underpinning the postmodern approach, namely that possibilities of intentionality and agency exist but are circumscribed by the disciplinary practices that are sanctioned or deemed inappropriate in local contexts. A postmodern approach allows for the recognition of how wider sociopolitical and historical contexts

influence nursing practices. It makes possible the challenging of contextual influences that affect patient care. Brown, Rodney, Pauly, Varcoe, and Smye (2004) assert that “whereas modern thinking tends to divorce individuals from their social context, postmodern thinking (re)centres the idea that human relations are rooted in both social and historical contexts” (p.141). For me such insights clarify how language works to construct reality, not simply mirror it. Thus, experience ceases to be looked upon as truth and can be examined in relation to the influence of local context on nursing practices.

Whall and Hicks (2004) cite Reed (1995) in declaring that at present there exists some support for neo-modernism for nursing research. A neo-modernist approach subsumes both positivist and postmodern views. Neo-modernism can be used to address current problems while taking into account historical values and traditions – a possibly more inclusive and liberating path than post modernism.

Gaps in the Literature

Three gaps were identified in the nursing literature. The first is the dearth of research featuring rich descriptions of what constitutes caring practices in hospital nursing units. The second gap is the failure on the part of nursing researchers to include an examination of the role of context in their analyses of clinical nursing practice. The third is the lack of a research focus on how nurses contribute to the emergence of caring practices in local areas. Wilkes and Wallis (1998) affirm the need for further research that examines the local work environment and its effects upon nursing practices of caring.

The following articles support the need for research aimed at addressing the three gaps identified above. Rodney, Brown, and Liaschenko (2004) note that “ texts of caring

have frequently constructed caring as evolving from a nurse's character and individual motivation for caring while ignoring both the material conditions and power relations in the particular contexts where nurses work (MacPherson, 1991)" (p. 161). McIntyre and McDonald (2006) elaborate upon the implications of events of the past two decades wherein nurses have confronted unprecedented changes and have struggled to maintain the undervalued facets of caring as part of their practices. The authors chronicle how nurses have sought to maintain and reclaim their connection with a feminist past and forge new ways for nurses' unions and professional associations to work collectively with a view to improving the quality of care for patients. Yet, at the same time, the gender socialization of nurses as caring practitioners has compounded the complexity of interactions between nursing and competing discourses in healthcare. McIntyre and McDonald further argue that changes in nurses' work during the past decade have seriously compromised nurses' ability to provide quality care and in some instances to provide even adequate care. They affirm that the burden for eliminating barriers to quality care does not rest solely on nurses; governments, professional groups, employers, and labor groups must also bear some of the responsibility. It is also argued that the most effective response for nurses may be to recognize and disrupt the dominant discourse in healthcare that functions to limit care. In tune with my own beliefs, the authors warn that failure on the part of nurses to articulate their own beliefs and ideas about caring will result only in complicity in maintaining power relations that limit or subordinate nursing knowledge of caring.

My Study

The intent of this study is to challenge dominant discourses that function to limit caring by making visible how nurses operationalize caring practices. The study design allows for the influence of local context on nursing activities to be taken into account. The nursing activities I examine are nursing practices of caring. My aim is to make visible how nurses operationalize caring practices in a local settings and the contextual influences that support or limit their practices. My assumption is that for nurses to be able to respond to the contextual influences affecting their practices, they need to recognize what caring practices consist of and the factors informing them. My hope is that this study will enable nurses to see nursing as a political event; to become aware that while nurses participate in the construction of their practices, they are not in total control of the process. My belief is that in arriving at a better understanding of how context influences nursing practices, nurses will come to envision different possibilities for action. They will then be in a stronger position from which to challenge societal practices that currently detract from the patient's experience of health and illness in ways that are unacceptable to him/her.

Research Questions

This study addresses two research questions: How does local context influence nurses' caring practices? How are nursing practices of caring sustained?

In the following chapter I focus on the theoretical perspectives that function as an interpretive lens for this study. The choice of theoretical perspectives was influenced in large measure by my review of the literature pertaining to knowledge of caring. These

provide a framework or lens through which to view nursing as a political event, one wherein the effects of context on nursing practices of caring can be seen. Nurses can be viewed as participants in, but not the sole authors of, the construction of caring practices.

CHAPTER THREE

THEORETICAL AND METHODOLOGICAL UNDERPINNINGS OF THE STUDY

Introduction

In this chapter I discuss the philosophical and theoretical underpinnings of this study. In addition, a rationale for my choice of ethnography as a methodology is provided, along with an outline of the study methods to be employed. Next, the hospital site and participants are identified and the recruitment process, including measures aimed at ensuring anonymity and confidentiality, described. I also discuss various tools used for interpreting and translating data into written text. Finally, criteria for ensuring scientific rigor are generated and discussed.

Philosophical and Theoretical Underpinnings of the Study

Philosophical underpinnings

All researchers approach their work from a particular worldview, i.e., a set of basic beliefs about the nature of reality and how it can be understood and studied (Guba & Lincoln, 1994). Although Lincoln and Guba (2000) identify five major worldviews or paradigms that structure qualitative research, they acknowledge that “the various paradigms are beginning to ‘interbreed’” (p. 164) and that theorists who locate their work in different paradigms are beginning to inform one another’s arguments.

The paradigm wherein my research is located is a constructivist worldview, one that holds that all knowledge is constructed. One of the pioneers of constructivism is Kurt

Lewin (1948, 1951, & 1997), a practical theorist best known for his "field theory" and investigations of the conditions and forces that support or resist change. The term 'field' is defined as the totality of coexisting facts that are conceived of as mutually interdependent. Lewin's underlying assumption is that for change to take place, the total situation has to be taken into account. Thus, the social environment is viewed as a dynamic field that impacts human consciousness in an interactive way. Behavior is determined by the totality of an individual's situation, personal characteristics, and the social situation in which he/she is situated. Individuals behave differently according to the way in which tensions between perceptions of the self and the environment are worked through. Lewin coins the term "life space" to represent the different subsystems, e.g., family, work, and church that make up a dynamic field. They are viewed as separate though they interact and combine with one another through the individual's participation in them.

Peavy (1997) contends that much of the recent thinking with respect to qualitative research methods is predicated upon a constructivist framework. The greatest value in constructivist thinking, in his view, is that it does not become mired in disputations regarding the relative merits of various theoretical perspectives; rather it offers new and different ways of understanding social reality.

The constructivist worldview that constitutes the philosophical underpinning for this study is informed by Peavy's (1997). Constructivism represents a radical departure from the Newtonian-Cartesian paradigm: "This shift is from the mechanistic world view of Descartes and Newton to an ecological, constructivist world view springing from quantum theory, non-linear systems theory, and postmodern philosophers" (p. 30), such

as Foucault (1970) and Rorty (1989). Peavy argues that constructivist thinking differs from positivist thinking in five respects. First, thinking is viewed as not merely psychological but also philosophical, sociological, and literary. It extends, moreover, beyond theories of individualism. Language is thought not simply to mirror social reality but to construct it. Social interactions, communications, and inter-relating perspectives within local contexts result in the generation of meanings, making multiple realities a possibility. Second, the aim of constructivist thinking is not to arrive at answers or compile facts but to remain open to invention that is directed by noticing and making differences. There is the belief, moreover, that questions have greater intrinsic power than answers because they open pathways to envisioning and exploring alternatives rather than closing off options. Third, there exists an inclination toward “making” rather than “finding” meaning; toward diversification and novelty rather than convergence on the already known. Fourth, there is greater concern with describing rather than explaining and generating fixed categories; and with creating a space for the re-describing and re-making of meaningful and alternative forms. The fifth aspect is that constructivist thought is receptive to poetic expression and metaphor. There exists an appreciation that external reality can never be directly known because human realities are metaphorical and constructed through the use of language. Thus, we all live storied lives; we are a result of the stories we tell ourselves about ourselves. “A self is not a ‘thing’ but is a complex configuration of meaning and a metaphorical way of referring to the subjective sense of who we are” (Peavy, 1997, p. 36). Thus, as human beings we are all a part of the whole and although we are not in total control, we participate in constructing whatever it is we call reality.

Of note is that a constructivist worldview is identified as with the practice of informing certain actions directed toward helping others (Kierkegaard, 1959 cited by Peavy). These actions involve listening from the viewpoint of the other, exercising patience and humility, letting the other teach you, restraining your own vanity and the need to be viewed as superior in knowledge and skill to the client, and being willing to admit your own ignorance. Such actions are thought to result in the privilege of hearing others' stories and joining the storyteller in the task of "re-authoring" (Peavy) them so that they more accurately reflect what the storyteller wants for the future. Of special significance for this writer is that such practices and understandings create a complementary fit with the carative practices defined by Watson (1985, 1988, 1999, 2005), practices I have honed as part of my nursing practice. In addition, the constructivist worldview is compatible with my understanding of nurses' practices of caring as constituting a daily construction.

Consistent with the aforementioned worldview are three theoretical perspectives relating to culture/context, practices and power. These draw heavily on de Certeau (1984) and Polkinghorne (2004) and to a much lesser extent Foucault (1972, 1979, 1980, & 1994).

Theoretical Underpinnings of the Study

Understanding culture/context as a construction

In defining the term "culture", I draw from Polkinghorne (2004) who challenges essentialist models that view culture as a static construct of beliefs, values, and customs inhering within individuals located within a specific cultural group. Polkinghorne contends that the primary source of understanding is culture. Within local cultures,

socialization processes function to transmit knowledge practices to new members. Individuals approach situations out of a “background understanding” which, in turn, provides an interpretive framework for “reflective understandings” of practices within a particular culture. Through the use of reflective understandings, practitioners of caring are able “to consider new or different practices” (Gadamar, 1998 as cited by Polkinghorne, p. 164). The benefit accruing from such thinking is that by questioning previous understandings, one is able to develop new practices. Individuals are able to make discretionary judgments that influence normative cultural patterns. This may not radically change existing norms, but minor variations in existing patterns are made possible. Thus, individuals are able to participate in the construction of their own practices.

Sawicke (1991) argues that culture is a set of government and other practices directed at “producing certain sorts of persons, not a collection of phenomena which hold meanings like a bank, from which people draw and to which they deposit” (p. 122). The implicit assumption is that individuals are co-creators not passive actors in the local construction of culture. They participate in the constant making and remaking of culture. Rodney (1997) arrives at a similar understanding of culture as the culmination of “the processes that happen between people as individuals and as groups within organizations and society” (p. 68). She concludes that culture plays out in local areas: the individual and collective human experiences that are situated within the larger context of mediating political and institutional agendas. Hence, such understandings provide recognition of a space for social agency.

Foucault (1990) posits that culture and context are in relation with one another. He views culture, not as a fixed, preexisting entity, but rather as an historical and contextual form that is constantly forming and re-forming through the intersection of complementary and conflicting relations of knowledge and power that are always at play in local areas. Such understandings of culture have created for this writer a new understanding of context. I am able to recognize how nursing practices are situated within a larger social context of competing professional perspectives and political, economic, and institutional agendas that function to support or limit nursing actions. These perspectives allow me to understand more fully how agendas are diffused through social systems, operating, often in disguise, at micro and local levels of practice. Context becomes recognizable as the site wherein the intersections of various disciplinary practices produce particular cultural arrangements that privilege certain practices and provide subject positions for individuals to fill. McWhorter (1999) views context as a terrain of practices and belief structures, wherein individuals do not construct their own practices, but instead, choose from among the varied patterns of choices available to them within the culture. Important to note is that in selecting from among various alternatives, individuals participate in the unique construction of local patterns of organization. The local culture is formed as a result of the choices that are made and the consequent configuration of specific patterns that emerges.

Kaminski (2006) asserts that despite the myriad of cultural lens evident across disciplines, one unifying concept for nursing is that of context. "Nursing culture is situated within the bureaucratic context of the health care system, manifested across various institutional settings" (p. 18). Organizational culture is ultimately co-constructed

by the various participatory groups within the functional and cultural restraints of the bureaucratic hospital structure. A hidden problematic for nursing being when nurses are unable to recognize how they participate in the construction of local cultural norms they fail to identify how certain activities that they become co-opted into performing may result in constraining nursing actions rather than enabling them. This failure stems from a lack of recognition of how power relations play out in local contexts.

Knowledge/power relations

Foucault (1972, 1979, 1980, &1994) contends that power relations are a part of everyday life. The notion that “we are drawn into relations of power when we make meaning and meaning makes us who we are” (The Bolton Discourse Network, 1999, p. 6) elucidates how power relations are operationalized. Rather than a force held by individuals or groups, power is seen as part of a power- knowledge relation. Individuals are viewed as both using and being used by power.

Foucault (1972) defines power as a scientific method of inquiry and particular type of analysis that produces certain truth statements. Power is a type of authority granted to the spokespersons of a particular discourse wherein they are charged with articulating what counts as truth. Watson’s (1985) construction of caring as a type of phenomenological inquiry that allows for a unique type of holistic nursing analysis may be viewed as an exemplar of such. Du Plat-Jones (1999) argues that the ability of a discipline to represent itself as important depends on the perceived legitimacy of its analyses. Of note is that privileged norms come to be seen as a consequence of how the authority of different types of analyses plays out differently in different contexts.

The above understandings run counter to my humanist understandings of a reality that positions the individual as an independent agent, solely responsible for his/her own choices and actions. In the latter schema, language is viewed not as a mirror of reality but as a tool for the construction of reality. Experience is reinterpreted; it is no longer viewed as the result of reality but the result of what one thinks and says owing to the particular perspectives of the language systems that one inhabits. Thus, I am able to recognize nursing as a political event of complex inter-relational effects located in local spaces. This new understanding of power, not as a force held by others but as a political game, enables me to recognize that while there is no such thing as unlimited agency for nurses in local contexts, there is a space for varying degrees of social agency. Once nursing is recognized as a political event, a space is created for the development of strategic moves that serve to persuade others to comply with actions that better serve nursing and nurses. Purkis's (1994) argument that reality is constituted within social relations occurring amongst members in specifiable contexts now makes sense. I concur with her analysis that nurses are not victims of external forces, but instead are persons drawing on rules and resources within local contexts in a knowledgeable manner, participating in the construction of the structures constituting the local practice world.

Practice as strategic moves and individual judgments

Polkinghorne (2004) expands understandings of practice in differentiating two types of practices within human-cultural contexts: ones that are technically based (strategic) and a second type that are judgment based (communicative). The first type, strategic practices, is defined as part of a current "technified" worldview, wherein

techniques are developed to manage human beings. Foucault, Boudieu, and de Certeau are cited as authorities who describe this “technification” of society by means of bureaucratic operations grounded in technical-rational procedures. One manifestation of the latter is the encouragement given caregivers “... to follow scripts and program outlines, with the objective of making their practices technically based rather than judgment based” (Polkinghorne, p. 47).

The second type of practices, communicative, is those wherein the practitioner and person served interact face-to-face. Practitioner actions are decided by timely judgments on their, i.e., the practitioners’ part. Practitioner judgments are viewed not merely as expressions of background understanding, but as a reasoning model of reflective understanding that is informed by background understandings. Thus background understanding operates out of this reflective awareness. “Effective decisions about what to do require a type of reasoning that is responsive to the specific aspects of a situation and sensitive to changes taking place in that situation” (p. 151).

Polkinghorne (2004) contends that understanding practices as both strategic moves informed by technical rationality and personal judgments on the part of practitioners creates a point of tension. The latter stems from differing views among theorists as to the degree of “wobble room” available for personal judgments within the strategically ordered world of technical rationality (Polkinghorne). Foucault (1979) holds the view that disciplinary procedures have grown to such an extent that no space remains for individual agency. (cited in Polkinghorne). Bourdieu (1990) holds the view that personal judgments are limited to the choice of which strategic moves one makes within power games (cited by Polkinghorne). De Certeau (1984) allows for some scope for

personal judgments with respect to strategies of imposed order, arguing that there continues to be a space for social agency in local contexts (cited by Polkinghorne). Thus, Certeau's (1984) work is viewed, in part, to be a corrective to Foucault's picture of a fully controlled society (Polkinghorne).

De Certeau's (1984) space for personal judgments provides direction for my inquiry and insights for my analysis. His views, moreover, make the most sense in relation to my own experience of nursing within the context of hospital environments; they have also led me to examine the everyday world of nursing experience, taking into account contextual influences. De Certeau (1984) argues that strategic thinking is intended to simplify one's understanding of a given activity so that it can be more easily managed and controlled. He defines strategies as leveling frameworks, as objective calculations that impose order with a view to rendering environments predictable and manageable. In contrast, practitioners of care, deal with the complexity of individual human beings. They need to think about what to do, taking into account time, place, and personal histories. Strategies of imposed order, it is argued, sometimes fail to provide conclusive results and clear directions owing to the mutable, indeterminate, and particular nature of human circumstances. Thus, for practitioners, choices with respect to action have to be made on the basis of information that does not always make sense. De Certeau maintains that there exists some "wobble room" between the strategies of ordered knowledge for practitioners to make personal judgments in choosing alternative actions. He perceives openings within the social fabric of everyday life for actions based on personal judgments, actions that resist the "technologizing" of society, i.e., the transformation of individuals into objects. He labels these individual actions "tactics".

The latter define ways of operating that disrupt imposed order, subverting and redirecting everyday practices. Tactics are opportunities seized upon, procedures articulated in the details of everyday life. They bring into play imaginative initiatives, the result of cues originating within the moment being attended to. Tactics trace indeterminate trajectories that do not cohere with the constricted, written, and prefabricated space of predetermined strategies. Tactics are the innovative techniques and activities that allow for adaptations required to meet individual needs. De Certeau defines tactics as hidden or practical knowledge that is unique and specific to a local space and that allows for the operationalization of activities essential for completing day-to-day work. He describes the examination of everyday life as a “science of the singular and extraordinary” that challenges frameworks of leveling rationalities that trap human beings in a common fate, wherein everyone becomes a nobody, an anonymous object.

My reading of de Certeau (1984) has led me to view tactics as operating more like improvised theatre, producing an action that transforms the immediate space however momentarily. Tactics break down local stabilities to create a space for new ways of operating. They are practices that are immediate and invisible; the product of the weaving together of strands of local knowledge into forms that are used and then forgotten as other practices are enacted.

The Research Question

The above philosophical and theoretical underpinnings create a space for a reconsideration of the pervasive assumption that nurses are always able to operationalize caring practices, an assumption stemming from the belief, one implicit in nursing, that relational caring represents a *sine qua non* for beneficial care. They challenge an

assumption that has gone uncritically examined by this writer during the course of a thirty-five-year career in nursing spent in a variety of clinical practice settings in hospitals and communities.

The fore mentioned perspectives have allowed me to acknowledge and recognize how context exerts a decisive influence on nursing activities and how nurses contribute to the construction of daily caring practices in responding to this influence. This awareness led to my formulating a research question focusing on how context influences nursing activities and how nurses sustain their daily caring practices. The research question led, in turn, to my adopting ethnography as a methodology. This methodology enabled me to enter into a local nursing culture wherein nurses enacted caring and to see and experience factors influencing care. Participant observation and journaling as the methods used to generate data functioned as a counterbalance to one another. My “background understanding” of caring” and my “reflective understanding” of what I saw nursing to be on the unit functioned to inform one another and lend to this study a paradigmatic integrity that underwrites its quality and soundness.

Ethnography as Methodology

Ethnography was selected as a methodology because it provides direction for placing “specific encounters, events, and understandings into a fuller, more meaningful context” (Tedlock, 2000, p. 455). One of my chief concerns in conceptualizing this study was the lack of attention given the influence of context on nursing practices of caring. As noted in the literature review, much of the current knowledge of such practices in no way relates to the contextual influences that shape nursing practices. Ethnography enabled me

to enter into close and relatively prolonged interaction with nurses in the course of their daily working lives; allowing me to examine daily caring practices within the context of the local setting. At its core, ethnography is a theoretically based methodology used for constructing knowledge aimed at elucidating social contexts (Hammersley & Atkinson, 1995). Thus, ethnography has allowed me to describe in rich detail nurses' daily activities of caring in a local setting and to link my observations to a broader social context. I was able to move analysis beyond simple descriptions of observations to an explication of how nursing activities are influenced by local context and how nurses respond to these influences.

Ethnography has had a long and varied tradition in the social sciences. It has evolved as philosophies of science have developed, and various disciplines have adopted ethnographic techniques (Hammersley & Atkinson, 1995). The following are features identified by Atkinson and Hammersly that are common to ethnography and that inform this study: a strong emphasis on exploring phenomena rather than setting out to test hypotheses; a tendency to work primarily with "unstructured data" that have not been coded at the point of data collection in terms of a set of analytic categories; and an approach to analyzing data that involves the explicit interpretation of human actions and principally takes the form of descriptions and explanations. A significant feature of ethnographic inquiry is that descriptions can provide a high level of detail regarding the everyday life of the participants, thus making it possible to discern the culture of the local setting at work in their activities (Wolcott, 1994).

The following is an elaboration on the actual steps taken in carrying out the ethnographic study.

Sampling: Selecting a Site for the Study and Negotiating Entry

The site selected for this study was an oncology unit in a hospital located in **the** Greater Vancouver, British Columbia. The selection of this particular site was based on reports by nursing students and colleagues to the effect that this unit had a “culture of caring”. It seemed like a logical choice if one wished to explore how nurses’ sustained their daily practices of caring.

Entry to the site was gained following a bout of complex negotiations that spanned a six- month period and involved submitting formal applications to no less than three different ethics committees attached to three different institutions. Following approval, I submitted a formal letter explaining the particulars of the study (Appendix B) to the agency whose permission was required to conduct research. I met with the unit manager to secure her approval and schedule a meeting, the purpose of which was to recruit volunteers for the study. During the meeting I described the study and provided each candidate with an information sheet (Appendix C). In addition to a participant consent form (Appendix D) copies of both the information sheet and the consent form were supplied to the oncology unit for candidates who had been unable to attend the meeting. As pre-arranged, I returned to the unit to collect the consent forms. Copies were made available so that participants could volunteer anytime during the study. There was no screening process for participants, so that every nurse who volunteered became a participant in the study.

The object of the above procedure was to gain an in-depth understanding of what caring practices were comprised of by enabling nurses to volunteer throughout the course of the study. The study spanned over a three month period wherein I was on the unit for

one to two days each week. The openness to having participants volunteer for the study at any time enabled me to collect data from a wider range of participants than would have been possible had I restricted recruiting to the initial group of candidates. The data proved sufficient in that it allowed me to recognize patterns for caring practices that nurses operationalized in the unit.

The participants in the study consisted of 19 registered nurses employed either part-time or full-time in the unit. These nurses agreed to allow me to shadow them during their shifts, observe their practices and later corroborate what I had observed.

Approximately 50% of the nurses working on the unit had been there between 10 and 21 years; approximately 30% over 5 years; and the remaining 20% less than 5 years: 12 of the volunteers were from the 50% group; 4 from the 30% group; and 2 from the 20% group.

Study Methods

Participant observation

Participant observation is the primary method used in this study. It draws upon the perspective that there is an interactive, interpretative, and negotiated aspect to social life (Ackroyd & Hughes, 1992; Denzin & Lincoln, 2000). It has allowed me to experience the ways in which nurses' operationalize daily practices of caring. This method proved a complementary fit with Polkinghorne's (2004) view that social life consists of a multitude of practices and processes, constantly moving and changing as actors negotiate and renegotiate in an effort to make sense of and interpret the world in which they live. These negotiations are improvised tactics that occur in and are made possible by the

spaces existing between strategies of imposed order, e.g., theoretical models, standards, policies, and laws that we construct in an attempt to create and maintain order (de Certeau, 1984). The tactics are actions based on individualized judgments of what makes sense, practices that have yet to be constructed into a material reality (de Certeau). They are actions intended to make things work within one's everyday life. Participant observation enabled me to see how nurses integrate tactics with ordered strategies of nursing procedures, protocols, standardized care plans, and chart forms.

Achroyd and Hughes (1992) define the participant observer as an individual who, as a member of a particular culture, is familiar and competent but who, at the same time, is viewed by the group as requiring remedial instruction and tolerance within the local context. The term used to describe such a researcher is "interested incompetent"; it aptly describes how I felt within the confines of the high tech, fast-paced oncology unit. My intent was that my role as a participant observer would be a transparent one. There was no intention of concealing who I was or what I was doing. I made certain all the participants understood my role was that of an observer. I acknowledged that although I had worked in a variety of different nursing units in a number of hospitals and was thus familiar with hospital cultures, I had no nursing experience in their field of specialized oncology. I emphasized that my aim was to learn more about how they sustained daily caring practices in the fast-paced environment of an acute care oncology unit. The result was that the nurses appeared very comfortable with my posing naive questions and in responding to them. My experience was consistent with what Ackroyd and Hughes have to say about gaining acceptance into a group. My acceptance within the group depended

far more on the personal relationships I was able to develop than on any explanation or rationale for the study I might offer the participants.

Data collection, analysis, and interpretation

Denzin and Lincoln (2000) characterize participant observation as having three distinct and separate stages: stage one, data collection; stage two, data analysis; and stage three, data interpretation. What became apparent very quickly in this study was that the three stages tend to conflate into a single process – an interactive and integrated process that requires data to be gathered, analyzed, and interpreted simultaneously. This would prove a holistic process of inductive thinking that resulted in the data leading me in unpredictable directions.

The nonlinear process of qualitative research requires having pen and paper always at the ready to record what I was seeing and hearing during the course of observing nursing practices. These field notes are the chief source of data for this study. Initially, I made notes about everything I observed, read and heard. I scribbled furiously while: listening to reports; reading policies and procedures; observing interactions between nurses, other professionals, and hospital staff; and attending ward conferences. Notes were made describing the setting, i.e., the unit, and the nursing practices taking place within it. Also noted were overt observations; the meanings of what was observed from the perspective of the participants. The combination of observing and note taking enabled me to enter into and understand how practices of relational caring were operationalized by the participants. I recorded all the nursing actions that I observed, along with comments from nurses about their own specific actions and my own insights

gained from listening to and watching nurses work. I worked diligently to develop an understanding of the multiple perspectives and practices that constituted the culture of the unit. I asked nurses and gained permission to shadow them and observe their daily caring practices. I took advantage of observing nurses participating in individual and group activities; i.e., admitting a patient; ward conferences; preparing to assume responsibility for the patients they were assigned to; performing procedures, such as administering medications, changing dressings, and monitoring intravenous infusions; dealing with challenging situations, such as conflict; interacting with patients and their families about particular facets of their hospitalization and treatment. I documented everything I observed nurses doing and saying that was related to their daily practices.

Most of my observations were made while I shadowed nurses. I shadowed one nurse each day so as better to observe daily caring practices from the nurse's perspective. Having the participants corroborate my interpretations of the caring practices being observed proved to be an informal process involving unstructured conversations. I provided very little structure in order to avoid imposing my own assumptions. If anyone had a question, they posed it: if anyone had an insight, they shared it. The result was that participants talked and listened while sharing heart-warming insights regarding each others nursing practices. These conversations with nurses were always insightful and fascinating.

Computer-based notes were generated in response to the connections I made among my observations, evolving insights, and ideas gleaned from the literature. I usually compiled them as soon as possible following each day of fieldwork. These also

included more formal commentary related to questions I was struggling with or insights that I had gained.

The experience of observing participants is a reflection of what Denzin and Lincoln (2000) call the process of interpretation in human science research. The experience was an ongoing cycle of observing, listening, writing, reflecting, reading, and analyzing, in tandem. Eventually, I was able to identify emerging themes. Participants attendance at three presentations where I discussed with them my preliminary findings related to these themes, moreover, provided a means of corroborating my perceptions and analyses.

Journaling as method

Journaling is the second method used to generate data. Denzin and Lincoln (2000) argue that writing helps disrupt taken-for-granted understandings and allows for a more critical examination of privileged norms, creating distance from the sovereignty of self by allowing the emergence of different ideas to shift the focus away from everyday norms. The authors contend that reading and reflecting upon one's writing allows one to recognize and question assumptions that have become viewed as common sense. For Ely, Viz, Dowing, and Anzul, (1997) "writing is at the heart of our endeavors to reflect, to be thoughtful, to tame and to shape the compost heap of data that is filled with disparate, confusing, and overwhelming raw impressions" (p. 15).

Meloy's (1994) premise is that writing is an integral part of what qualitative research is all about. Her description of journaling parallels my own experience with this method: for both of us journaling represents a resource of one's own creation that goes

beyond the explicit commentaries of the participants. “A journal provides a solid link to the many simultaneous levels of experience that are involved in the process of qualitative research ... A journal can hold your heart ... [It is] a way of imaging a stream that flows through (underneath?) and surrounds the territory of qualitative research” (p. 60).

I used journaling as a free-flowing method for capturing my thoughts and feelings from the day. I engaged in this practice only after leaving the unit. Journaling became an, ongoing dialogue with myself, a type of debriefing that helped me process emotionally what I had experienced within the unit. I would journal in my car, before driving home, in order to capture and reflect upon what I had observed during the day. Journaling helped recall the specifics of the interactions and observations that had taken place. In my journals were entered not only my thoughts and feelings, but also poetic musings, drawings, and questions to follow up during the course of fieldwork. My journals mirrored what Collister (1993) defines as a subjective and objective chronicle of events, one that facilitates active and integrated learning which, in turn, helps to forge linkages among theory, research, and clinical practice.

My experience with journaling allowed for the tracking of questions that probed the causal factors underlying what I was observing; as well as the interests the various practices appeared to serve. Upon rereading the journals, I discovered viewpoints that required questioning and assumptions that called for examination.

Portrayal and Discussion of Findings

Found poetry

Found poetry is a tool used to assist in analyzing and interpreting data. It is a process of free flow writing that is followed by a rereading of the text and identification of words and phrases that resonate as truths (Oberg, 1998). These words and phrases create an art form called 'found poetry'. The free flow style of journaling I used generated a rich source of data for the creation of found poetry. The latter proved a useful tool in helping me sort through the data by providing snapshot views of very complex and real life experiences of nurses and patients on the unit. This art form enhanced the transparency of what it is that nurses do. 'Found poetry' helped condense the volume of data and enabled me to recognize the tactics or actions of personal judgments that nurses enact to sustain their daily caring practices. It also helped me identify similarities and difference among nursing practices. 'Found poetry' provided a framework for the nine themes of caring practice recognized as being unique to the local context.

An artistic portrayal in the form of a "closet drama"

Three months into the observation stage of the study I arrived at what Hills (2000) calls 'saturation' or 'redundancy', a point where new data fails to reveal new findings. In exploring options as to how I would present my findings, I was drawn to ethnographic drama as a form of representation. Donelan (1999) notes an affinity between ethnography and drama: "the capacity to project imaginatively into a situation and to identify with another perspective enables people to explore human experience in drama" (p. 256). Butterwick (2002) describes ethnographic drama as a process of creating a performance

based on data gathered through qualitative and ethnographic fieldwork. In her view the performance turn gives voice to research participants located at the margins. The intent is to create a dynamic interplay between text and reader. I was intrigued by the idea of using drama to keep nurses visible as agents of their own practices.

I was encouraged in this regard by Denzin and Lincoln (2002), who cite Raymond Carver's (1998) view of real experimenters as those "who make it new, who find things out for themselves, and who want to carry this news from their world to ours. Thus, will qualitative researchers find new and different ways of joining their interpretative work with constantly changing forms" (p. 915). Denzin and Lincoln (2000) assert that the world of human experience must be studied from the point of view of the historically and culturally situated individual. They note that performative ethnography makes experience concrete by anchoring it in the here and now. It is a storied retelling of lived scenarios witnessed and confronted. The text simultaneously moves from the personal to the political to reveal how people enact cultural meanings in their daily lives. The process involves narrators, drama and shifting points of view and is one of discovery, allowing for an intersubjective interpretation of data. Thus, I came to recognize the value of re-representing my field notes in the form of drama: the text would reveal how nurses operationalized practices of caring in unique and various ways, as socially mediated processes within the local context.

For Lepp (2000), an ethnographic drama has three phases. The first involves capturing experiences, describing critical events and choosing concrete situations for creation with different roles. This introductory phase is labeled "unfinished drama". The actual performance of the play represents the second phase. Reflection upon and

discussion of experiences that emerge during the performance of the play constitute the third or “reflective phase”. Lepp uses ethnographic drama to develop the inter- and intrapersonal skills of nurses and physicians. Lepp’s work underscored the difference between the introductory phase and the actual ethnographic drama. It was at this point that I reexamined my use of ethnographic drama as an appropriate form of representation for my findings.

Vanouwer & Saldana (2005) call for collaboration between researchers and theatre artists aimed at enhancing the quality and rigor of arts-based theatre, Saldana (2005) points out that while some of the ethnodramas with which he is familiar are the creations of educators, anthropologists, and sociologists, most have been written by researchers. What he views as problematic is that with virtually no theatre or playwriting background on the part of the authors, these works often suffer the effects of didactic dialogue and a lack of staging potential. This is hardly surprising given that they are purely textual representations intended for reading purposes only. Nor is it surprising that none have been performed. Saldana terms such representations “closet dramas” (p. 14). In recognition of my limitations, as a playwright, I elected to abandon all thought of producing an ethnographic drama and turn my attention instead to a less ambitious form: the closet drama.

The expression “closet drama” has great appeal because it is an apt metaphor for the focus of this study, i.e., nursing as practices of caring. It describes so graphically how caring practices play out behind the closed doors of every local nursing unit – elusive, hidden, forming and reforming, then disappearing. They resemble in so many respects an ongoing, unfinished drama played out in the closets of healthcare bureaucracies.

The aim of the “closet drama” is to highlight caring practices within the unit. The respective scenes elucidate how caring is woven into the local culture as a collective story whose subject is ‘caring comes first’. Another valid reason for choosing the format of the “closet drama” was to keep nurses visible as agents of their own practices; in the constantly shifting play that is the enactment of caring tactics. With this end in view, I reworked and transposed my findings into a script, one that revealed nine common themes that frame nurses’ caring practices. The anonymity of participants was maintained by assigning each a pseudonym; some nurses choose their own. At the same time, the participants remained visible to one another as agents and speakers whose voices mattered. I drew upon criteria generated by Denzin and Lincoln (2000) to evaluate the script: (i) characters had to be recognizable and located in well-described unforgettable scenes; (ii) the drama had to present cultural and political issues; (iii) it had to articulate a politics of hope; and (iv) it had to use direct and indirect symbolic and rhetorical means to communicate interpretations.

In sum, though initially I had no intention of writing a play, I became convinced that a “closet drama” would enable readers to draw on senses other than vision. The appeal of couching the findings in the context of a dramatic presentation is that there is no guarantee the audience will be receptive or even grasp the proffered meanings. Yet here was an opportunity for readers to re-live nurses’ experiences through the writer’s eyes. Rather than merely talking about practices of caring, my “closet drama” would make visible how caring looked and felt.

The titles for the respective acts in the drama are the themes that frame daily caring practices. The found poetry at the beginning of each act is composed of words and expressions drawn from my field notes and journaling. The poetry represents an artistic

interpretation of the lived experience of both nurses and patients within the context of oncology and the local unit. The themes create a frame for a collective story of ‘caring comes first’ within the culture of the unit. The scenes capture the plurality within caring practices: the unique and diverse tactics each nurse uses to construct his or her daily activities. The artful portrayal of the findings enables me to present the ever-changing drama of caring. The “closet drama” makes visible how nurses operationalize daily caring practices in response to unpredictable and ever changing cues from patients and their families.

I drew upon Butterwick’s (2002) concept of a “readers’ theatre” in presenting the preliminary findings to nurses on the unit. Readers’ theatre involves a presentation of a passage from a text or from different texts that are thematically linked (Don Moyer and Yennie-Donmoyer, 1995 cited in Butterwick, 2002). Readings allow for the voices of those whose accounts represent the source of data to be more vibrant and capable of being heard. A consequence of using such a format is that nurses’ readings of different scenes function as entry points to a discussion and examination of caring practices. The readings opened up a space for nurses to discuss the analysis and interpretation of the data. One outcome of the readings was that the nurses identified the “closet drama” as an accurate accounting of what they do within nursing. Of significance is the surprise they expressed upon realizing the complexity of all that they do and all that they have to know in order to operationalize their daily caring practices. For this reason they saw the script as having educational potential. They viewed it as a way of helping others to know what nurses do on the unit.

Ensuring Scientific Rigor

Throughout the course of the research phase of this study, two questions related to scientific rigor remained salient: How can I use research methods in a way that guarantees that the authenticity of my research findings is not questioned? What must I incorporate within the research process to ensure that the participants in the study feel respected and have their rights honored?

Four criteria were selected to address the above questions and ensure methodological rigor: consistency, applicability, neutrality, and credibility. Hills (2000) cites their utility for establishing rigor in the field of human science research.

Consistency refers to dependability; it is demonstrated by my detailed accounting of the research process that created an audit trail which allowed others to follow the course of my decision making.

Applicability was evinced in the ability to replicate the study in the same or a different area, made possible owing to the detailed and explicit descriptions of the research process that were generated. The applicability criterion wasn't applied in the traditional way, i.e. wherein the findings from one study are deemed generalizable to a similar setting. The findings from this study were never intended to be generalizable. Instead, I focused on whether they were relevant to other contexts. Specifically, I requested nursing colleagues working in other nursing areas to critique my findings. I was gratified to learn that the latter were relevant to their areas of expertise, i.e., maternity, oncology, and pediatrics. This relevance is referred to in the literature as "fittingness" (Guba and Lincoln cited by Hills, 2000).

Neutrality was not interpreted as being a characteristic of the researcher. A measure of neutrality was that the data was identified as being reliable, factual, and confirmable by those participants in the study who critiqued the findings. Strategies used to enhance the credibility of the study included making observations; debriefing participants following their reading of specific observations I had documented while shadowing them; providing participants with copies of the initial draft of my findings; and obtaining feedback from participants during informal presentations of my findings. The intent was to ensure that I had measured what I had intended to measure.

Credibility was evinced in the participants confirming that my findings are believable.

Methodological rigor lay in the detailed examination of data related to the research question and in the use of a methodology and methods that enabled me to answer the research question. Sharing and later corroborating findings with participants allowed for a review of the constructed meaning of what I observed and ensured that the interpretations of what I was seeing and hearing was consistent with the participants' understandings. Having participants corroborate the findings proved to be a very effective way to generate both deeper and broader as well as alternative interpretations of my analyses. Field notes and journaling provided rich descriptions that resulted in an interpretation of daily caring practices that was plausible. This study provided a clear and concise analysis of how nursing is structured as practices of caring in part by contextual factors that function to inform such practices.

Ethical Considerations

Denzin (1997) stipulates that ethnography is an inquiry wherein the identities of participants are protected and wherein each has the right to know what is being written by the researcher. I made every effort to satisfy these two normative criteria. I ensured that informed consent was obtained prior the fieldwork. I kept the research process transparent by sharing what I was doing and by providing individual participants with opportunities to critique what I had written and raise questions related to my observations. The following is a description of informed consent and an explication of how anonymity, volunteerism, and confidentiality were maintained throughout the study.

Hills (2000) defines anonymity to be a state or condition wherein the identity of individuals or organizations is not revealed. In this study anonymity was maintained, in part, focusing on how daily caring practices were operationalized in the unit. The behavior of individuals was not the focus of my attention. My interest lay at the level of practice and contextual influences affecting nursing activities. The tracking of individual behavior was not required. In addition, individual nurses had access to only those portions of my notes that related to them, and to them alone. At the same time, however, participants understood – and if not, I ensured they did – that other nurses, along with other health care workers and supervisors, were aware that they had volunteered to participate in the study. Thus, although I had promised to conceal the identities of participants in writing up the study and in all preliminary reports, full anonymity could not be guaranteed. There was, however, no apparent concern over this.

The term “volunteerism” is used here to indicate the voluntary nature of participation in the study, along with the fact that participants could withdraw at any time

without concern of retribution. To ensure volunteerism, I was, throughout the whole process, at pains to make participants and patients, along with their respective families, **for** cognizant of their rights. The consent form every participant was required to sign made clear the right to withdraw at any time and to have data relating to their practices destroyed. I also made available copies of an information sheet for patients and their families (Appendix E) who might have questions or concerns about the study. This document included contact information. To ensure confidentiality, any information that might have revealed the identity of a participant was removed from the data. All data was stored in a locked drawer in my office desk.

The three primary principles of anonymity, volunteerism, and confidentiality were upheld in how power relations between the researcher and the participants were addressed. Perceived benefits of the research were discussed with candidates prior to their volunteering to be participants. The primary benefit identified was that the knowledge gained from the study would better enable nurses to maintain their caring practices. At no time were nurses coerced into participating in the study. I recognized that not every nurse might be comfortable with volunteering. I asked if any of the nurses on the unit who were comfortable with my observing them would agree to let me shadow them for a day. Some nurses elected to be participants and invited me to shadow them; others did not. There were no consequences for anyone who declined to participate in the study. Using an artful portrayal to present my findings had the effect of disrupting traditional power imbalances between researcher and participant. The practice of engaging nurses in corroborating with me about my findings and vetting of the “closet drama” script disrupted the traditional relations of dominance existing between observer

and observed. As researcher, I no longer had sole authority over the writing of what was determined as truth. Nurses through their comments and discussions participated in the mapping of what was real about their caring practices. In sum, my “closet drama” represents a response to Lather’s (1991) call for new research approaches based on a politics of empowerment that foster political commitment to new forms that do not perpetuate power imbalances.

Summary

This chapter made explicit the process of ethnographic research used in the study. I explained how participant observation and journaling were used as study methods and how found poetry worked to strengthen my analysis. I explained how an artistic portrayal of the findings provided both greater transparency with respect to the analytic process and an audit trail that allowed for the evaluation of the study’s authenticity. I concluded with an explication of the study’s methodological rigor and a discussion of ethical considerations.

The following chapter includes the artistic portrayal and discussion of my findings in the form of a “closet drama”.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS FROM THE STUDY

The ordinary practitioners ... live 'down below' the thresholds at which visibility begins ... Practitioners make use of spaces that cannot be seenThe everyday has a certain strangeness that does not surface, or whose surface is only its upper limit, outlining itself against the visible

de Certeau (1984, p. 93).

Introduction

This chapter of the study includes the presentation and discussion of the study's findings. The findings are presented through an artistic portrayal, a "closet drama" of nurses' operationalization of their daily caring practices. The closet drama format is a re-representation of my field notes. It is comprised of nine acts. The title of each act is one of nine themes found to frame nursing on the unit as a collective story of 'caring comes first'. The different respective scenes reveal the diverse tactics that nurses use to operationalize their daily practices of caring. Rather than the drama depicting a universal and essential identity for caring, what the work reveals is the commonalities interlaced with differences, how nurses' discretionary judgments relate to specific patients and situations and result in caring taking different practice forms. Within each act there is a section titled "after wards", wherein a discussion of the findings are found. The discussions include analyses of how contextual influences assist or limit nurses in their sustaining of their daily caring practices in the local unit.

A "Closet Drama" of Caring

Actors in alphabetical order. (The names of nurses and patients have been changed to ensure anonymity. Nurses corroborated in choosing fictitious names for themselves).

Nurses

Amy	Lysa
Amerri	Michelle
Burt	Patty
Bob	Sharra
Colleen	Tanya
Donna	Tara
Fyora	Tina
Greta	Tyler
Laurie	Zera
Lily	

Patients

Herbie	Hank
John	Charlie
Rebecca	Claude
Shareen	Fred
Wayne	

Researcher

Joan

Production notes

The drama begins with a piece of found poetry called *Making Do* being projected onto the wall screen. The words used within the poem are drawn from a document created by nurses titled “Unit beliefs”. The poetry is left on the screen for the duration of the play.

At the beginning of each act there is a piece of found poetry; intended to create for the audience a visual image of one aspect of nurses’ lived experience in the unit. The narrator reads the found poetry at the beginning of each act. My reflections and analyses, as a researcher, are within the sections labeled “After wards”.

Prologue.

A wall video screen displays the following poem:

Making Caring Work

Believe
 'in what we do'
 'best at what we do'
 Consistent standards
 Diversity valued
 Workplace
 caring, compassionate,
 spontaneous, fun

Communication respectful,
 Non-judgmental responses
 Patients identify who family is
 who's included in communications
 how much they're involved in care

Advocating
 Education for patients
 Education for nurses
 mentors, buddies
 Everyone informed of educational opportunities
 Funding provided
 encouraged to go

Proactive approaches
 Responsibility to entire unit
 not only patient assignment for the day.

ACT 1: Making Connections: Seeing the Person

Face to Face

A new admission
 anxious pacing,
 searching gaze,
 Not understanding
 how__
 well last week
 now facing
 life threatening disease,
 a fractured life
 a before and after
 cancer being
 a defining divide

SCENE 1:

The scene begins in the conference room, back of the nursing station. Bob and Tara are reading their patients' charts. Joan is writing in her notebook.

NARRATOR: It is shortly after morning report. Tara and Bob have each been assigned to one of the two patients, Charlie and Shareen, who are about to be admitted to the unit.

JOAN: *(looking at Tara and Bob)*: Would you let me shadow you and observe you admitting your patients?

BOB: Sure, but I don't know where my patient is. She was to arrive a while ago. I am going to go check it out.

TARA: Yes, you are welcome to come with me. I am going to admit the patient right now. *(Joan and Tara walk down the hall to the patient's room. At the door Tara turns to speak to Joan before they enter the room)*

He is really anxious. Can you blame him? But, we can't change it. So, as the nurse I have to take charge.

(Tara and Joan enter the room)

Hello, I am Tara and this is Joan *(Tara looks toward Joan)*.

Joan is a nurse researcher who is observing how I work. I am here to admit you. I have this form that needs to be filled out. *(Tara shows him the admission sheet that she has in her hand.)* This form has information that will help everyone who is caring for you to have a fairly good overview of your health.

Would you like to sit here on your bed so that I can pull up a chair and sit across from you while we talk?

CHARLIE: Yes, I will sit there. *(Charlie sits down on the bed)*

(Tara pulls up a chair in front of him and sits down. They are at the same level, meeting one another eye-to eye.)

TARA: Tell me what brought you here? *(She listens intently, sitting very still, nodding her head occasionally)*

Yes, I can understand you wanting to see an ostomy nurse about concerns you have. I will organize a visit from her with you for this afternoon. Also, I noted on your admission sheet that you have a hearing problem. I want to answer all your questions and give you a brief idea of what you can expect to happen to you today, but before I do, I am wondering which ear you hear with best?

CHARLIE: It is this ear. *(Charlie points to his left ear)*

TARA: Okay, I will note that on your chart. *(Charlie is seen quietly talking to Tara. The researcher is seen writing in her notebook. Tara is seen nodding her head and listening intently before she responds)* Charlie, your health status will be followed moment by

moment and you will be involved in all decision-making related to your treatment. We will be watching to see what you need during your treatments. We will help you manage any signs and symptoms that you experience. Is there anything else that you feel we need to be aware of or that you have questions about?

CHARLIE: I don't think so.

TARA: Okay, after the doctors talk with you and we are all on the same page then I will be back, and we can talk in more detail... *(As Tara gets up, the doctor walks in. Tara smiles at the physician and then looks back at Charlie.)*

The doctor is here now. But, if you need me for anything, just press this call bell

(Tara shows Charlie the call bell and tells him how to operate it; then she and Joan leave the room.)

After Wards

What is evident during the admission is that although the admission form is at the foreground of the admission procedure, it is really the background. The foreground of Tara's work is the relational caring practices that she operationalizes, specifically her use of interpersonal communication skills. I could see her gauging what and how much to share with the patient. She clarified when information wasn't clear, building on what he understood rather than giving rote information. She listened attentively and learned new things. She used a phenomenological approach for inquiry, noting how the experience is affecting the patient. Caring practices were evinced in her spending the time to get to know Charlie in order to develop a trusting relationship with him.

Watson (2005) defines trust as a practice informing all communication. It involves laying oneself open, making oneself vulnerable. Tara's practices resonate with this definition of trust. Tara can be seen laying herself open, relinquishing her authority role as health care provider in her acknowledgment of Charlie being a knower of his own health issues and concerns. Tara participates with Charlie in the meaning making of the current health care crisis he is in the midst of; becoming a co-participant with Charlie in a process of teaching and learning about what is needed for care. Tara's practices make sense in light of Rodney, Brown, and Liaschenko's (2004) conclusion that nurses' actions arise from a primary commitment to patients, a site for moral agency wherein trust is an important component. Tara's actions exemplify the expanded definition of trust posed by Lindquist (1997), who identifies interpersonal trust to be central for an effective nurse-

patient relationship. The purpose of Lindquist's study was to investigate the lived experience of interpersonal trust in the context of the helping-relationship from the perspectives of both the patient and the nurse. Nursing practices believed to promote trust encompassed therapeutic relationship skills, humor, touch, presence, collaboration, meeting patient needs, nursing competence, and advocacy. The experience of trust for the patients was identified as a sense of rapport, positive feelings, gratitude, caring, comfort, security, hope, and self-confidence. The experience of trust for the nurses consisted of a sense of comfort, closeness, satisfaction, and self-confidence. The conclusion arrived at is that when nurses and patients trust each other they collaborate and cooperate with the other and the result is that the nurses spend more time with the patients.

Tara's practices succeed in reducing Charlie's anxiety level. In the period between his arrival on the unit and his admission, his equanimity undergoes a profound change. When we came into the room, he was pacing back and forth, appearing anxious and lost. After Tara was through with him, he was sitting calmly on the side of the bed, getting ready to talk to the doctor.

When Tara talked about "hav[ing] to take charge", I was puzzled as to what she had meant. Upon reflection, I realized that Tara's practices – staying at eye level with the patient, sitting calmly and listening intently to what he was saying, not turning her attention away from him, hearing his concerns and acting on his requests – were her practices for taking charge of a tense and potentially demoralizing situation. These caring practices keep her focused on Charlie and grounded in the present moment. Her tactics help Charlie obtain control; enabling him to take the lead in conversations. Now more confident in knowing some of what he can expect to happen, he is willing to share

information he wishes the health care team to know and ask for specific care related to his own unique needs. He is willing to articulate what he wants and needs within the present moment in time.

Following Tara's admission of Charlie, Tara read what I had written. Her response was one of surprise at all that she had unconsciously known and done. In turn, there was also a taken-for-grantedness attitude about her practices. She explained that she had cared for Charlie during his admission to the unit in the way that nurses in the unit were expected to care for patients in this unit. Her work assignment had been arranged with the intent of providing her with sufficient time to spend with him not only to conduct a holistic assessment, but also to provide time for Charlie to ask questions and share his concerns. Tara identified that having enough time with patients during their admission to the unit was essential in facilitating their transition through this very difficult time. Tara explained that work assignments for all nurses who were admitting new patients were made in this way. A consequence was that most often a relational connection was developed between the nurse and patient during the admission procedure. Because this connection was believed to be beneficial for patient outcomes, the admitting nurse often assigned him or herself as the primary nurse for that patient. As the primary nurse this meant that nurse would be assigned to the care of this patient throughout the patient's hospital stay and even during future stays in the unit. Hence, the method of organizing individual nursing assignments was one of the first contextual influences that I observed promoting nursing as a practice of caring on the unit. What I came to recognize was the possible value of examining patient outcomes based on the method of organizing nursing assignments in a particular area.

Tara's perceptions seemed to capture Watson's (2005) description of the science of caring as a process that requires the nurse to look into the face of the individual and see him or her as a person: a relationship developed through a process of caring between the healer and the healee that requires rigorous discernment by the nurse: a process that might or might not involve a cure.

SCENE 2:

NARRATOR: It is early afternoon of the same day. *(A stretcher, carrying a slim dark-haired woman, is wheeled through the door to the unit).* The patient was expected to arrive earlier in the day but, instead, was taken directly to the catheter lab for the insertion of a Hickman line. Then she was taken up to the wrong ward. During the procedure she became confused as a result of the medication she had received and was incontinent of urine.

The patient, whose name is Shareen, is crying quietly, tears running down both cheeks, and avoiding eye contact.

Joan follows Bob into the room as he helps the porter move the stretcher beside the bed.

Joan moves to the far corner of the room.

BOB: Hello Shareen. I am your nurse. My name is Bob. I am going to get you moved from the stretcher into a much more comfortable bed. I will get you some warm water for washing up and make you more comfortable right away.

SHAREEN: I'm so embarrassed. Why am I here?

BOB: *(While moving Shareen to the bed)* You were taken to the wrong unit. You are exactly where you need to be now. We have been expecting you. *(At the same time that Bob is talking to her, he is checking the insertion site from the*

procedure, the dressing, the infusing solutions, and her physical status. Before she even realizes it, she is bathed and wearing a clean gown and pajama bottoms)

I am just changing your dressing because the area around the procedure is oozing just a bit.

SHAREEN: It is a bit sore.

BOB: I will go and get you something for the pain right away. I am finished here. I will get you something to drink. Would you like water, Gingerale, Sprite or Fresca? Sorry, but there's nothing to put in it!

SHAREEN: *(laughs)* I'll have a Sprite.

Bob leaves the room. Joan, who is standing near the door of the room, hears Bob talking to the ward clerk at the desk

BOB: So, what does this mean that she isn't in the system yet? Can I get the medication?

JOAN:*(reflecting on what she observes)* The problem Bob is alluding to is that because medication administration is now lined with a computerized program Bob cannot get the medication from the drawer in which it is stored until the patient has been registered in the system. The drawer won't open. I wonder how Bob will get around this problem. Within institutions, practices are never as simple as they are presented to be. Creativity is a must! Oh, there is Bob. He has obviously outwitted the technology somehow because he has the pain medication as well as a soft drink.

BOB: Shareen, here is your pain medication and drink. Now I am going to change your dressing and have you tell me what you know about why you are here and what will be happening to you. I will be asking questions because I don't want to be

repeating what you already know. So, make sure you ask questions if you don't understand or ask me to repeat things if you don't hear them... Let's try for little bits of information, slowly, so that it isn't too much.

NARRATOR: While listening to her account of what she is expecting to happen, Bob clarifies the information she shares, picking up on current health issues and serious financial issues that the family is facing as a result of her prolonged illness. Bob confronts the issues he is hearing.

BOB: Would you like to have the social worker and dietician come to see you and explore some possible options with you?

SHAREEN: Yes, that would be alright. (*Shareen closes her eyes, pulls the blankets up around her neck, and takes a deep breathe.*)

BOB: Are you on any restrictions related to your diet?

SHAREEN:(*opens her eyes and laughs slightly*) Yes, I am on a see food diet. When I see food I eat it!

After Wards

What is amazing here is the seamless way that Bob weaves all his nursing practices together. While doing his assessments, he is, at the same time, collecting information related to Shareen's experience of her illness, reassuring her that she is now in the right place, answering questions, involving her in decision making, implementing hygiene practices, providing comfort measures and pain relief, and changing her dressings. His caring practices function to decrease her embarrassment and give her back a sense of control. Involving the social worker and dietician creates a space for her to talk

about the impact of her illness and hospitalization on her family and her life at home. It creates a space for envisioning new options. His tactics help her in her transition from home back into hospital as a result of her need for further treatment.

Tara and Bob's encounters with their patients reveal how cancer is like a huge tear in the fabric of both patients' everyday world. It fractures one's life world, not only in a purely physical way – the result of admission to hospital and the effects of the disease and treatment – but also in a socioeconomic respect. Shareen struggles with financial issues, child care costs, loss of employment earnings, and house payments. Charlie faces social and emotional issues, these being related to living a considerable distance away from the hospital and thus being separated from all that was familiar and his social networks of support. It is so much more difficult for anyone to come to visit him owing to the additional costs relating to travel and local lodgings that the visitors would incur.

SCENE 3:

The clock on the wall reads 1500 hours. Joan is meeting with four nurses who are in the conference room. The nurses are reviewing their patients' charts and making notations. Joan is talking with one of the nurses.

JOAN: Caring seems to be a very important part of your practices on the unit.

FYORA: What do you mean by caring?

JOAN: *What I mean by caring are the relational practices that you as a nurse use to ensure that your patients are seen as persons and that their unique needs are addressed.*

The other nurses enter into the discussion.

GRETA: On this unit caring makes us what we are: what patients see and feel; what families see and feel. Although we as nurses are usually the first responders because we are the ones here all the time who really get to know the patients, by the same token the social worker and every team member responds to patients needing help – answering call bells and doing what they can. But, not doing what you don't know. The message of caring on this unit is a very rare team approach.

AMY: We do work together. But, you have to learn to speak for yourself; you don't speak for others.

GRETA: You have to take a deep breath and look at what you can control. A sense of control is gained by being proactive, never letting yourself feel helpless or hold on to anger. Anger is not complementary to what we are doing.

LYZA: You have to be proactive and advocate with your patients. To be proactive you have to seek to understand, reflect, and then come back to what your patient wants to happen differently.

AMY: I try to teach new nurses that if you can't be heard advocating for your patients then make sure you give patients the information – and educate patients to what they need to know so they can be an advocate for themselves.

After Wards

The tactics that the nurses use to operationalize relational caring , on the unit, resonate with Watson's (2005) understanding of caring as heart-centered evolutions that are very different from traditional head-centered practices. She identifies that one of the major ethics underpinning heart-centered practices is an "ethics of face" (p. 144), wherein, by looking at the individual person who is directly in front of you and seeing

them as a person, humanity is sustained. By looking into the face of another, one sees not an object but a unique and special human being. Thus, the person's face serves as a mirror of one's own uniqueness and serves to resist the totalizing of one's own humanness.

The insight that I gained from the above observations is how formalized chart forms skew how nursing is interpreted. Although I know that the admission form is a strategy of imposed order that predetermines what information nurses are expected to collect from patients, I seldom think about what would be missed if admitting a patient was reduced to just the collecting of information on the form. The filling in of the admission form is merely the tip of an iceberg amidst Tara and Bob's many other activities. Therefore, although the completion of the form foregrounds the admission process, it is the least of their nursing responsibilities for their patients.

My observations reveal how formalized chart forms, such as the admission form, are a mechanism that functions to privilege head-centered activities over heart centered activities. There are predetermined. The questions and categories are designed to direct nurses to fill the blank spaces with a certain kind of information. The heart-centered practices of caring that function to help patients deal with the shock of their diagnoses and the transitions they face are not an evident part. The heart-centered practices of caring remain invisible. This invisibility of caring work is noted in Tara's comment, made after reading my observations of her admission practices: "I didn't realize that I did all that!" It is also apparent in one of Bob's facetious comments: who jokingly says, "This makes me want to work in that unit. Oh, just a minute! This is me! I do work there!"

ACT 2 Creating Form

Changing frameworks

*A nurse gets up
 closes a door
 behind it a patient sleeps
 A delightful middle aged man
 used to being in charge
 a very rough night
 a journey*

*Let him sleep
 limit the noise
 Gain strength for the day*

SCENE 1:

NARRATOR: It is 7 am on a beautiful, sunny summer morning. The morning report on the unit has just finished, and the researcher is going off to shadow Tyler, one of the nurses who works on the unit. Tyler has been assigned three patients that she will be caring for today. Presently, Tyler is seated at the nursing station by the computer, busy writing on a blank sheet the information she determines that she will need for the day. Each of the other nurses on the unit are busy doing the same thing, the finished product being called by many of the nurses their “cheat sheet”. When asked, the nurses were unable to explain the reason for the name.

TYLER: If patients only knew how long it takes to prepare before going into their rooms....

JOAN: How do you prepare?

TYLER: I do a quick preliminary check of all my patients’ current information. I check medications, vital signs, glucose, weight, blood counts
(looking down at a chart as she talks out loud to herself) White cells are going down as supposed to. His hemoglobin and platelets are going down. But, I still

need to pay attention to his ability to fight infection. (*looking back toward Joan*) I do a quick look through the chart, sign signature sheets, check doctors' orders, compare nursing notes to physician notes. You can see here that the doctor noted renal function is improving based on blood work. Both physician and nurse say chest is clear during the day. During the night, nurses hear crackles in the bases. By 6 am he is short of breath --- I better check that.

(*While Tyler writes what she is planning for the day, she is interrupted by a medical resident who is looking for the medication administration record for insulin.*)

MEDICAL RESIDENT: Excuse me, I can't find how much insulin is being given. It isn't charted.

TYLER : (*looks up*) Insulin isn't charted on the medication administration record. (*Tyler stands up and shows the resident where she can find that information on the chart.*) You'll find the information on this sheet behind this form. (*Tyler sits back down to resume her review of her own patient's chart.*)

MICHELLE: (*Comes out of her patient's room and walks up beside Tyler*): Do you have a minute? (*Tyler looks up from her review of the chart*) I have a question. I need help with the lines; one line doesn't seem to be working right. There is a lot of pain. when I attempt to run medications into the other line.

TYLER: Have you tried to irrigate the line?

MICHELLE: Yes, it seems to be running.

TYLER: I'll come and have a look? (*Leaves the desk to go with Michelle into the patient's room*)

After Wards

What is obvious from watching Tyler prepare for the day is that there is little resemblance between the activities that she is noting on the form she is creating and the predetermined activities on the formalized care plan. I am reminded of my first day as a nurse researcher on the unit. Listening to morning report is like listening to a foreign language; I understood little of what I was hearing. The reason for this is exemplified in watching Tyler construct her practices for the day. Tyler's activities go far beyond the list of activities identified in the standardized form. The many new activities that Tyler is writing down are gleaned from her collection of data during morning report and from night nurses notes on the patient's chart. As she thinks out loud her reflective and critical thinking skills are easily identified. What I hear are analyses drawing upon practical knowledges that form a unique part of the nursing culture on the unit. My observations reinforce that the nurses working on this unit require an extensive knowledge that goes far beyond anything they might learn in nursing school. Just a few of the different knowledge perspectives I hear Tyler using are: medical perspectives required to interpret what is happening physically as a result of the disease process; knowledge about medical and nursing protocols and procedures related to the treatments for specific illnesses; particularities related to hospital and unit policies; computer knowledge related to how to access and utilize knowledge; knowledge needed to prepare patients for and coordinate care for patients requiring services from related areas; knowledge of how to discuss with patients and families issues and implications related to difficult life altering situations. The nursing challenge that I see Tyler embracing is that of linking the specialized medical knowledge specific to each patient's health issues with nursing knowledge about

the patient as a person, how the patient is responding to the illness and treatments, and what the patient wants for care, a sine qua non so that Tyler can operationalize the care that is needed for the patients she is caring for during the shift.

As I watch Tyler forming an outline of the day's anticipated activities, I note that she leaves considerable space for additions. Her loosely drawn up activity form is more a work in process than a predetermined formal structure for outlining her nursing practices for the day. Rather than a normalized script, Tyler's creation more closely resembles stage directions for an improvisational theatre production, wherein there exists lots of room for individual initiative and creative expression. So too, the activity form leaves ample scope for improvisation to be enacted within the drama that is everyday nursing on the unit. There exists space for modifying daily caring practices in accord with cues from patients and families.

My observations of nursing on the unit concur with what Fairclough (1992) identifies as being the discontinuities between the technomedical view of illness and the nursing life world view of illness. Fairclough highlights how medical approaches are based on analysis of biological systems and how nursing approaches are based on phenomenological analysis of lived experience. Technical medicine is viewed as a rationality that treats the world of illness in terms of context-free clusters of physical symptoms. Nursing, on the other hand, is understood as a study of patient's lived experience with a particular phenomenon, one that features a rationality that places illness in the context of other aspects of the patient's life. The latter reinforces that caring is never a linear process. Caring is always a contextual process, one characterized, moreover, by contingency.

Nurses' creation of what some nurses call a "cheat sheet" is a recognition of the discontinuities between what is noted on standardized forms and the information needed to operationalize nursing care. There is a recognition and acceptance of how practices cannot always be predetermined. The form that Tyler creates provides space for posing questions, for exploring, noting unexpected happenings, keeping track of newly needed or changes to practices. Hence, the "cheat sheet" is a nursing tactic for coping with contingency. The name itself being an apt description for how nurses become deviants by constructing a new process and form to direct care that challenge the adequacy of the current system of organizing information. The "cheat sheet" is an unarticulated acknowledgment of discontinuities between medical and nursing views as identified by Fairclough (1992).

What I reflected upon was how formalized documents such as the nursing care plans, the admission form, and the doctors order form create an illusion of what it is that nurses do. Although these documents reveal important parts of nursing, they also function to subjugate nursing knowledges. This subjugation of knowledge is a result of an assumption that the standardized forms will provide all the necessary information needed to ensure the implementation of essential care. The spaces between the black lines serve as the designated areas where nurses insert information, while at the same time functioning to limit the amount of information that nurses share. Thus certain knowledge practices remain undocumented. Hence, they remain invisible as the hidden part of nurses' work. The black lines become like closed doors and deep crevices that obscure important nursing practices.

SCENE 2: *Joan enters the nursing station where Lily is working at the computer, checking her patient's diagnostic test results. She looks up and smiles at the researcher, then resumes her work. Moments later she murmurs to herself: Why is that on the low side? The night nurse said his face was red. Did I miss that? Better check. (Leaves to go into for the patient's room)*

DONNA: *(A junior nurse, looks up from her chart)* Hi, I am still here. It takes me awhile in the morning.

COLLEEN: *(joins in the discussion)* When you are new, it is really hard work to make sense of everything. Skills are the easiest part. Learning how to care is the hardest. For you are figuring out what medications to give, how to do assessments, and what to do with them and all that. You are not operating at a level that you think introspectively how to work with patients and their families. That takes a lot of reflecting and energy. You need to get comfortable with what you are doing before you can get to that level. On this unit you learn about caring.

SCENE 3 *(A short while later, Tina comes over to Joan, who is now sitting at the nursing desk.)*

TINA: Would you like to come and watch my morning assessment for my patient, Claude. I am his primary nurse.

JOAN: Tina, that would be great. Thank you.

NARRATOR: Tina and Joan enter the patient's room to be greeted by a spectacular urban vista appearing through the large window directly opposite the door. At the same time the sour, musty odor of perspiration that has dried on the skin of someone with a

fever, is evident. The humming sound of three infusion pumps can be heard faintly. Claude is hooked up to five different infusion lines through which various fluids are being administered. Though according to the morning report this patient is supposed to be slightly confused, it is apparent that he recognizes Tina. As he tries to smile through a pair of cracked lips, a swollen tongue and inflamed mouth can be seen. His speech sounds muffled as though he were trying to talk with a mouth stuffed with cotton batten.

CLAUDE: Hi. Nice to see a face that I know!

TINA. (*Looks him in the eye, smiles, and talks with him all the while checking the infusion lines, pumps, and site*) Hello, how are you feeling today?

CLAUDE: I didn't sleep very well. I was thinking, and I thought I was being kidnapped.

TINA. Sometimes the medications you are on can make your mind race – lots of thinking----

CLAUDE: Yes, and I was thinking about little things – things I need to tell my wife.

NARRATOR: As Tina listens to Claude and responds to his comments and requests, she continues morning assessment, checking for any changes in his condition that may have occurred since his previous shift. . She listens to his chest, takes his vital signs and checks his dressing. During the assessment, she talks of the progress he is making and about those areas that require further improvements before he can return home. Claude listens attentively, and then both talk about how to organize his care for the day: his bath, treatments, scheduled test for 1000 hours, and time to rest before his wife arrives to visits.

What is obvious is that Tina and Claude know one another: Tina has cared for Claude before. I note how much easier it is to organize care when the patient and nurse

know one another. They have a history of how to work together. Tina has a baseline to better evaluate change and is familiar with Claude's preferred activity regimes. They can both pick up from where they left off, rather than spend time and energy reviewing past patient history.

After Wards

Reflecting upon my observations, I came to realize how nurses being the constants on the unit results in two competing effects on nursing and nurses. First, it makes nursing unique. Being the constant within the unit facilitates nurses' physical proximity to patients and their ability to know and understand the particularities of individual patient's responses to their illness and treatments. This is evident in Tina's care of Claude. Being the knower of such particularized knowledge marks nurses as unique. Nurses use this knowledge in the individualizing of patient care. At the same time others draw upon nurses for assistance in organizing their own practices. Nurses are the resources for anyone coming to the unit: other health care disciplines working within the unit, student nurses, nurses new to the unit, medical residents, patients and family members. As constants, nurses are expected to know what is going on with patients. They are relied upon by others to provide information about system issues related to the functioning of the unit. Consequently, nurses' work is always being interrupted. The extra additional time nurses allocate to dealing with these interruptions and the work resulting from these interruptions remains a hidden part of nurses' work. Thus, the second effect of being the constant within the unit is that nurses can be worn out.

ACT 3: Making do

The Act of Creating: Maneuverability

*A beautiful vibrant young woman
Brown eyes filled with humor and dread
A recurrence of cancer
in a fight for her life*

*Her husband beside her
a constant support*

Amy helping her live in the moment

*Caring an unfinished drama
of dexterity, ease,
freeing feelings, emotions, and thoughts*

SCENE 1:

NARRATOR: Amy, followed by Joan, leaves a patient's room, having just completed her initial morning assessment. She explains what she has observed while recording information that will later be charted. Proceeding down the hall, they arrive at her second patient's room which is near the end of the hall. Entering, they find the patient's husband sitting on the side of the cot in which he sleeps. His wife Rebecca is lying supine on the bed visiting with him.

HUSBAND (*looking up and seeing Amy, he smiles in recognition*): Hello there!

AMY: Hello, I have brought someone along with me. This is Joan. She is doing some nursing research and will be following me around for the day. Is that all right with you?

HUSBAND (turning his attention toward Joan): Well, you are with the right nurse. She is the best!

AMY: (*smiles at Rebecca*) How are you today? I heard you had a Hickman line put in yesterday.

REBECCA: Yes, Bob was there with me. He's the one who got me through it without

fainting. Just being there, right beside me and talking me through it helped me not to pass out.

Joan leaves the room and walks back to the conference room.

JOAN: (thinking to herself) Observing Amy work is like watching a symphony orchestra perform. Her actions flow and are woven together in a seamless, effortless way. Amy is fully engaged in what Rebecca and her husband are saying performing all the the activities required for a thorough assessment. Even while listening, answering questions, teaching, checking infusion sites and solutions, taking vital signs, listening to chest sounds, and checking for circulation status, she continues to maintain eye contact. It is obvious that a trusting relationship has developed between all three: they know Amy and Amy knows them. The benefit is that Amy is able to base her actions on more holistic assessments, building on what she already knows and has tried.

After Amy leaves the room. Amy turns and speaks to Joan.

AMY: I'm addicted to the process of going in cold, talking and listening, picking out pieces, plugging important ones in. It's not just getting the task done – nursing is much more than that. Caring takes a lot of energy and knowledge. A lot of caring isn't languaged; it's enacted. There may be a seeking of boundaries and lines, but they don't work. For, caring is not a business. There is no line between us and them. There is a way of coping and being appropriate, but there is no line. We might be in that bed tomorrow.

JOAN (*thinking aloud to herself*)

Amy's caring practices mirror what Diderot calls "*bricolent*" (in Polkinhorne 2004, p. 66). It is the everyday art of making do; the adapting, designing, and operationalizing of activities required for the day. It is a kind of knowledge that requires creativity, tolerance of ambiguity and execution of intelligence which go largely unnoted. Most of this knowledge can't be appropriated or put into words. Thus, Amy's notion of caring as something that is enacted, not languaged, is consonant with the concept of *bricolent*. Amy's operationalizing of caring practices is a complex work of art that goes unnoticed by everyone in the room but me. Her practices are elusive forms that appear and are then gone and forgotten. They survive only because I record them in my field notes.

Of note are the contextual and personal factors that support Amy in operationalizing of caring practices. One such influence I noted is the lower patient-nurse ratio that is a norm in specialty areas. Another is Amy's long experience working in the area which accounts for her expertise and confidence. A third is design of the one and two person rooms that ensure conversations are not easily overheard and care can be administered in privacy. A fourth influence is that primary nursing is the mode of organization for nursing on the unit and it promotes the continuity of care by the same nurse. It supports the development of a strong relational connection, such as those that have occurred between Amy and Rebecca and Amy and Rebecca's husband. A fifth factor is that the unit is a high profile, highly specialized oncology unit. I had expected that this would work to limit nurses caring practices. Kuhse (1997), Heartfield (1996),

and Heslop (1998) argue that medical specialization, along with the increased use of technology that characterizes it, has a negative effect on nursing practices of caring. This unit, however, appears to challenge what is a generally held notion. Physicians rely heavily upon nurses for their particularized knowledge of patients. Cancer does not progress in a predictable and uniform manner. Patients present with variances in symptoms to the same type of cancer. The distinct and particular nursing knowledge that nurses provide regarding patients' unique responses to cancer and different treatment regimes is valued and deemed essential by physicians responsible for directing medical care; such knowledge supports physicians in their diagnoses and treatments. Thus, the increased legitimacy of nursing knowledge lends increased authority to nurses' caring practices.

Of equal significance so far as my reflections about relational caring are concerned is that Amy's close relationship with Rebecca and with her husband puts in question the assumption that professional boundaries are essential for effective care. Amy resists the idea of professional boundaries and is open to the notion that the nurse-patient relationship progresses like any other. Richardson (1999) concurs with this view, arguing that there are disadvantages to setting boundaries that result in one disconnecting oneself from others. In contrast, opportunities for engaging in life affirming practices present themselves when one connects with and witnesses another person's life. "In walking with' we are embodied, self-consciously reflexive, partial knowers, conveners, ministers, -- not 'insiders' or 'outsiders' " (p. 185). 'In walking with', one witnesses and hears testimony from others and comes to view them as shadows and doubles of oneself.

After Wards

De Certeau (1984) argues that the art of *making do* is not without science. It is an unrefined knowledge of actions, where words have not yet been found to describe the techniques. De Certeau uses the word “tactics” to describe the maneuverability of the art of *making do*. The term “indeterminate trajectories” is used to indicate a temporal movement through space, describing how tactics do not cohere to the constructed, written, and prefabricated space of a technologized society. Tactics “circulate, they come and go, overflow and drift over an imposed terrain, like the snowy waves of the sea slipping in among the rocks and defiles of an established order” (p. 34). *Making do* is viewed as an art of creation, a performance.

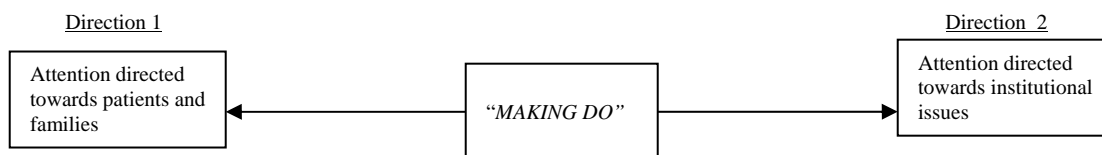
My analyses revealed how nurses’ practices of caring have both similarities and differences to de Certeau’s definition of *making do*; a consistent theme of caring practices on the unit. Phenomenological inquiry as characteristic of caring practices represents an essential component that sustains *making do*, keeping nurses open to whatever presents. *Making do* functions to maintain a focus on the unique particularities of each patient’s situation and experience with illness. Moreover, *making do* challenges the assumption that professional boundaries are beneficial and serve to enhance nurses’ abilities to envision alternative possibilities for action. Yet, of equal significance is that *making do* is also a fault line for caring practices. Nursing skills of *making do* can draw nurses into directing their attention towards issues not directly related to nursing; often system issues related to system problems. In the aforementioned *making do* was seen to be an unrefined knowledge practice that enabled nurses to create a space for patients to participate in the assessment, diagnosis, implementation, and evaluation of their own

care. Nurses ability to corroborate with patients and other professionals in the envisioning of alternatives and the enactment of different practices was seen as beneficial to care.

Nurses *making do* was recognized as an art of creation that involves nurses' integration of their background knowledge with the reflective knowledge gained through conversations with patients, families, and other professionals.

Of note, *making do*, as a faultline for caring practices, was not a result of nurses focusing their attention on institutional issues. The problematic was nurses' uncritical acceptance of the responsibility for solving institutional issues not necessarily related to nursing. Hence, *making do* had the potential for limiting caring practices by directing nurses' attention away from patients, becoming a constraining factor for nursing practices. *Making do* became a site for the complicity of nurses in the maintaining of hegemonic norms in healthcare.

Figure 1: The two directions of *making do*



What I realize is that the two directions of "*making do*" are a result of nurses being the constants in local areas and becoming looked to for the coordinating of interdisciplinary care.

An example of nurses being drawn in the direction of institutional issues is the nurse on the night shift who stayed overtime when a nursing colleague called in sick. Even though she was working the coming night she stayed for a good part of the morning until another nurse was found to replace her. A second example of nurses being drawn

into institutional issues was the way that the nurses on the unit responded to a national political agenda. The clinical nurse educator on the unit was directed by administration to coordinate an interdisciplinary team meeting to gain buy in for a national initiative intended to reduce the increasing rate of incident reports related to drug and treatment problems for patients in hospital. During one meeting, errors and potential errors were identified as a result of problems with recent computer systems installed in pharmacy for the labeling of medication times. What wasn't being taken into account was the incompatibility with times for other patient medications. During another meeting a problem was identified in the current system for physicians re-ordering medications. At both meetings, nurses were the ones who identified and assumed responsibility for implementing solutions. One solution was the increased tracking and assessment by nurses of whether the times on the medication labels from pharmacy were accurate. A second solution was for nurses to assume responsibility for checking if physicians' re-ordered patient medications. What went unacknowledged was that the problems did not originate within nursing. What went unaccounted for was the increased work for nurses that took time away from patients. In discussing the impact of the hidden work on nurses, one of the nurses responded by saying that 'making things work is what nurses do'.

Of note was how easily nurses are drawn into caring for the institution and serving other professionals because nurses care; they care about patients and they care about others. Because they care, the cost to nursing, nurses, and patients of nurses taking on and solving others' problems goes unexamined. The possibility that nurses doing such may adversely affect patients care goes unacknowledged.

ACT 4 Tolerating Ambiguity (Uncertainty)

Not Easy

Lying propped up in bed

Conflicted feelings revealed

A smile of greeting,

aggression, manipulation

directed towards nurses

A tough road of treatment ahead

SCENE 1:

NARRATOR: During morning report, Tanya informs everyone that Bick, a long time drug user, has been readmitted for the recurrence of his disease. This patient is known to have mental health issues. Currently Bick's aggressive manner and skill at manipulating caregivers represents a challenge for nurses. After report, the doctors, a social worker, the patient- services coordinator, Tanya, and Bick and his father are to have a meeting to discuss treatment issues. There is no current agreement among members of the team as to what would be deemed appropriate treatment for this patient. The father assumes the meeting is about coordinating plans for his son's treatment. But, the underlying purpose of the meeting for the team is to arrive at a decision as to whether Bick is a suitable candidate for medical treatment.

Later in the day, Tanya has a conversation with Bick's father that she discusses with her colleagues. The discussion takes place in the nurses' lunch room. There are 5 nurses including Tanya.

TANYA: I tried to be realistic while trying not to diminish hope. Bick's father thinks that a more aggressive treatment is the best option for his son. The medical team doesn't think so. They haven't cancelled it out, but they have said that they need to see how Bick does with the initial treatment. So, I told his Dad: "There are steps to go through in treating his disease and he needs to go through each step

of treatment before going to the next one. The treatment you are thinking about is a very complicated procedure, and it is not the first step. It requires a great deal of follow up and compliance with medications. That step might be very hard for your son. It doesn't seem like follow-up and compliance are a strong suit for Bick, are they?" It was here that Bick's Dad started to cry *and said, "I don't want my son to die."* After he finished crying he said that he agreed that Bick would need to take it one step at a time. But, he admitted it was really difficult for him to think about not doing everything that could be done.

BURT: I know how difficult it must have been to be so direct. Yet, patients and families need to be aware of different potential scenarios – that you go down a particular path, then if you hit a wall, you stop, and do something else and continue like this till the end of the route.

TINA: It's hard to always know what to say because prognosis for patients undergoing treatment is really a best guess. Patients will be undergoing treatments that have all the right reasons for success, and they don't do well. Then, a patient, whom we do not expect to do well, lives.

BURT: It's important not to be secretive. If you keep patients well informed and you are both on the same page, you can have a better relationship. They trust you and this trust sets you up for better conversations, like Mrs. Wolf saying to me, "This has been on my mind (*Burt has turned towards Tanya; you can no longer hear what she he is saying.*)

TYLER: What I have come to realize is that it is easy to get judgmental and think that you know the right thing to say and what they should do. But, I always try

to remember that no one knows how they will respond – One can anticipate but never know.

JOAN: How do you not judge?

TYLER: I look for the patients' strengths and work with those. I'm like a coach in this job a lot of time – there is a shared responsibility

AMY: I try to stay open, avoid dichotomies. If there is a right and a wrong, then it is easy to blame or judge others.

After Wards

Nurses' caring practices are embedded with theories and models that the nurses seldom, if ever, made specific mention of in day-to-day discussions. I would doubt that they realize their discussions are embedded with such array of different knowledge practices. These discussions evince a knowledge and use of interpersonal communication theories originating from in the human sciences. Watson's (1985) carative factors are evident in nurses' sensitivity to self and others, acceptance of positive and negative feelings, and development of trusting relationships with patients and families.

Phenomenological inquiry is a process of discovery that the nurse could be heard using in her exploration of what it is the patient and his father wish in the way of medical care. In addition, teaching and learning are made visible as a combined process of inductive and deductive thinking. Nurses discuss the importance of listening to patients' lived experience with their health issues while using problem solving skills to envision possibilities for care that would seem appropriate. The nurses' commitment to patients being included in the process of decision-making process and having options for care is evident in the emphasis on advocacy practices. Finally, the nurses reify that patients need

to know what is happening in order to decide on options because they are the ones who have to live with the consequences.

SCENE 2 (As they walk along the back hallway, Amy is talking with Joan about a nursing project involving aromatherapy that was introduced on the unit a couple of years previously but was recently discontinued.)

AMY: There is so much discomfort when trying to care for people who are ill – to mobilize patients who are in pain or dealing with severe nausea or vomiting; getting them involved in their own care, dealing with elimination issues. Not everyone does the same thing to help alleviate problems . There are different ways of doing things. But, the basis of caring is valued on the unit. I have my own ways. Everyone cannot do the same thing. There are different ways of caring.

JOAN: Is there an openness to alternative therapies that might help patients deal with their symptoms?

AMY (*smiling*): Alternative therapies are spoken of as valued, but, not in practice. I wish there was a model to follow. Maybe there will be if we persist – There is plenty of talk. But, how do we operationalize it? How do we show that it is valuable? I am interested in the continuation of an old project. A nurse who previously worked on the unit did a lot of work with aromatherapy when she was here. At present I am working at formalizing aromatherapy and therapeutic touch on the unit. A dream of mine is to bring acupuncture onto the unit and have an RN as a liaison for alternative therapies available to patients on the unit.

After Wards

For nurses, a high level of creative synthesis and critical evaluation are essential to operationalizing their caring practices. Nurses pay attention to the uniqueness and subtleties of the particular nuances of each patient's response to disease and treatment. They treat patients with kindness and respect. They talk to and listen to patients. They look patients in the eye maintain eye contact with patients and pay attention to what is going on. They discuss patient assessments with their peers when they have questions, examine different options, and seek to identify better ways and means of addressing their patients' patient needs. Nurses draw upon support from one another while they talk, reflect, and critically analyze uncertainties and options related to what seems best for patients – this being particularly true in oncology, where patients with the same diagnosis present so differently and have such varied responses to the same treatments. I could see how nurses on the unit feel supported by one another's mutual tolerance for ambiguity.

Within the unit, nurses' tolerance for ambiguity appears to counter the desire for uniformity that Tully (1997) identifies as one of the major blocks obstacles to appreciating and honoring difference. By not being rule bound in their practices, nurses challenge the overriding central tenet of bureaucracy: as a pursuit for the elimination of uncertainty through the control of knowledge using practices of uniformity and implementation of uniform practices (Ferguson, 1984). There is a space created for nursing discriminatory judgments and reflective thought.

The theme of tolerance for ambiguity in the unit relates to a mode of thinking Arendt (1995) calls "thinking without a banister" (p. xvii) and which she defines as "thoughtfulness". What this involves is an act of thinking that shuttles back and forth

across the gap that separates the experience of everyday life from the contemplation of it. It requires one to start thinking about some phenomenon or event as though no one has thought about the happening before and then start listening to and learning from everyone else. This approach challenges one, first, to think for oneself and, second, to use an inductive process of thinking that goes beyond the traditional deductive thinking mode of problem solving. From my observations, it is obvious that nurses on the unit are using thoughtfulness as a central part of their caring practices. This is reflected in their openness to what patients are feeling, attention to the opinions of other team members, ensuring that they have up- to- date reports of current issues, and, finally, in their creative and informed approaches to care.

ACT 5: Committing to Diversity, Dealing with Differences

Nursing: A political event
Manage time,
Anticipate care
If one patient goes sour,
everything sideways from there
To be informed, essential
Discuss, confront,
persuading others
Teach patients
how to advocate
for themselves

SCENE 1:

NARRATOR: It is 7am on a cool, cloudy autumn day. Morning report is taking place. The nurses are listening intently. The atmosphere is filled with tension: not only is the acuity on the unit uncharacteristically high; a number of the patients are not doing well. There is an added weight of sadness on the unit, one of the patients has just died.

TYLER: (*When completing a report on one of her patients, Tyler addresses the group with an intent seriousness*) We have a problem here. Fred's pain is not being managed. He is having IV analgesics every hour, oral analgesics every three hours, and on top of his extended relief he gets breakthrough medications. In spite of all the meds, this combination isn't working. In addition, it isn't realistic for us to be going into his room constantly to administer meds. Why doesn't he have patient controlled analgesic? Why hasn't the pain management team been contacted?

SHARRA: The physician has been talked to, but he hasn't contacted the team because he doesn't think that the team will do anything he isn't doing.

TYLER: That's ridiculous! The pain management team are the experts and something needs to be done! The physician is just placating the patient rather than dealing with this very complicated patient's issues. He is a drug user. He is anxious, not outwardly stressed, but talking about lots of issues! He's using drugs for coping.

SHARRA: What about methadone?

TYLER: That's an interesting idea. I don't know if it would work but maybe. So, we won't wait for rounds to discuss this. We will talk with the physician as soon as he arrives, or this will drag on and not be addressed for another day.

(After report, the two nurses leave the room to talk to the physician who is just arriving on the unit).

SCENE 2: (Later in the day, Joan is discussing the incident with Tyler.)

JOAN: What was the outcome of your talk with the physician?

TYLER: I told the physician how much morphine Fred has had in the last twenty-four

hours and discussed the patient's ability to cope or lack thereof. I requested that he involve the complex pain service to help us get this patient's pain under control. I know the physician thinks that he should be able to deal with the pain management issue, but I know the patient and recognized that he is dealing with much more than just pain. I communicated this to him and stressed that Fred has the type of issues that is the complex pain service's specialty. The outcome was that the physician consulted the complex pain service team.

JOAN: What do you think made him hear you?

TYLER: Persistence. It is a large and frustrating part of nurses' work on the unit. It is a frustrating part. There are different levels of commitment and many different factors, such as knowledge, level of experience, comfort in the unit, and one's own personal life and commitment to persisting. A couple of nurses have voiced their concerns about Fred's situation to the physician, but maybe they didn't feel comfortable with pushing, wanting to go the extra mile, or committing enough energy.

JOAN: Is persistence the key factor?

TYLER: Not only persistence. You have to feel like taking on the challenge of confronting issues. You don't have to. You can get through the day without taking it on and give good care – adequate care. But you won't be giving great care. For great care, you have to go the extra mile. You have to make sure that you are familiar with the patient. With regard to Fred, I decided today that that was what I was going to accomplish; speaking to the doctor and getting some action for improved pain control. It would have been very easy for me to just keep giving

him all the morphine that he wanted, whenever he felt he needed it, but, that isn't helping him. He has become focused on the dark, just waiting until he can have his next medication. He needs to see the complex pain service. Plus, I spoke with Fred about the fact that he may never get a zero level of pain. This changes his focus. If he can get to a livable level, then he may learn to live with pain in a different way.

JOAN: *(talking to herself.)*

Tyler's comment about 'going the extra mile' makes me realize how easily caring practices can be moved to the margins or erased if confrontation and persistence aren't the norm for nursing practice in local cultures. Tyler, a nurse with many years of experience, identifies the effort it can take to challenge privileged medical norms. It makes me wonder how nursing students might be better prepared to advocate on behalf of their patients. Questions raised for me are: Should students first be placed in units that model agency and relational practices of caring? If it takes nurses in this unit two-to-three years to operationalize caring practices, how can students learn to operationalize caring unless they are placed in similar areas. Does more careful assessment of what students will be learning need to be done before we send them there? Should students be assigned to sites causing dissonance, only after students have learned how caring practices are operationalized, or not at all? How can nursing students or nurses recognize how caring is being affected by contextual influences if they don't have a solid understanding of how daily caring practices are operationalized?.

After Wards

Advocacy and persistence are tactics used by nurses on the unit to position themselves as social agents. Advocacy is a tactic used to support the unique differences that distinguish patients. Nurses talk with their patients about their right to expect that they, i.e., nurses, advocate on their behalf. Nurses provide patients and their families with education needed to advocate on behalf of themselves. Nurses' explore the concept of advocacy in ways that help patients self determine. These practices concur with conclusions on the part of other nursing scholars that this is a critical role that nurses play (Bevis & Watson, 1989; Brown, Rodney, Pauly, Varcoe, & Smye, 2004)

Persistence is another tactic that the nurses use to resist the limiting of caring. Persistence is viewed as being necessary for ensuring patient care to be excellent or great. It requires nurses 'to go the extra mile'. Yet, there is also an implicit understanding that nurses can not always do so: contextual issues, social encounters, and individual capacity are influencing factors that can all effect the nurse's ability to go the extra mile.

SCENE 3: Joan and Frya are sitting at a table in a room immediately behind the nursing station. Joan is reviewing notes.

JOAN: Do you feel like sharing what you know about the history of the unit and the emergence of what students call a "culture of caring"?

(Patty and Amy enter the room.)

FYRA: The manager who was here for over twenty years always said that she loved "rangytang" nurses. We bring our own personalities. To think and act differently

helps to maintain resistance to things that don't work. You don't fit yourself into someone else's box. You don't mind that because you don't fit for all the right reasons.

PATTY: We aren't hired to this unit because of our high tech skills. We are hired because of our abilities to care, to reach out to our patients and their families, perhaps maybe someone who is watching his or her son or young daughter die. This is a very high- tech unit – one where a patient may have 8 infusion pumps while still you have to figure out how to get the blood and platelets administered.

AMY: Caring is not always by the book. Caring is getting patients what they need. It takes courage to care and willingness to put yourself out there – to become more comfortable being out there. You are not always doing things by the book.

After Wards

Foucault (1994) posits truth as being conceived in its own multiplicity within local contexts where different perspectives play out as games of power. In the case of nurses, this process is evinced in their awareness of the unpredictable nature of individual responses to disease and treatment and their commitment to maintaining diversity and difference. Difference is supported within the context of nursing on the unit. Nurses see not only patients as different but also themselves as different. Indeed, the nurses identified that they had all been hired because they are different. Even though the unit is a high tech specialized area, the nurses were hired because of their caring practices, not their technical skills. This is recognized by everyone on the unit as representing a very

different hiring practice relative to that of any other high tech specialty unit in the hospital – it is a practice that they all value.

There is a theme within feminist thought that difference promotes skepticism and skepticism resistance. Rich argues that only by remaining skeptical of what is taking place within bureaucracies can resistance assist one in becoming an active creator in one's own space (cited in Ferguson, 1984). Thus, one needs to resist fitting into bureaucracies and instead take a more critical view of taken for granted conventional assumptions.

The recognition and acknowledgement by nurses of caring practices being distinct and unique to their unit creates a space for nurses in which to speak out on behalf of caring, answer questions about caring, and respect the use of different approaches to caring. Nurses' strategic use of extended orientation, mentoring, and buddying programs for nurses' newly hired to the unit are talked about as unique approaches that support nurses in their enactment of caring practices.

Rodney, Brown, and Liaschenko's (2004) define agency as occurring when nurses as engaged actors draw on all their various sources of knowledge as they live their caring work. The nurses on the unit are seen to do this. Are the above programs for nurses newly hired to the unit essential for their developing agency?

ACT 6: Facing the Possibility of Death, Facing Dying

Facing losses

A young man angry,

silent

grieving losses of a life changed

A dream, playing hockey

identity held for 9 years

Now, partially blind

Unable to drive

Heart worsening

Difficulty getting enough air

SCENE 1: *(A 28 year-old man who has been in and out of hospital for the past 9 years has just been readmitted to the unit. His admissions have all been related to side effects resulting from medical treatment for his disease condition at age 19. He is crouched down huddles in the bed, with the covers drawn up to his chin.)*

TYLER: *(leaning over so that she is closer to eye level):* Hello, Wayne. I'm Tyler, your nurse today. This is Joan, who is doing some nursing research and is shadowing me today... I hear that you have a really sore mouth?

WAYNE: Yes, but I don't want to take any of that medication.

TYLER: Okay. How about I just ask you a few questions so that I can get to know you a little better?

(Tyler talks with him while she does her initial assessment, then helps him get positioned in how he wants to eat his breakfast)

TYLER: *(Outside the room, back at the nursing station, Tyler is speaking to the researcher)* It helps to interact and build up a rapport with him. I don't want him to feel like a specimen in his bed. He knows what is going on and knows himself; he is overwhelmed by one more problem. Another side effect is just exacerbating his tendency towards dependency. I want to keep him informed about what I am doing and keep him involved in decisions.

SCENE 2: (It is a beautiful, summer morning and the sun is shining brightly streaming into Hank's room as Laurie and Joan enter the room. You can almost feel the warmth of the sun's rays through the window and smell the scent of the cedar trees in the early moist morning air. Hank, who has just arrived on the unit, is lying stretched out on his bed. Hank has just arrived on the unit. He is being readmitted to the unit due to the recurrence of his disease. In the morning report, the night nurse noted that he is very angry. No one has had a chance to check it out what is bothering him.

(Laurie goes over to Hank and introduces herself. Hank looks at them, makes no response, and looks away).

LAURIE: Let's get this admission done in a hurry for you. You know the drill. *(Laurie checks his infusion lines and site, takes his vital signs, checks his circulation. Just before listening to his chest she says)* Are you upset because you don't know what is happening or because of why you are here?

HANK *(looks up at Laurie)*: I am upset because I don't know what is going to happen next.

LAURIE: Okay. I can't take what is happening away, but I can tell you what I know usually happens and we can work together to set things up so that you can have a say in what happens. *(What follows is a discussion between Laurie and Hank. They discuss what will mostly likely be happening to him, what he is feeling, and what he wishes to happen.)*

(Later, in the conference room , Joan is talking with some of the nurses as to how they communicate with patients and their families who are dealing with the possibility of imminent death)

AMY: As a nurse, you have to be able to face the reality of the seriousness of their disease. You have to be able to talk about it with patients. Patients and their families have to face it.

TYLER: It's understood that you can't be afraid to face the reality that 'you may die'. --- This creates a space to talk about death. --- I can't tell you how often my patients ask me: What will it look like when I die? --- It's not fair to walk away from the possibility (probability) of death even though you may want to.--- when they feel that you will be honest with them, you can have that fun relationship with them. They don't want nurses to be down. They come to live.

MICHELLE: *(Joins in the discussion, making reference to Susan, the twenty- year- old patient who has just been readmitted to the unit for her second stage of her treatment)*

Susan says that she just wants her life back. Her mom says that she doesn't want to live if she can't have children as a result of treatment. At twenty this is where she is at. This is all that she can see – wanting children and a family. We can't change that but we can give her a chance to talk about how she is feeling, if she wants that... We can ask her if she would like to talk with someone.

SHARRA: It's really hard for family. One of my patients, seventeen years old, was dying. She and her boyfriend wanted to get married before she died, and the parents were really supportive of this happening. But, as a nurse you have to stand back and try to look at the bigger picture. I was concerned about the seventeen-

year- old boy and all the effects of being a widower at seventeen. I suggested that they get a minister who would instead do a special ceremony of commitment, to avoid all the paper work and hassles of a real marriage. So, they did. But, later, when their daughter was dying, the Mom saw the young boy with another girl in the mall. She was really upset. I had to help her see other sides to the situation. He was only seventeen and dealing with all sorts of things. ---- He had been unbelievable – better than lots of husbands of many years, trying to deal with someone dying.

JOAN (*thinking out loud*)

There is a positive energy (for want of a better word) on the unit. It is as if once there is an acceptance of death as a natural part of life the patients allow the nurse to witness this new relation, there is an openness that can develop between the nurse and the patient. There is a space created to honor whatever the patient is thinking and feeling. No longer is there a need on the part of the patient who is dying to filter out or judge their emotions. They are accepted and valued for what they are.

Noddings (1984) identifies joy, insight, or whatever the positive emotion is as being the result of a creative transformation that occurs during the intuitive search and quest for meaning, wherein one opens up to the world around one. In nurses talking with their patients about the possible reality of death, there is a space created for this intuitive search for meaning. Thus, patients and families are able to acknowledge and talk about death and what they are thinking and feeling. In so doing, they are able to open up to the world and more simply share whatever it is that are in the midst of in their experiences. They are able to complete unfinished business, to say all the things that they need to say

to one another. They don't fear that they will be outcasts or abandoned of rejection by those caring for them. Patients come to trust that their families will be supported through whatever happens.

After Wards

Nurses on the unit resist the silencing of their patients in relation to issues and concerns that matter to them. They talk with their patients about difficult issue, two of those being the possibility of death and dying, the ultimate concerns.

De Certeau (1984) identified that persons who are dying are often treated as deviants: by dying, they are doing the unnamable. Hospitals are organized for the purpose of conserving life. In dying, patients become deviants, because they leave a field circumscribed by the possibilities of treatment. Thus they are moved to the margins of health care, made to feel invisible, erased as a person. When death is not openly discussed, the terminally ill patient – already alone in hospital – is consigned to face death alone – loneliness compounded by more loneliness.

On the unit, the nurses challenge societal norms that seek to avoid both the reality and the thought of death of turning away from death avoidance. In turn, they call into question the restrictive culture around death in hospitals. In acknowledging the possibility of death, they mark the limitations of allopathic medicine. This acknowledgement prevents death from going unmarked as a social journey, and, therefore, as part of life. De Certeau (1984) notes that if the possibilities and implications of death are not acknowledged, death becomes an inappropriate subject to be talked about. With nurses' acknowledgment of the possibility of death, nurses give permission for death to be a subject of conversation among the terminally ill, by the person who is ill and by their

families and friends. Thus nurses create a social space for death. Families and friends can then talk about the possibility of a loved one dying to one another as well as neighbors and concerned members of the community. Death is no longer a secret to be kept hidden. This creates a space for stories about death and dying to be shared. Moreover, when death is viewed as part of life, all those affected have an opportunity to support one another.

ACT 7 Thinking Outside the Box of Strategic Moves

Discovery

*Mother overwhelmed
daughter discharged,
unresolved issues
walking real hard
vision is failing
infection a fear
Nurses walk into chaos
listen and hear
improvise, create options*

*Invisible knowledge
brought to light*

SCENE 1: *(It is 8:00 in the morning. Amerri is the primary nurse who has been caring for Zera all night and comes into report to talk to the day nurse assigned to care for Zera today).*

AMERRI: *(She has a really serious look)* I have been caring for Zera for the past three nights. She is really not doing well. She is immobilized, trapped in her own fears and emotions. I just talked to her and said: “You have survived the intensive care unit, you’re in remission. But, if you don’t get up and move around you will die --- Something else will get you. Plus you need to let up on your mother. She is scared too.

(The scene is a week later. Joan comes into the conference room for morning report)

TINA: *(looks over at Joan.)* Guess what? Zera is being discharged today.

(Tina laughs at the surprised expression on Joan's face and shrugs.) You just never know here. You can't predict. Some patients you think are going to do really well don't, and some patients that you think aren't going to make it do. That's what keeps us going.

SCENE 2 *(It is 1600 hours. Nurses are in the conference room catching up on their charting)*

JOAN: I have noticed that you use humor a lot on the unit.

LYZA *(looking over at Joan)*: Yes we do. *(Laughs.)* To stay here, one needs a warped sense of humor.

COLLEEN: Humor is a coping mechanism. Sometimes you need to be a goof and let it out.

JAZ: Humor is something we use with one another and with patients *(begins to laugh)*.

I remember a few years ago when one of the junior nurses came rushing up to me, exclaiming there was something really wrong with her patient's intravenous therapy. I went rushing down to see what the problem was. There was a gold fish swimming around in the bottle. The patient had been in on it too. The nurses had set the system up, pretending to have it running into the patient. It was April Fools day and the joke was on me. That fish remained swimming in a bowl on the nursing station for a long time.

MICHELLE: *(Laughing and looking at her colleagues)*: Remember Bob and the plastic

spider? (*Looking towards Joan*) You need to ask him about that story.

SCENE 3 (*The next time she is on the unit, Joan asks Bob about the incident involving the spider*).

BOB: Yes, I remember the event. But, I have to premise the story with the understanding that humor has to be something spontaneous and totally situational. When using humor, particularly with patients, you must tailor it to the patient and where they are at. I knew Delores. I knew her really well ... During morning report I was informed by the night nurse that although Delores, who was my patient for the day, was oriented she was having visual hallucinations from the morphine she was on to control her pain. It was around Halloween, so there were a lot of plastic spiders on the unit. I taped this black plastic spider to my forehead before I went in to see her and just stood by her bed until she opened her eyes. She looked at me and then she registered what she was seeing and started laughing ... called me an impossible jerk. We both laughed ... But, then we could talk about how she really was.

JOAN (*Thinking aloud*)

Nurses' non-judgmental practices with patients acknowledge and honor whatever it is that patients are experiencing. This creates a space for patients to feel, think, and talk about what they are in the midst of. Nurses respond to their patients' using different tactics to accommodate different situations. In this example, Bob uses humor.

What seems obvious is that thinking outside the box represents a key strategy used by nurses on this unit to resist being objectified and reconstructed into docile bodies. Nurses voice their ideas and confront practices with which they disagree. They challenge

the traditional hierarchical ordering within the bureaucratic system in hospital that reproduces medical hegemony. Simultaneously, they are supported in doing so by nursing management. The nurses shared with me how, over the twenty-year period the unit has existed, nursing management has supported nurses' resistance to obedience and subservience. This has been accomplished by decisions about nursing being made at the grass roots level. Nurses participate in the identification of problems, discuss issues and concerns and envision possible solutions. Managers advocate on behalf of nursing at higher management levels, proposing and defending solutions developed by nursing staff. Staff nurses are invited to attend some of the management meetings with hospital administrators in order to voice their own concerns whenever possible. Nurses in nursing management positions on the unit have historically resisted the impetus of economically based agendas being used as the only basis guiding decision making regarding nursing practices. Thus, over the years caring practices have been sustained because there is a political agenda on the unit that is aimed at nurses thinking outside the box and resisting hegemonic norms that don't serve the interests of nursing and nurses.

After Wards

Nurses recognize the need to think and act outside the box of traditional norms ordered within the unit. Hutchinson identified a variety of rule bending behaviors that nurses used to benefit patients (cited in Rodney, 1997). Hutchinson argued that the nurses' rule-breaking behaviors were responsible actions because they used "best" nursing judgment to decide what rule to bend and when to bend it. On the unit humor was one such rule breaking behavior that nurses used to benefit patients. Streiker (2000) posits that humor allows one to step out of the moment, look at it, and sum it up with no

great reverence. Billy Graham argued that “Humor helps us to overlook the unbecoming, understand the unconventional, tolerate the unpleasant, overcome the unexpected, and outlast the unbearable” (cited in Streiker, 2000, p. vii).

ACT 8: Caring for Self and Others

Caring: A Rare Team Approach

How's your assignment?

Do you need any help?

Questions asked, unexpected

Shoulder massage to relieve tension

common practice, not asked

Care about others

Care about self

Work as a team

Each wants everyone to succeed

SCENE 1:

NARRATOR: It is mid-afternoon on the unit. One of the nurses, Laurie comes out of the room of a patient. The patient is seriously ill and Laurie has been very busy, seldom leaving the patient's room. As Laurie sits down at the nursing desk to update the records on the patient's chart Amy, the nurse sitting next to her, gets up and standing directly behind her, begins massaging the tension from Laurie's neck and shoulders. Laurie puts her head back, closes her eyes and leans into the massage. Neither speaks a word.

JOAN: *(Taking note of this interaction, she comments to the nurses who are sitting next to her around the nursing station)*

Each of you seems to respond to one another's signs of stress without even being asked. I see quick neck and shoulder massages occurring often and spontaneously between each of you. There are offers of help, and help is given without anyone seemingly needing to ask.

DONNA: (A junior nurse.) It's amazing when you come here; the non-verbal communication. You can be in a bad situation, and you just need to look at someone, you don't even have to speak; they will say: "Okay what can I do for you? How about I prime this? How about I do this? How about I do that – and it just seems to all flow together.

LILY: It doesn't even have to be someone new. It can be anyone – everyone just kind of pitches in; and it is amazing to watch.

PATTY: There was an incident when my patient kind of went to pieces, but, my colleagues were looking out for me, even though they were busy. The next time I can better deal with that situation. As my time goes on, I can see that I almost feel comfortable and like caring. I can show my patients more of me – like I'll take care of you rather than just focusing on taking care of myself. I can see myself changing from the biological to more of the emotional caring and tying it all together.

JOAN: A consistent pattern seems to be that it takes a long time to integrate relational caring into your technical practices. There is so much to learn. Initially, you're so busy focusing on doing skills correctly that your patients don't get your full attention.

DONNA: Luckily, the manager's strategy is that education is delivered up front in a healthy dose. She doesn't scrimp in her support of the newer nurses on the unit. Everyone has input into the beginning of someone's career so that really helps sustain caring.

TARA: In this unit, you are given permission to care for yourself here. It is acceptable to say that you are burnt out and need a break. With primary nursing being what it is and our patient stays increasing in length, you do get burnt out and need to take time to rejuvenate yourself.

SCENE 2: (*Joan is at the nursing station, looking at a chart with Bob who is explaining about a patient who has just had recent treatment. He looks up at Tyler who has just come around the corner and stops what he is saying in mid sentence*)

BOB: (*Saying out, in a clear and distinct voice*) Tyler, are you okay?

TYLER: (*Stops and looks over her shoulder at Bob*) Sure.

BOB: Are you sure you are okay? You look a bit off.

TYLER: Well, ----- (*Tyler turns around and comes over to Bob, who places an arm round her shoulders. They just stand there without speaking a word. A few moments later, Tyler looks at Bob and smiles*) Thanks, I'll be fine.

SCENE 3: (*Later, in the conference room Joan is talking with a number of nurses and comments on the support she has observed nurses receiving from one another on the unit*)

JOAN: I've observed you all giving one another a great deal of support.

(*Tyler walks in just as Joan is speaking*)

TYLER: That's really true. Your care is dependent on who you are, the life you have, your perspectives and how you are feeling that day. Some days you have a lot going on in your own life and don't have that extra push. That is why you see nurses rubbing one another's shoulders or offering to help. If I'm feeling this way then probably everyone else knows that they will be feeling it on some days.

MICHELLE: This is a very interdisciplinary unit. It comes down to mutual respect. We are respected by those we work with, and we respect them.

BURT: There are high expectations of how relationships work here between patients and us. For some physicians, it can be rough for them for a few weeks. But, then they learn that we have a certain way of relating and doing things that is maintained. With expectations made clear at the very beginning to all professionals who come to work here, then they are maintained.

JAZ: Surveillance is kept to a minimum. The manager works to make changes from the grass roots level. We manage ourselves. Yet, we all work together to try to set things up so that we can continue to care for our patients out there.

MICHELLE: We are knowledgeable, and know that we are smart. We get a lot of recognition of this from physicians and patients.

TARA : Usually physicians like to come here because they are working with nurses who really know what they are doing.

SHARRA: This is a specialty unit. Specialty floors have a leg up on general medical and surgical floors. I do not have to know a million other diseases and treatment options related to them. I have to know how we treat diseases common to this unit so, it is easier to learn. You have to learn depth, but the broad scan of knowledge isn't as great as say on medicine.

JOAN (*Thinking out loud*)

Nurses are sustained in their caring practices of self and others as a result of how they are positioned as part of an inclusive interdisciplinary team that includes professional staff and support staff. Communications are open and informal. Mutual

support for one another within the team is taken for granted because it is a universal expectation for everyone in the local culture. Embedded in that culture is what Watson (2005) identifies as a primary focus of caring science: the ethical demand of understanding that the basic expression of life is both to give and receive. Contextual influences that support the caring of self and others include, but are not limited to, nurses' ability to access education funds so they can keep up to date in their skills and knowledge.

Nurses participate in sustaining the care of self and others. They have created a space for reflective and critical thought through their use of maintaining silence when reviewing charts, accessing information on the computer, listening to and caring for patients, even during their breaks. Experienced nurses mentor and buddy newly hired nurses to the unit. Nurses pay attention when colleagues need help and offer assistance without having to be asked. Nurses participate in fund raising events sponsored by patients and their families aimed at providing increased monies for the unit. Funds are used for patient comfort measures, such as the purchase of a "game boy", sleeping chairs for patients' family members, and other amenities intended to enhance the comfort of patients and their family members. A small amount of the fund has been used for supporting nursing research projects. Funds have been used for renovations of patient areas. Thus caring for self and others constitutes an integrated, extended circle of giving and receiving that the nurses identify as a product of their history and that they believe to be unique to this unit. These nurses have enacted what Watson (2005) cites as a challenge presented by Jon Kabab-Zin: "to turn attention toward what is referred to as 'inner

technologies', to become more contemplative, mindful, caring, and compassionate" (p. 141).

After Wards

With primary nursing the mode of organization, nurses usually work alone with patients. Yet, they can always be seen watching out for one another. There is, moreover, never any suggestion or insinuation that needing help is symptomatic of weakness on the part of the individual.

Foucault (1984) posits that caring for self is a practice of freedom. It is the result of turning one's gaze upon oneself. This turn allows for self-recognition; it also helps one recall and reflect upon what is important. It requires continual examination of the effects of one's practices. It requires asking the question: What am I doing when I am doing this? This kind of self-reflection results in reflexivity, i.e., a reflection upon the world and others. In this way caring for self becomes a caring for others. At the same time individuals are brought together on the basis of shared concerns.

What I find interesting is that the nurses unknowingly engaged in reflexivity as a way of caring for self and others. An example of this practice emerged while I was conducting fieldwork on the unit. When the nurses were informed that off-service patients might be admitted to a holding area next to the unit, nonetheless, viewed by administration to be a part of the unit, they immediately organized a meeting aimed at discussing the issues and concerns raised by this latest initiative. A major concern was that off-service patients required care that the nurses, by virtue of their experience and training, were unqualified to provide. Issues of patient safety, quality care, education, and recruitment were all discussed. The outcome was that the nurses refused to accept

responsibility for care requiring skill sets they believed they lacked. Although various options were tried with a view to accommodating the new policy, in the end the patients admitted to the unit were those identified as most appropriate by the nurses. Although the care for these patients proved more complicated than that for the previous off-service patients, there was consensus among the nursing staff that they possessed the requisite knowledge and skills. This response reflects Rodney, Brown, and Liaschenko's (2004) view of moral agency as a relational connectedness of everyday health care encounters, one involving "rational and self-expressive choice, notions of identity, social and historical relational influences, and autonomous action" (p. 156). The historical relational factor was nurses' involvement in grass roots decision making. Nursing management had a history of always involving the unit nurses in patient care issues, developing problem-solving strategies, and presenting alternative proposals. Thus the nurses were supported in their enactment of moral agency by participating in decision making affecting nursing, such as refusing to assume responsibility for knowledge practices that they didn't possess.

My conclusion is that moral agency is enacted in ways contingent upon local context. Caring for self and relational connectedness are concepts that nurses can draw upon to support their enactment of moral agency.

Act 9: Staying the Course

Dreams

*Her head, hairless,
bent forward on pillow,
too weak to hold upright
So very ill
very young
Her stuffed animals,
tied to pole on her bed
(gifts from her school buddies)
Her slender body, taking little room in the bed*

SCENE 1:

NARRATOR: It is 0700 hours on a dull, rainy Vancouver day. The drive to work is brutal: traffic all gnarled up, progress slow and tedious. It is obvious the nurses are in for a very busy day as virtually all the patients are seriously ill. Yet, there is something else afoot. Everyone is quieter than usual. The mood on the unit seems to reflect the weather outside.

JOAN: *(After report Joan turns to Donna)* Is something going on? Everyone's so reserved and quiet.

DONNA: Brian died last night. None of us were expecting it.

SCENE 2: *Later that day, Joan is talking with some of the nurses during their break.*

JOAN: The work on this unit is very hard work. Acuity is always high. You are constantly busy. Getting away for breaks is a daily challenge. It's doubly hard when you lose someone. What makes you stay here?

DONNA: Well, it is hard work both emotionally and physically, especially when you look at the number of deaths and acuity on the unit. I thought it might be a depressing place, but it is a really a very happy place. Patients are hopeful because they are receiving treatment.

MICHELLE: Lots of people ask me how I can work in such a depressing place. But I tell them that it is not depressing work. It is a privilege to be a part of the lives of people who come to us to be treated. To work with people who are so courageous, who are going through such difficulty. I wouldn't have an opportunity to meet such courageous people if I didn't work here. It is an honor to be with them. I go home and think: my problems are nothing!

GRETA: I love coming to work. I can hardly wait. I work here, not for the money, although we all need money, but for what I receive from my patients and families. It is okay to be upset when you have lost someone. I was there with the wife and children of one of my patients when they were celebrating his possible cure. I was there to watch him hold his little girl's hand while watching a video of her play at school that she was in, both of us knowing that he would never see another one.

PATTY: No one says "toughen up and get on with it." They may say, take some time, go have a coffee. Others look out for the fact that you have suffered a loss as well. It is a good place to know that you are accepted in allowing yourself to feel the loss.

TYLER: I feel like I make a difference and that helps to balance the angst and tension of the work. If you felt like you didn't make a difference, why would you want to do the work?

JOAN: Do you have difficulty recruiting staff to the unit?

SHARRA: No. There are always nurses who want to work here.

JOAN (thinking aloud to herself)

There appear to be three key factors that account for the willingness of nurses to remain on the unit. One is the close fit between their understanding of nursing as practices of caring and the way in which nursing is operationalized in the practice setting. The second is the close relationships that nurses develop with their patients. Nurses value the relationship they have with each of their patients. For their part, the latter come to trust their nurses and are willing to share what they are experiencing. This enables the nurses to make better holistic assessments which result in more personalized care. That efforts to provide more personalized care are valued is evinced in the cards and letters of thanks and donations received from patients and their families. The third factor is the recognition on the part of the nurses that their efforts can make a difference in the lives of patients and their families. This is possibly the most significant reason nurses choose to remain on the unit.

After Wards

Even though nursing is perceived as work of the most demanding, challenging and emotionally draining kind, the difficulties and personal costs are balanced by the nurses' perception that they are making a difference in the lives of patients and their families. They know they are smart and that the care they provide is perceived to be excellent. This perception is reinforced by nursing peers, other healthcare professionals, and patients and their families.

Implicit in the perception of care making a difference is an understanding that the aim of nursing is "to do good", an ethic drawn from Aristotelian thought. Nurses accept the fact that cures are not always possible. They understand, moreover, that being

proactive can counter the paralyzing feelings of sadness and hopelessness experienced by nurses, patients, and families who must confront the possibility of loss. This understanding reflects Bickford's (1997) concept of a "transformed political ethic". The latter moves beyond suffering, innocence and compassion to embrace anger, responsibility and courage. Bickford cites Audre Lorde who argues that anger can be put to creative uses, so orchestrated as to constitute strength rather than weakness that torn apart people apart. Bickford asserts that the political use of anger requires creative action on the part of all stakeholders. This can take various forms, but two are critical: articulating with precision and listening with intensity so that each individual is responsible for how they speak to and how they hear one another. There is here an implicit invitation to explore the phenomenon of resistance rather than seek to circumvent it.

Being proactive is a tactic viewed by nurses to release anger and dissipate feelings of hopelessness. Being proactive requires that nurses engage with patients, seek to understand what they are experiencing, reflect on new information and seek to fulfill the wishes of patients. Being proactive is consonant with Bickford's "transformed political ethic". It transforms nurses into moral agents possessing the courage to act on their knowledge, accept responsibility for actions, and find creative ways to work with fear and anger. Thus, Bickford's (1997) concept reflects a more contextual approach to ethics. More recently, nursing scholars have sought to create conceptual frameworks for ethics that include contextual approaches as an adjunct to traditional meta-theories and principles of ethics (Tuckett, 1998; Rodney, Pauly, & Burgess, 2004; Brown, Rodney, Pauly, Varcoe, & Smye, 2004).

Epilogue

The “closet drama” format makes visible the tactics nurses use to operationalize caring practices in a local context. Revealing how caring is operationalized in a real practice setting serves to challenge assumptions that everyone knows what it is to care and that caring practices are an implicit part of nursing activities. What is revealed is that caring practices embody many theoretical perspectives. What is observed, moreover, is that caring practices weave together two strands of knowledge: that related to the uncertainties of the patient’s lived experience with illness and that housed in the certainties of imposed rules of order within the local context. In addition, contextual issues are shown to intersect with nursing activities in a way that insidiously influence the sustainability of daily practices of caring. Hence, nurses can be seen to participate in their own construction as caring nurses, responding to systems issues in a way that serves to sustain the culture of caring within the unit. In Act 1 and 2 nurses establish their authority through their use of phenomenological inquiry combined with a focus on capacity building that resulted in a holistic type of analysis. Contextual influences, such as the mode of organization of nursing work, nursing management of economic resources for the unit; and nurses being the constants on the unit were evident in their effects on nursing practices. In Act 3 through Act 7, nurses use of caring tactics were seen as complementary with what Bickford (1997) defines as a “transformed political ethic”. Hierarchical ordering and medical hegemony were two of the major contextual influences nurses were forced to confront in order to operationalize caring tactics. Nurses countered restraining effects on nursing knowledge practices through their use strategic efforts to persuade others to pay attention to the particularities of patient situations. Caring

practices in Act 8 and 9 revealed what nurses did to help sustain their capacities to care. Contextual influences shown to support nurses in this were: nursing management use of grass roots decision making and methods of hiring nurses; fundraising by patients and families in support of nurses' work; educational programs and opportunities for nurses.

Thus, the unit selected for this study proved ideal for examining nursing as relational practices of caring as the latter constituted the norm within its culture. Such practices reflected the choices available to nurses, choices determined by contextual influences. Owing to such influences, nurses on the unit were able to fill the subject position of caring nurse. Thus were positioned to model relational caring as distinct practices within their daily nursing activities. Questions that arose were: Are the contextual influences identified supporting a "culture of caring" in this unit the same for other units viewed to be caring? Do the same contextual influences exist in other units that are viewed to have a different type of culture? What contributes to the similarities or differences between units?

Conclusion

During my fieldwork, I came to discern the interbreeding of worldviews talked about by Lincoln and Guba (2000); nurses drawing upon theories and approaches from different paradigms in order to make caring work. Nurses used modernist frameworks; such as the admission form, medical protocols, medication guidelines, technical procedures, nursing procedures, and nursing care plans. At the same time, caring practices served as a mechanism for bringing the uncertainties, unpredictability, and particularities inherent in the individual's lived experience with health issues and

treatments into decisions about health. Of note, caring practices created a space for questioning assumptions by persons who were positioned to challenge the status quo. Being hospital employees, assigned responsibility for providing patient care yet not always having the authority to enact certain practices, resulted in nurses recognizing and responding to the effects of domination generated by the subjugation of knowledge. Having experienced subordination provided a motive for nurses to challenge dominant norms, two in particular: the privileging of predictability and certainty and the notion of strategies of imposed order always being beneficial. Thus, nurses used postmodern approaches such as tolerating ambiguity, dealing with difference, thinking beyond strategic frameworks, persistence, and “going the extra mile”. Nurses challenged the assumption that stability is normal and natural, instead positing the existence of multiple meanings and unpredicted realities. Thus, caring thinking functioned to resist uncritical compliance with standardized frameworks assumed to outline care that was beneficial for patients; providing an opportunity to involve patients in making decisions about their care and for changes to be enacted in new and creative ways. Thus in recognizing how practices of caring are sites of resistance, I was able to identify the function of each of the nine themes representing the respective titles of the acts in the “closet drama”. By way of contrast, the “u-turn” in Act 3 can be seen as a fault line for the limiting of caring practices when nurses’ attention is directed away from patients and towards system issues. A more extensive examination of the nursing practices that are operationalized along this fault line might benefit nursing by identifying who or which interests these practices best serve. The following identify the function of the nine practices and the u-turn:

Act 1 Making connections: resisting detachment.

Act 2 Creating form: resisting discontinuities in care.

Act 3. Making do:

Direction one: Resisting the loss of possibilities.

Direction two (u-turn): Maintaining hegemonic norms.

Act 4 Tolerating ambiguity: resisting uniformity.

Act 5: Committing to diversity, appreciating difference: Resisting predictability.

Act 6 Facing the possibility of death, facing dying: Resisting silencing.

Act7 Thinking outside the box of strategic moves: Resisting the creation of a docile subject.

Act 8 Caring for self and others: Resisting a loss of self.

Act 9 Staying the course: Gaining expertise, resisting mediocrity.

To note, there are similarities and differences between Aoki's (2000) idea of there being a third mode of intellectual thinking and nursing practices of caring observed within the study.

Aoki (2000) identified there being three modes of intellectual thought that take place in separate spaces. One mode is that of modernity (certainty), wherein the intent of thinking is to create order and control. The second mode is postmodern thought, wherein there is an acceptance of uncertainty; a recognition and acceptance of difference and the multiple realities that are a result of this. Aoki defined the third space as a type of thinking that lies between certainty and uncertainty and is comprised of three distinct characteristics. The first characteristic is that it forms a bridge of understanding that allows individuals to converse across the two different worldviews of modernity and postmodernism. It is a type of thinking where there is an interest not only in what is said

but also in what is not said. Thus, thinking employs postmodern, not just positivistic thought. Secondly, it is a space of thoughtful conversations; a dialogue that returns to the lived ground of human experience and results in reflective understandings that expand previous background knowledge and challenge assumptions. Thirdly, it is a space of generative tension that results from the dialogical encounters with others about differing ideas and practices. New insights and alternate possibilities are envisioned as a result of the dialogical encounters.

Hence, Aoki (2000) provided a new lens with which to view caring practices. This new lens culminated in the identification of caring practices not fitting smoothly into either modernist or postmodern thought; a recognition that there were similarities between caring practices and the three characteristics of thinking identified by Aoki as taking place in a third space. Caring practices could be seen integrating ordered thinking, such as hospital policies, nursing procedural skills, medical protocols aimed at ensuring certainty, with thinking about uncertainties evoked by patients' everyday lived experience with illness. As evinced in Act 1 through Act 3, caring practices formed a bridge between the two different types of thinking, modern and post modern thought, wherein a high level of critical evaluation and creative synthesis were involved before nurses acted. Nurses thinking, doing, and being became one.

Nurses' caring practices were comprised of thoughtful conversations. Act 4 highlighted how caring practices require a type of meaning making that is contingent and situational as a result of knowledge being a human construction influenced by social relations and contextual factors. In Act 5 through Act 7, generative tensions were revealed to be a consequence of how nurses confront difficult situations and engage in

conversations with others across terrains of difference. Reed (1995) adds support that for complex problems approaches using a variety of theory and methods may be required to address them (cited in Whall and Hicks). Reed argues that nurses need to capitalize on useful aspects of both positivism and postmodernism and go beyond both approaches in order to enact care. Such may allow nurses more freedom to explore and propose alternative ways while taking into account traditional norms.

Two additional characteristics not talked about by Aoki (2000) but identified as unique to caring practices were *consideration of contextual influences in decisions related to patient care* and *caring practices as capacity building*.

With regard to the former, although nurses seldom if ever referred to contextual influences as affecting their practices, from Act 1 through Act 9 contextual influences were observed taken into account on a macro and micro nursing level. Contextual factors, such as, medical specialization, high acuity and challenging technology, hierarchical ordering, and private fundraising were but a few of the contextual influences nurses used to their advantage in strategic moves that supported caring practices on the unit. To note, nursing management's grass roots leadership style was a key contextual influence in sustaining the culture of caring on the unit. Nursing managers and nurses on the unit collaborated and functioned as partners in ways that supported nurses in their care of patients. Nursing management recognized nurses as the constants in hospital who came face to face with the reality of how standardized protocols and practices often provided less certainty than they promised. The difference between what was predicted and what actually happens as a result of treatment was acknowledged. Thus difference became a site for skepticism and skepticism a site for resistance to uncritical acceptance of

predetermined practice norms. Hence, nursing managers supported nurses in their daily quest of constructing care. There was an unacknowledged acceptance of the quest being more like a use of unrefined knowledge of actions wherein words had not yet been found to describe the techniques; the enactment of situated and timely judgments that resulted in practices that were formed and then forgotten as nurses moved on to the next event. Therefore, caring practices appeared similar to what Polkinghorne (2004) identified as prelinguistic understandings that are not yet integrated into formal language systems; the inability to articulate them serving to sustain the subjugation of them.

With regard to the latter difference, caring practices were observed as capacity building. Nurses caring for one another helped nurses pay attention to and respond to what patients needed. Caring for one another served to enhance nurses' individual caring capacity and promote efficiency and effectiveness of nursing care. Nurses stayed on the unit. They became experts in their caring practices and felt like they 'made a difference' on the high tech unit where nursing was known to be 'hard work'. The effects on the system were a reduction of costs related to orientation, recruitment, and retention.

Aoki's (2000) idea of there being a "third space" for a third type of thinking seems an apt description of how the nurses in the study took into account traditional metanarratives of health, illness, and person, listening and attending to particularities in patient care, and critiquing standardized practices in light of local influences. Nurses used a type of thinking that was comprised of tolerance, creativity, embracing of difference, and execution of intelligence that enabled them to design and adapt activities to what patients required in different situations. Caring practices were evinced as a type of

thinking that moved back and forth between paying attention to what patients were experiencing and a contemplation of such.

What my 'closet drama' and accompanying analysis have made visible is the multiple tactics that nurses use to operationalize caring practices in the oncology unit where this study was conducted. The question of the effects of my use of a drama is in keeping with my recognition of the shifting paradigms and interbreeding in nursing of different worldviews. I recognize that I have drawn upon modernism and postmodern approaches in my use of a drama. The word drama carries with it the meaning of a fictitious play. Yet I did not use artistic license to change what I heard and saw. In turn, the following are in keeping with post modern and constructivist approaches. The representation of my findings as an artistic portrayal challenges the traditional way of writing up findings. The word "act" to describe the themes for caring practices is representative of how caring is often assumed to be an action without theory; something everyone does. The scenes created from actual field notes and journal entries are rich with theories, models, and practices made visible rather than first locked away with the writings and later discarded, as usually happen to them. The word drama preceded by the word closet honors the history of nurses' caring as invisible and unacknowledged. Hence, the play kept in the forefront the nurses who participated in the study and the caring practices that they operationalized. One of the most important functions of my drama may have been for the nurses to be seen and recognized for having value. As deviants, resisters of hegemonic norms, there is always a risk that you can lose everything including yourself.

Questions that arose as a result of my analyses were: Are there dangers to nurses in making caring practices visible? Are there contexts where living in the shadow denotes a place of vulnerability that provides freedom? Does the shadow keep nurses under the radar to enact some discretionary judgments? Does being in the shadow prevent caring tactics from being classified, standardized, and imposed as another set of competencies nurses could be held responsible for?

The following chapter discusses the significance of the study and recommendations for further research.

CHAPTER FIVE

CONCLUSIONS, SIGNIFICANCE, AND RECOMMENDATIONS

Introduction

This study makes visible how nursing practices of caring have emerged and been sustained for over twenty years in an acute, high tech specialized unit in a Greater Vancouver hospital. The unit is identified by nurses and nursing students as being a “culture of caring”. Nurses are seen not as independent authors of caring practices, but as agents participating in their construction. Caring practices come to be viewed as the outcome of social interactions between nurses, various professionals and other hospital staff in light of the local contextual influences. There is room for optimism that if such a culture can be created in one hospital unit, it can or has been created in others.

Expanding Understanding of the Disciplinary Field of Nursing as a Practice of Relational Caring

In recent years nursing scholars have been focusing attention on the need to heed the distress nurses experience in local areas. Nurses development of lens that would enable them to understand power relations, particularly their dynamic, fluid nature and the fact that they allow room for realizing micro changes in everyday life could enable nurses to address issues causing distress. “Possibly the first step in the search for small changes may be an analysis of nursing practices in distinct clinical settings” (Gastaldo and Holmes, 1999, p. 235). This study does just that. It is an analysis of how nurses

operationalize caring practices in a local oncology unit within the dynamic and fluid nature of social relations and contextual influences affecting their practices.

In focusing on caring practices, this study constitutes a project of liberation, one that opens up possibilities by revealing how nurses operationalize practices of caring as a mechanism of resistance. Of note is that although the nurses on the unit could not identify or quote the works of primary nursing sources promoting caring, their practices reflected many of the ideas. For example, rather than positioning patients as helpless victims of disease, nurses seek to involve them in their own care and in decisions relating to that care. They seek to motivate patients to make small changes in their everyday lives. Most importantly, emotions aren't judged; they are talked about openly. Nurses' use of proactive approaches, e.g., patient advocacy, innovation and persistence, function to resist the anger and hopelessness created by disease. Nurses advocate on behalf of patients, exercising their authority in a positive way, one that supports rather than subordinates the patient. They draw upon formalized theories and standards of practice while at the same time keeping patients needs and requests for care at the forefront. Their practices are consonant with the caveat that "normalization and discipline should not always be perceived simply as coercive use of professionals' power" (Gastaldo and Holmes, p. 235).

Insights are as follows:

1. Although a worldwide shift from modern to postmodern discussions have received limited attention in nursing, a shift is noted in the clinical practice unit where the study took place. There is an interbreeding of modernist and postmodernist worldview approaches. Caring practices take place in a third space

as a type of thinking that weaves together modernist approaches, i.e., strategies of imposed order with postmodern approaches, i.e., improvisational techniques to address each unique situation.

2. Of significance is that the theoretical perspectives bearing on culture, practice, and power relations used in this study provide an interpretive lens that enables nursing to be seen as a political event. Nursing authority (power) on the unit is evinced as a phenomenological inquiry that focuses on the building of patient capabilities and gives nurse direction. Caring analyses structure nursing actions as a positive and productive, not repressive, force. Thus, the often invisible, often overlooked practices of caring operationalized by nurses in their daily work achieve recognition, are rendered visible. Practices of caring as a mechanism of productive resistance are seen to challenge traditional norms operating in the unit and to enable the recognition of nurses as social agents. Nurses were observed to resist or be drawn into processes and practices that maintain or limit caring.
3. The artistic portrayal of findings in the form of a “closet drama” increases the transparency of how it is that nurses operationalize daily practices of caring in a local area. The ‘closet drama’ proved to be an appropriate vehicle for doing so; making visible how practices are constituted within the matrix of social interactions in local contexts that nurses are situated in. Nurses remained visible as social agents who respond to contextual influences in unique and different ways. Nurses could be seen drawing on understandings that both challenge or reinscribe longstanding patterns of norms for practice within the local culture.

Significance of the Study

I make no claims to having captured the “whole” of caring practices. It is important to bear in mind that the artistic portrayal of my findings in the form of a “closet drama” is but a partial account of how practices of caring are operationalized by nurses working in the oncology unit. It is not the only account I could have written. But it is the one I was able to write. Merleau Ponty compares examining experiential life practices to shining a beam of light into a dark well (cited in Polkinghorne, 2003). It is only possible to see the surface. The closet drama is my interpretation of the surface elements revealed to me at a point in time when my observations took place. And though only a snapshot view, the drama succeeds, I believe, in revealing how contextual influences impact nursing practices and how nurses respond to these influences; contributing to the construction of their daily caring practices.

Implications of the Study

Implications for Nursing Practice

Although practices of caring are presently being sustained in the unit for my study, the government initiatives directed towards the restructuring of healthcare makes it vitally important that nurses pay attention to the particular worldviews that are underpinning changes to local policies and practices. Nurses not understanding the nature of the different worldviews will fail to understand the effects of them on nursing and nurses. Of note, is that the medical technocure bureaucratic culture of hospital is embedded with modernism. The postmodern turn of nursing as caring practices creates a space for alternative approaches. Yet, I would argue that caring practices are poorly

understood by nurses as being a postmodern approach. Postmodernism is not a term commonly referred to in nursing. This underlines the importance of enhanced caring literacy wherein nurses have the theoretical perspectives needed to critically evaluate the effects of contextual influences on nursing practices and the consequence of nurses' responses to these influences on nursing, nurses, and patients.

Of note, Gibb (1998) identifies a modernist approach emerging in hospitals as a new set of social relationships under the aegis of a corporate managerial approach aimed at increasing productivity. The shift in thinking is structuring new strategies that are becoming a site of authority for professional practice. An example of one such strategy is an increasing overlay of frameworks of leveling rationalities being imposed on nurses' clinical practices, such as, the aforementioned national program. Other examples of frameworks being imposed are by nurses themselves, such as Scope of Practice, standardized competencies, Professional Conduct Review, the Practical Standard Duty to Provide Care. Thus, imperative for nursing is not to reject all leveling frameworks but to examine critically the broader views that underlie them and the possible effects on nursing and patients. What gets in the way of critique is the assumption that such frameworks are always beneficial because they provide procedural uniformity that promotes safe practices. What goes unattended to, be that policy is, usually, an expression of the values held by a politically dominant group (Cheek, 1997) is that policy often serves to entrench control and even limit practices. Therefore, the threat is that nurses' uncritical acceptance of frameworks will result in policies that are assumed to be essential to ensuring good nursing practice by promoting coherence and standardization, possibly at the expense of caring practices.

The challenge put forward in this study is for nurses to increase caring literacy by developing perspectives that enable them to see nursing as a political event. By doing so nurses can recognize how different practices represent a particular view of reality. This reading can be used to inform nurses' analyses and their responses to the various influences affecting nursing practices. Questions nurses will be able to examine are: What are the worldviews structuring local practice norms? How do particular practices enhance nursing authority or limit nurses' discretionary judgments while altering the identity of nursing itself? Who are strategic initiatives and leveling frameworks best serving? What will be the effects on patients being seen as persons? How do different practices alter the way patients are perceived?

Implications for Nursing Education

What was reinforced during the initial phase of my research is the inherent wisdom of nursing students and a need for nursing students to gain perspectives that enable them to look beyond individual behavior and examine how contextual influences affect the construction of their practices. Questions that were raised for me as an educator were: What are the perspectives that students currently have that enable or prevent them from seeing nursing as a political event? How do nursing students learn how to operationalize practices of relational caring when these practices are not a visible part of nursing in the clinical practice areas where they are learning how to care? How would nursing faculty informed by a postmodern perspective respond differently to student learning situations than nursing faculty informed by modernist worldviews? What might

be the benefits and barriers to students developing a lens wherein they recognize themselves as participants in but not solely responsible for their own practices.

Implications for Nursing Research

There is a need for further research examining the influence of context on nursing activities within local practice areas. Questions for further research are: Rather than inability to meet nursing standards being a result of individual deficits are they a result of contextual influences constraining nurses in their practices. How do nurses respond to contextual influences in ways that support the constraints or challenge them? How are nurses complicit in the subordination and marginalization of nursing within their local practice areas? Is increasing distress of nurses a result of them not seeing themselves in the practices of the unit? If increasing distress is not paid heed to by management and administration does nursing become perceived as just a job? In local areas, how is what patients think about nursing practices of caring and their effects on both the treatment of their diseases and outcomes being examined?

Conclusions

In revealing innovative tactics nurses use to operationalize nursing norms within a local cultural context, this study represents a beginning to a larger project aimed at enabling nurses to look beyond individual behavior to examine how contextual influences affect nursing practices. The “closet drama” presented here constitutes a virtual reality that is sufficiently recognizable to be credible but also protected the anonymity of the participants. This study affirms the value of artful portrayals as a pedagogical approach to

qualitative inquiry related to nursing practice. It reveals how context influences the enactment of caring practices. It enables nurses to gain new insights regarding their practices. What the nurses on the unit came to recognize is that a large portion of their practices go unrecognized and unexamined, even by themselves.

Lynn Butler-Kisber (2002) argues that there is a need to support researchers interested in arts-based qualitative research. Although, the process of transforming observations and narratives into written and poetic forms is fraught with difficulty, there is value to it. Her contention is that art forms, such as found poetry, create a kind of ‘mental kaleidoscope’ of sights and sounds, a much needed corrective given that “educational research suggests that the more traditional, textual descriptions of qualitative findings do not adequately reflect the complexity of studying human behavior” (p. 229). Thus, ‘artful portrayals’ used as analytic approaches provide multiple ways of looking at research material, leading inevitably to new insights and understandings. I believe that such was the consequence of employing a ‘closet drama’ as a pedagogical approach to qualitative inquiry. This dramatic form serves to increase the transparency of what it is that nurses do in their daily caring practices. Thus, not only can readers more effectively critique my interpretations of what was observed on the unit; they can make their own interpretations based on my findings. I believe that future studies using artful portrayals as analytic approaches will provide nurses new insights regarding the challenges nurses face within local contexts as well as understandings that will help them address such challenges and effect changes in healthcare that better serve nursing and patients.

From a personal perspective, the most significant outcome of this study has proved to be the development of a critical lens for identifying and examining how nursing practices in local areas are shaped by contextual influences. I am now able to recognize the various factors informing nursing practices and am cognizant of strategies appropriate to addressing them. Thus, I no longer view nursing as a neutral event, wherein one simply applies nursing knowledge to practice. Instead, I see how one's ideas and beliefs structure practices; I also see how these practices are transformed in local areas as a result of the playing out of relations of power. Within the social context of each unit, there exist certain practices that are supported and other that are constrained. In this matrix what constitutes knowledge is determined by how social relations play out and how contextual influences affect practices. Thus, I have come to recognize that games of power are always being played out within the social context of each particular unit: there exist in each a plethora of informal and strategic practices aimed at contesting or sustaining the authority of respective players, i.e., nurses, other disciplines, and hospital staff.

My insights have revealed the benefits accruing to nurses of having a lens that enables them to answer questions such as the two that I have sought to address in this study, namely: What contextual influences enhance or constrain nurses' operationalization of nursing practices and how do nurses respond to these in ways that support or undermine nursing practices required by patients? Although I clearly perceive the benefits to be gained from a postmodern lens, in my view one of the greatest challenges confronting the nursing profession lies in envisioning how to enable nurses to develop such a lens and how to inspire them to do so. Whall and Hicks (2003) identify that the failure of nursing to recognize the shifting worldviews from modernism to

postmodernism and now to neomodernism may forestall opportunities related to the changes. My own experience has made me aware of the difficulties inherent in developing postmodern perspectives, difficulties that stem from the fact that modernist thought permeates all facets of nursing as well as the very thought processes of nurses. It is embedded in normalized frameworks for directing care in hospital, such as Standards of Practice, Codes of Ethics, standardized competencies, nursing care plans, medical protocols, and policies and procedures, for directing care. Such frameworks function to reinforce the need for certainty. Thus the promise of certainty becomes a seductive allure for nurses living within the chaos of the front lines of health care that can increase resistances to adopting new perspectives. Hence, I believe that if nursing scholars are convinced that a postmodern perspective offers pedagogical approaches that allow nurses to better interpret what they are in the midst of and challenge the status quo in healthcare, then they need to work closely with nurses in the front lines so that the nurses can receive the support and mentoring that will be required for the development and use of such a lens.

REFERENCES

- Acorn, S., Ratner, P., & Crawford, M. (1997). Decentralization as a determinant of autonomy, job satisfaction, and organizational commitment among nurse managers. *Nursing Research*, 46(1), 52-57.
- Ackroyd, S. & Hughes, J. (1992). *Data collection in context* (2nd ed.). New York: Longman.
- Adams, Patch. (2005). Gesundheit Institute. Retrieved December 12, 2005, from <http://www.patchadams.org/>
- Adlersberg, M., & Regan, S. (1999). Dispelling the myths about continuing competence. *Nursing BC*, (March-April), 13-15.
- Aiken, L., & Havens, D. (2000). Magnet nursing services recognition program: a comparison of two groups of magnet hospitals. *American Journal of Nursing*, 100(3), 26-34.
- Alcoff, L. (1998). Expert discourse of critique: Foucault as Power/Knowledge. In L. Langsdorf & S. Watson (Eds.), *Reconstructing the political: Continental philosophy and political theory* (pp. 307-316), New York: SUNY Press.
- Anderson, R. (2000). Intuitive inquiry: Interpreting objective and subjective Data. *Revision: A Journal of Consciousness and Transformation*, 22(4), 31-39.
- Arendt, H. (1973). *The Origins of totalitarianism: New edition with added prefaces*. New York: Harcourt Brace & Company.
- Arendt, H. (1998). *The human condition: With an introduction by Margaret Canovan* (2nd ed.). Chicago: University of Chicago Press.
- Arendt, H., & McCarthy, M. (1995). *Between friends: The correspondence of Hannah Arendt and Mary McCarthy 1949-1975*. New York: Harcourt Brace & Company.
- Armstrong, M., Pettigrew, M., & Read, D. (1991). *The burning times* [video]. Canada: The National Film Board of Canada.
- Armstrong, S. (2001). The crying shame. *Chatelaine*, (March), 86-94.
- Arnold, T. (2001, Thursday, February 8). Doctor internet is in. *National Post*, pp. A17.
- Arvay, Marla. (1998). Narratives of secondary traumatic stress: Stories of struggle and hope. Dissertation, University of Victoria, Victoria.

- Baer, E., & Gordon, S. (1994). Money managers are unraveling the tapestry of nursing. *American Journal of Nursing, October*.
- Bailey, I. (2002, Monday, April 22). B.C. health strategy greeted with fear: Cuts in disguise. *National Post*, pp. A1, A11.
- Bailey, P. (2001, Monday, July 2). Health bosses seeking ban on strikes. *The Vancouver Sun*, pp. 1-2.
- Bains, C. (2001, Thursday, August 9). Nurses picket hospitals in B.C: Outrage over legislated contract sparks walkout. *Winnipeg Free Press*, pp. A1, B2.
- Bakhtin, M. M. (1986). *Speech genres & other late essays* (V. McGee, Trans.). Austin: University of Texas Press.
- Bamford, P. (1995). *Moral distress: An inability to care*. Unpublished dissertation, Adelphi University.
- Barker, P., Reynolds, W., & Ward, T. (1995). The proper focus of nursing: a critique of the "caring" ideology. *International Journal of Nursing Studies*, 32(4), p. 386-397.
- Beare, P., & Myers, J. (1990). *Principles and practices of adult health nursing*. Toronto: C.V Mosby Company.
- Beatty, J. (2002, Tuesday, April 23). Care for seniors shifts to their homes. *The Vancouver Sun*, pp. A1, A4.
- Belenky, M. F., Clinchy, B. M., Goldberger, N. R., & Tarule, J. M. (1986). *Women's ways of knowing*. Boston: Basic Books.
- Benner Carson, V. (1989). *Spiritual dimensions of nursing practice*. Philadelphia: W.B. Saunders Company.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. San Francisco: Addison-Wesley Publishing.
- Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (1999). *Clinical wisdom and Interventions in critical care. A thinking-in-action approach*. Toronto: W.B. Saunders Company.
- Benner, P., Tanner, C., & Chesla, C. (1996). *Expertise in nursing practice: Caring, clinical judgment, and ethics*. New York: Springer Publishing Company.

- Benzie, R. (2002, Thursday, January 9). Health revolution spreads to Ontario: Follows Alberta's lead. *National Post*, pp. A1.
- Bergen, E., & Fisher, P. (2003). When working hurts: Stress, burnout and trauma in health care. *Nursing BC*, 35(5), 12-15.
- Bevan, M. T. (2000). Dialysis as 'deus ex machina': a critical analysis of haemodialysis. *Journal of Advanced Nursing*, 31(2), 437-443.
- Bevis, E., & Watson, J. (1989). *Towards a caring curriculum: A new pedagogy for nursing*. New York: National League of Nursing.
- Bickford, S. (1997). Anti-anti-identity politics: Feminism, democracy, and the complexity of citizenship. *Hypatia*, 12(4), 111-131.
- Bishop, A., & Scudder, J. J. (1996). *Nursing ethics: therapeutic caring presence*. Boston: Jones and Bartlett Publishers.
- Bishop, A., & Scudder, J. J. (1999). A philosophical interpretation of nursing. *Scholarly Inquiry for Nursing Practice: An International Journal*, 13(1), 13-28.
- Bliss, M. (2002, Thursday, January 10). Health care reform still evades us. *National Post*, pp. A16.
- Bohn, G. (2002, Wednesday, January 9). Public health advocate predicts tough year of cuts. *The Vancouver Sun*.
- Borton, J. (1999). Winnipeg's Pediatric Cardiac inquest: The patient's and parent's advocate. *Canadian Operating Room Nursing Journal*, (December), 34-38.
- Borysenko, J. (1990). *Guilt is the Teacher, Love is the Lesson*. New York: Warner Books.
- Boykin, A., & Schoenhofer, S. (1993). *Nursing as caring: A model for transforming practice*. New York: National League for Nursing Press.
- Bradshaw, A. (1998). Defining 'competency' in nursing (Part 11): an analytical review. *Journal of Clinical Nursing*, 7(2), 103-112.
- Braun, V., & Gavey, N. (1999). The suppression of sexual risk factor information. *Social Science & Medicine*, 48, 1463-1474.
- Brencick, J., & Webster, G. (2000). *Philosophy of nursing: A new vision for health care*. Albany: State University of New York Press.
- Brightman, C. (1995). Introduction: An epistolary romance. In H. Arendt & M. McCarthy

- (Eds.), *Between friends* (pp. vii-xxxvi). New York: Harcourt Brace & Company.
- Brown, D. (2000). *The challenge of caring*. Victoria: British Columbia Ministry of Health and Ministry Responsible for Seniors, Women's Health Bureau.
- Brown, H., Rodney, P., Pauly, B., Varcoe, C. & Smye, V. (2004). Working within the landscape: Nursing ethics. In J. Storch, P. Rodney, & R. Starzomski, *toward a moral horizon* (pp. 126-153). Toronto: Pearson Prentice Hall.
- Brown, Y. (1998). *What are the options in education for nurses to address the challenges today and into the future?* Saskatoon: Saskatchewan Registered Nurses' Association.
- Brunke, L. (2005). Regulating registered nurses in the public interest. *Nursing BC*, 37(3), 24-27.
- Brunt, J. (1994). *Caring Thinking: The new intelligence*. Paper presented at the 6th International Conference on Thinking, Boston.
- Bryman, A., & Burgess, R. (1996). *Analyzing qualitative data*. London: Routledge.
- Buerhaus, P., & Staiger, D. (2001). Trouble in the nurse labor market? Recent trends and future Outlook. In Elinor Hein, *Nursing issues in the 21st century* (pp.79-88). New York: Lippincott. .
- Butler –Kisber, L. (2002). Artful portrayals in qualitative inquiry: The road to found poetry and beyond. *The Alberta Journal of Educational Research*, XLVIII(3), 240-253.
- Butterwick, S. (2002). Your story/my story/our story: Performing interpretation in participatory theatre. *The Alberta Journal of Educational Research*, XLVIII(3), 229-239.
- Calkins, L. (1986). *The art of teaching writing*. New York: Lippincott.
- Callister, L. (1993). The use of student journals in nursing education: Making meaning out of clinical experience. *Journal of Nursing Education*, 32(4), 185-186.
- Campbell, M. (1994). The structuring of stress in nurses' work. In B. S. Bolaria & H. D. Dickinson (Eds.), *Health, illness, and health care in Canada* (second ed., pp. 592-608): Harcourt Brace and Company.
- Campbell, M. (2001). Textual accounts, ruling action: The intersection of knowledge and power in the routine conduct of community nursing work. (unpublished paper), University of Victoria.

- Canadian Nurses Association. (2003). Primary health care-The time has come. *Nursing Now: Issues and Trends in Canadian Nursing*, 9(16).
- Canadian Nurses Association. (2002). *Code of ethics for Registered Nurses*. Ottawa: Canadian Nurses Association.
- Canadian Nurses Association on behalf of the nurses of Canada. (1998). *The quiet crisis in health care: A submission to the House of Commons Standing Committee on Finance and the Minister of Finance*. Ottawa: Canadian Nurses Association.
- Canadian Nurses Association. (1993). *The scope of nursing practice: A summary of issues and trends in provinces and territories of Canada*. Ottawa: Canadian Nurses Association.
- Carson, V., & Arnold, E. (1996). *Mental health nursing: The nurse-patient journey*. Toronto: W.B. Saunders.
- Cash, K. (1995). Benner and expertise in nursing: a critique. *International Journal of Nursing Studies*, 32(6), 527-534.
- Ceci, C., & McIntyre, M. (2001). A 'quiet' crisis in health care: developing our capacity to hear. *Nursing Philosophy*, 2, 122-130.
- Ceci, C. (2006). When difference matters: The politics of privilege and marginality. In J. McIntyre, E. Thomlinson, & C. McDonald (2nd Ed), *Realities of Canadian Nursing: Professional, practice, and power Issues* (pp. 398-433). Philadelphia: Lippincott Williams & Wilkins
- Ceci, C. (2003). *Analyzing and reflecting upon limits: A Foucaultian-influenced study of some recent events of concern to nursing*. Unpublished dissertation, University of Calgary, Calgary.
- Cheek, J. (1996). Policy matters: Critical policy analysis and nursing. *Journal of Advanced Nursing*, 25, 668-672.
- Cheek, J. (2002). *Foucault, aged Care*. Paper presented at the Eighth Qualitative Health Research Conference, Banff Centre, Banff, Alberta.
- Cheek, J., & O'Brien, B. (1997). Using critical incident technique to inform aged and extended care nursing. *Western Journal of Nursing Research*, 19(5), 667-680.
- Cheek, J., & Rudge, T. (1994). The panopticon re-visited?: an exploration of the social and political dimensions of contemporary health care and nursing practice. *International Journal of Nursing Studies*, 31(6), 583-591.

- Cheung, J. (1998). Caring as the ontological and epistemological foundations of nursing: a view of caring from the perspectives of Australian nurses. *International Journal of Nursing Practice*, 4, 225-233.
- Chinn, P. (2001). *Peace & power: Building communities for the future* (5th ed.). Sudbury: Jones and Bartlett Publishers.
- Clarke, J. B. (2000). Evidence-based practice: A retrograde step? The importance of pluralism in evidence generation for the practice of health care. *Journal of Clinical Nursing*, 8(1), 89-94.
- Cohen, J. (1991). Two portraits of caring: A comparison of the artists Leininger and Watson. *Journal of Advanced Nursing*, 16, 899-909.
- Copnell, B. (1998). Understanding change in clinical nursing practice. *Nursing Inquiry*, 5, 2-10.
- Corley, M., & Goren, S. (1998). The dark side of nursing: Impact of stigmatizing responses on patients. *Scholarly Inquiry for Nursing Practice*, 12(2), 99-122.
- Cotter, J. (2002, Wednesday, January 9). Alberta health plan a threat to Medicare: Dave Barrett. *The Vancouver Sun*, pp. A2.
- Cotton, A. (1997). Power, knowledge, and the discourse of specialization in nursing. *Clinical Nurse Specialist*, 11(1), 25-29.
- Crellin, L. (1999). Caring in an environment of change and case mix funding. *Contemporary Nurse: A Journal for the Australian Nursing Profession*, 8(2), 14-22.
- Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks: Sage Publishers.
- Crigger, N. (1997). The trouble with caring: A review of eight arguments against an ethic of care. *Journal of Professional Nursing*, 13(4), 217-221.
- Crowe, M. (1998). The power of the word: some post-structural considerations of qualitative approaches in nursing research. *Journal of Advanced Nursing*, 28(2), 339-344.
- Davies, B. (1990). Agency as a form of discursive practice. A classroom scene observed. *British Journal of Sociology of Education*, 11(3), 341-361.
- Davies, B. (2000). *Keynote address: Weaving for the future: Using rulers and roses*. Paper presented at the CANO conference, Victoria, BC.

- Davis, B., & Logan, J. (1997). *Reading research: A user-friendly guide for nurses and other health professionals* (2nd ed.). Ottawa: CNA.
- de Certeau, Michel (1984). *The practice of everyday life* (S. Rendall, Trans.). Berkeley: University of California Press.
- DeKeyser, F., & Medoff-Cooper, B. (2004). A non-theorist's perspective on nursing theory: Issues of the 1990's. In P. Reed, N. Shearer, & L. Nicoll (eds), *Perspectives on Nursing Theory* (4th ed.) (pp. 159-168). Philadelphia: Lippincott
- Denzin, N. (1997). *Interpretive ethnography: Ethnographic practices for the 21st Century*. London: Sage Publications.
- Denzin, N., & Lincoln, Y. (2000). *Handbook of Qualitative Research* (2nd Ed.). London: Sage Publications, Inc.
- Disch, L. (1994). *Hannah Arendt and the limits of philosophy*. London: Cornell University Press.
- Donelan, K. (1999). The drama of ethnography. In C. Miller & J. Saxton, *Drama and theatre in education: International conversations* (pp. 256-264). Victoria: American Education Research Association, Arts and Learning Special Interest Group, International Drama in Education Research Institute.
- Dossey, B. M. (2000). *Florence Nightingale: Mystic, visionary, healer*. Springhouse, Pennsylvania: Springhouse Corporation.
- Drengson, A. (1999). *Wise dwelling: Transitions from modern to ecological paradigms*. Unpublished manuscript.
- Dreyfus, P., & Rabinow, S. *Interpretive social science: A second look*. Los Angeles: University of California Press.
- Du Gas, B. W., Esson, L., & Ronaldson, S. (1999). *Nursing foundations: A Canadian perspective* (2nd ed). Scarborough: Prentice Hall Canada Inc.
- Du Gas, B. W., & Knor, E. (1995). *Nursing foundations: A Canadian perspective*. Scarborough: Appleton & Lange Canada.
- Du Plat-Jones, J. (1999). Power and representation in nursing: a nursing review. *Nursing Standard*, 13(49), 39-42.
- Duke, S. & Copp, G. (1992). Hidden Nursing. *Nursing Times*, 88, 40-42.

- Dumas, R. (1999). President's message. *Nursing and Health Care Perspectives*, 20(1), 1,34.
- Editor. (2000). CNA: Data to reflect nursing impact. *The Canadian Nurse*(March), p.10.
- Editorial. (2002, Thursday, January 10). The start of serious health care debate. *National Post*, pp. A17.
- Editorial. (2002, Monday, May 6). Bed closures in Hope will mean 'mayhem': doctor. *The Vancouver Sun*, pp. B4.
- Ely, M., Vinz, R., Downing, M., & Anzul, M. (1997). *On qualitative research: Living by words*. London: The Falmer Press.
- Engebretson, J. (2001). Alternate and complementary healing: Implications for nursing. In Elinor Hein, *Nursing issues in the 21st century*. (pp.150 -165). New York: Lippincott.
- Epp, J. (1986). *Achieving health for all*. Ottawa: National Health and Welfare.
- Epstein, I., Kazanjian, A., & MacAulay, D. (2001). *Health Professions Council: Safe choices: A new model for regulating health professions in British Columbia; PartII, Volume 2: Preliminary legislative review reports*. Vancouver: BC Ministry of Health.
- Estes, C. P. (1995). *Women who run with the wolves: Myths and stories of the wild woman archetype*. New York: Ballantine Books.
- Evans, R. G. (1984). *Strained mercy: The economics of Canadian health care*. Toronto: Butterworths.
- Evans, R. G., Barer, M. L., & Marmor, T. R. (1994). *Why are some people healthy and others not? The determinants of health and populations*. New York: Aldine De Gruyter.
- Fairman, J., & D'Antonio. (1999). Virtual power: gendering the nurse-technology relationship. *Nursing Inquiry*, 6, 178-186.
- Fayerman, P. (2002a, Wednesday, January 9). Alberta proposed stay-healthy incentive: Medical savings accounts idea gains momentum. *The Vancouver Sun*, pp. A1,A2.
- Fayerman, P. (2002b, Thursday, January 10). Green tea kills cancer cells, researchers discover. *The Vancouver Sun*, pp. A1, A2.
- Ferguson, K. (1984). *The feminist case against bureaucracy*. Philadelphia: Temple University.

- Fletcher, M. (2001). The Manitoba Pediatric Cardiac Surgery Inquest report. *Canadian Nurse*, 97(2), 14-16.
- Flynn, T. (1988). Foucault as parrhesiast: his last course at the college de france (1984). In j. bernauer & d. rasmussen (Eds.), *the Final Foucault* (pp. 102-118). Cambridge: MIT Press.
- Fondiller, S., & Nerone, B. (1995). *Nursing: The career of a lifetime*. New York: National League for Nursing Press.
- Foucault, M. (1970). *The order of things: An archaeology of the human sciences* (R. D. Laing, Trans.). New York: Pantheon Books.
- Foucault, M. (1972). *The archaeology of knowledge and the discourse of language* (A. M. S. Smith, Trans.). New York: Pantheon Books.
- Foucault, M. (1977). *Language, counter-Memory, practice: Selected essays and interviews*. New York: Cornell University Press.
- Foucault, M. (1978). *The history of sexuality: Volume 1 An introduction* (R. Hurley, Trans.). New York: Pantheon Books.
- Foucault, M. (1979). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). New York: Vantage.
- Foucault, M. (1980). *Power/Knowledge: Selected interviews & other writings 1972-1977* (C. Gordon & L. Marshall & J. Mepham & K. Soper, Trans.). New York: Pantheon Books.
- Foucault, M. (1982). The subject and power. In H. Dreyfuss & P. Rabinow (Eds.), *Michel Foucault: Beyond structuralism and hermeneutics*. Chicago: University of Chicago Press.
- Foucault, M. (1984a). The ethic of care for the self as a practice of freedom: an interview translated by j.d. gauthier,s.j. In j. bernauer & d. rasmussen (Eds.), *The Final Foucault* (pp. 1-20): MIT Press edition.
- Foucault, M. (1984b). *The history of sexuality: Volume 2 The use of pleasure*. New York: Penguin Books.
- Foucault, M. (1988). Technologies of the self. In L. Martin & H. Gutman & P. Hutton (Eds.), *Technologies of the self: A seminar with Michel Foucault* (pp. 16-49). Amherst: The University of Massachusetts Press.
- Foucault, M. (1990). *Politics, philosophy, culture: interviews and other writings 1977-1984* (A. Sheridan, Trans.). New York: Routledge.

- Foucault, M. (1991). *The Foucault effect: Studies in governmentality*. Chicago: The University of Chicago Press.
- Foucault, M. (1994). *The birth of the clinic: An archaeology of medical perception* (A. M. S. Smith, Trans.). New York: Vintage Books.
- Foucault, M. (1997). *Health and Medicine*. New York: Routledge.
- Francis, D., Owens, J., & Tollefson, J. (1998). 'It comes together at the end': the impact of a one-year subject in Nursing Inquiry on philosophies of nursing. *Nursing Inquiry*, 5, 268-278.
- Frank, A. (1998). Foucault or not Foucault? Commonwealth and American perspectives on health in the neo-liberal state. *Health*, 2(2), 233-243.
- Fraser, N. (1987). What's critical about critical theory? The case of Habermas and gender. In S. Benhabib & D. Cornell (Eds.), *Feminism as critique* (pp. 31-56). Cambridge: Polity Press.
- Fuller, C. (1999). *Reformed or Rerouted? Women and change in the health care system*. Vancouver: British Columbia Centre of Excellence for Women's Health.
- Gadow, S. (1999). Relational narrative: The postmodern turn in nursing Ethics. *Scholarly Inquiry for Nursing Practice: An International Journal*, 13(1), 57-69.
- Gallagher, S. M. (1999). The ethics of compassion. *Ostomy Wound Management*, 45(6), 14-16.
- Garon, M. (2002). Science of unitary human beings: Martha Rogers. In J. B. George (Ed.), *Nursing Theories: The Basis for Professional Nursing Practice* (pp. 269-294). Upper Saddle River: Prentice Hall.
- Gastaldo, D., & Holmes, D. (1999). Foucault and nursing: a history of the present. *Nursing Inquiry*, 6, 231-240.
- Gatens, M. (1992). Power, bodies, and difference. In M. Barret & A. Phillips (Eds.), *Destabilizing theory: Contemporary feminist debates*. (pp. 120-137). Cambridge, UK: Polity Press.
- Gaut, D. (1983). Development of a theoretically adequate description of caring. *Western Journal of Nursing Research*, 5(4), 312-324.
- Geanellos, R. (2000). Exploring Ricoeur's hermeneutic theory of interpretation as a method of analyzing research texts. *Nursing Inquiry*, 7, 112-119.
- Gergen, K. (1991). *The saturated self*. New York: Basic Books.

- Gibb, H. (1998). Reform in public health: where does it take nursing? *Nursing Inquiry*, 5, 258-267.
- Gifford-Jones, W. (2001, Tuesday, October 23). Cholesterol war is being wages on wrong front. *Winnipeg Free Press*, pp. B3.
- Gilbert, T. (1998). Towards a politics of trust. *Journal of Advanced Nursing*, 27, 1010-1016.
- Gilligan, C. (1982). *In a Different Voice: Psychological theory and women's development*. Cambridge: Harvard University Press.
- Giorgi, A. (1970). *Psychology as a human science*. New York: Harper & Row.
- Giurgevich, P. L. (1996). Perspectives on dichotomous thinking. *Nurse Educator*, 21(4), 41-44.
- Gordon, C. (1991). Governmental rationality: an introduction. In G. Burchell & C. Gordon & P. Miller (Eds.), *The Foucault effect* (pp. 1-51). Chicago: The University of Chicago Press.
- Gordon, S. (1997). *Life support*. Boston: Little, Brown and Company.
- Gordon, S. (1999). *From silence to voice*. Boston: Little, Brown and Company.
- Gordon, S. (2001). Nurse interrupted. In Elinor Hein, *Nursing issues in the 21st century*. (pp.79-88). New York: Lippincott. .
- Gordon, S., Benner, P., & Noddings, N. (1996). *Caregiving: Readings in knowledge, practice, ethics, and politics*. Philadelphia: University of Pennsylvania Press.
- Gray, Ross (2002). *Standing Ovation: Performing Social Science Research about Cancer*. Walnut Creek: AltaMira Press.
- Gregory, D. (2000, Sunday, May 21). Invisible nurses given strong voice. *Winnipeg Free Press*, pp. D4.
- Griffiths, H. (2006). Advanced Nursing Practice: Enter the Nurse Practitioner. *Nursing BC*, 38:2, 12-16.
- Grosz, E. (1994). *Volatile bodies: Towards a corporeal feminism*. Indiana: Indiana University Press.
- Growe, S. J. (1991). *Who cares: The crisis in Canadian nursing*. Toronto: McLelland & Stewart Inc.

- Haines, J. (1997). Questions from an inquest. *Canadian Nurse*, (November), 3.
- Haines, J. (1998). Nurses in the media. *Canadian Nurse*, (December), 3-4.
- Hallam, J. (1998). From angels to handmaidens: changing constructions of nursing's public image in post-war Britain. *Nursing Inquiry*, 5, 32-42.
- Halldorsdottir, S. (1999). The effects of uncaring. *Reflections, Fourth Quarter*, 28-30.
- Hamilton, G. (1993). The nurses are innocent. *The Canadian Nurse*(December), 27-32.
- Hammersley, M. & Atkinson, P. (1995). *Ethnography: Principles in practice* (2nd ed.). New York: Routledge.
- Hardingham, L. (2006). Ethical and legal issues in nursing. In J. McIntyre, E. Thomlinson, & C. McDonald (2nd Ed), *Realities of Canadian Nursing: Professional, practice, and power Issues* (pp.317-333). Philadelphia: Lippincott Williams & Wilkins.
- Harris, J., Graham, L., & McKeown, K. (2002). Over the edge: Governments can't wash their hands of their responsibility for those among us who need extra care. *The Vancouver Sun*, pp. A5.
- Hartrick, G. (1997). Relational capacity: the foundation for interpersonal nursing practice. *Journal of Advanced Nursing*, 26(3), 523-528.
- Hazelton, M. (1999). Psychiatric personnel, risk management and the new institutionalism. *Nursing Inquiry*, 6, 224-230.
- Health Professions Council. (2001). *Registered Nurses Scope of Practice*. Vancouver: British Columbia Ministry of Health.
- Heartfield, M. (1996). Nursing documentation and nursing practice: a discourse analysis. *Journal of Advanced Nursing*, 24, 98-103.
- Heidegger, M. (1962). *Being and time*. New York: Harper and Row Publishers.
- Henderson, A. (1994). Power and knowledge in nursing practice: the contribution of Foucault. *Journal of Advanced Nursing*, 20, 935-939.
- Henderson, V. (1960). *Basic principles of nursing care*. Geneva: International Council of Nurses.
- Heslop, L. (1997). The (im)possibilities of poststructuralist and critical social nursing inquiry. *Nursing Inquiry*, 4, 48-56.

- Heslop, L. (1998). A discursive exploration of nursing work in the hospital emergency setting. *Nursing Inquiry*, 5, 87-95.
- Hills, M. (1993). *Images of nursing: A review and analysis of literature relevant to the images of nursing in British Columbia*. Victoria: School of Nursing, University of Victoria.
- Hills, M. (1998). Student experiences of nursing health promotion practice in hospital settings. *Nursing Inquiry*, 5, 164-173.
- Hills, M. (1999). Perspectives on learning and practicing health promotion within hospitals: Nursing student's stories. In L. Young & J. E. Hayes (Eds.), *Transforming health promotion practice: Concepts, issues, and applications (To be published Spring 2000)*. Philadelphia: F.A. Davis.
- Hills, M. (2000). Human science research in public health: The contribution and assessment of a qualitative approach. *Canadian Journal of Public Health*, 91(6), 14-18.
- Hinam, I. (1999). Winnipeg's Pediatric Cardiac Inquest: The Ethical Issues. *Canadian Operating Room Nursing Journal*(December), 13-16.
- Hodgson, K. (2001, Tuesday, October 23). A system gone mad: Mentally ill left to own, inadequate, devices. *Winnipeg Free Press*, pp. B1.
- Hoepfner, M. M. (1996). *Conversations of care: A description of the phenomenon of care in nursing leadership*. Unpublished dissertation, University of St. Thomas, St. Paul.
- Hogben, D. (2002, Wednesday, May 8). Health-care workers dismissed: First 100 of 700 staffers get 'displacement notices'. *The Vancouver Sun*, pp. A4.
- Holmes, C. (1992). *Critical theory and the discourse of nursing ethics. (Ph.D. dissertation)*. Unpublished Doctor of Philosophy, Deakin University.
- Huebner, D. (1998). Personal comments during discussion in graduate seminar at University of Victoria. British Columbia.
- Huebner, D., Hillis, V., & Pinar, W. (1999). *The lure of the transcendent*. Mahwah, New Jersey: Lawrence Erlbaum Associates, Publishers.
- Huntington, A., Gilmour, J., & O'Connell, A. (1996). Reforming the practice of nurses: Decolonization or getting out from under. *Journal of Advanced Nursing*, 24, 364-367.

- Internet Encyclopedia of Philosophy. *Aristotle Overview* [2003, May 22].
- Iowa Intervention Project. (1996). *Nursing interventions classification (NIC)* (Second ed.). St. Louis: Mosby.
- Jacobi, J. (1973). *The psychology of CG Jung*. New Haven: Yale University Press.
- Jennings, B., & Loan, L. (2001). Misconceptions among nurses about evidence-based practice. *Journal of Nursing Scholarship*, 33(2), 121-127.
- Johne, M. (2001, Tuesday, November 20). Medicine: Digital breakthroughs, a technological fix. *Financial Post*, pp. IT 1.
- Johns, C. (1999). Reflection as empowerment? *Nursing Inquiry*, 6, 241-249.
- Jones, E. (1961). *The life and work of Sigmund Freud*. New York: Basic Books, Inc.
- Joudrey, R., & Gough, J. (1999). Caring and curing revisited: Student nurses' perceptions of nurses' and physicians' ethical stances. *Journal of Advanced Nursing*, 29(5), 1154-1162.
- Kaminski, J. (2006). Nursing through the Lens of Culture: a multiple gaze. Retrieved September 25, 2006 from <http://www.nursing-informatics.com/sitemap.html>
- Karp, M. (Producer) (1998). 24 Hours special report: The broken hearts club. Winnipeg: Canadian Broadcasting Company.
- Keating, M., & Smith, O. N. (2000). *Ethical and legal issues in Canadian nursing* (second ed.). Toronto: W.B. Saunders Canada.
- Kellett, U. (1999). Searching for new possibilities to care: A qualitative analysis of family caring involved in nursing homes. *Nursing Inquiry*, March, 6(1), 9-16.
- Kendall, G., & Wickham, G. (1999). *Using Foucault's methods*. Thousand Oaks, California: Sage Publications.
- Kennedy, M. (2001, Thursday, January 25). Medicare 'Crisis' a Sham:Report 'Money to be Made'. *The Vancouver Sun*, pp. A1, A9.
- Kent-Wilkinson, A. (1993). After the crime, before the trial. *The Canadian Nurse*(December), 27-31.
- Kerr, J. R., & MacPhail, J. (1996). *Concepts in Canadian nursing*. Toronto: Mosby-Yearbook Inc.

- Kikuchi, J., & Simmons, H. (1999). Practical judgment: A moderate realist conception. *Scholarly Inquiry for Nursing Practice: An International Journal*, 3(1), 43-55.
- Killick, A., & Jennison, K. (1999, Thursday April 9th). Nurses not valued. *National Post*, pp. A10.
- Kines, M. (1999). The risks of caring too much. *Canadian Nurse*, 95(8), 27-30.
- Kirby, C. & Slevin, O. (1992). A new curriculum for care. In O. Slevin and M. Buckenham (Eds), In *Project 2000: The Teachers Speak-Innovations in the Nursing Curriculum* (pp. 80-93). Edinburgh: Campion Press.
- Kirkley, D. (2000). Is motherhood good for women? A feminist exploration. *JOGNN*, September/October, 459-464.
- Kirkham, S. M. Reimer, (2000). *Making sense of difference: The social organization of intergroup relations in health care provision*. Unpublished dissertation, University of British Columbia, Vancouver.
- Kornfield, J., & Feldman, C. (1996). *Soul Food* (2nd ed.). New York: Harper San Francisco.
- Kramer, M. (1990). Trends to watch at the magnet hospitals. *Nursing* 90, June, 67-74.
- Kuhse, H. (1997). *Caring: Nurses, women and ethics*. Maldon, MA: Blackwell Publishers Ltd.
- Kuokkanem, L., & Leino-Kilpi, H. (2000). Power and empowerment in nursing: three theoretical approaches. *Journal of Advanced Nursing*, 31(1), 235-241.
- Lakeoff, G., & Johnson, M. (1980). *Metaphors we live by*. Chicago: The University of Chicago Press.
- Lalonde, M. (1974). *A new perspective on the health of Canadians*. Ottawa: National Health and Welfare.
- Lather, P. (1991). *Getting smart: Feminist research and pedagogy within the Modern*. New York: Routledge Publishers.
- Lea, A., Watson, R., & Deary, I. (1998). Caring in nursing: a multivariate analysis. *Journal of Advanced Nursing*, 28(3), 662-671.
- Leghorn, L., & Parker, K. (1981). *Women's worth: Sexual economics and the world of women*. Boston: Routledge & Kegan.

- Leininger, M. (1978). *Transcultural Nursing: Concepts, theories, and practice*. Toronto: John Wiley & Sons.
- Leininger, M. (1985). Forward. In J. Watson (Ed.), *Nursing: The philosophy and the science of caring* (2nd ed., pp. xi-xiv). Niwot: University Press of Colorado.
- Lenniger, M. (1995). *Transcultural nursing: Concepts, theories, research, & practice* (2nd ed.). New York: McGraw-Hill.
- Lepp, Margaret. (2000). A thousand mile journey begins with a single step. In J. O'Toole J. & M. Lepp, *Drama for life: Stories of adult learning and empowerment* (pp.305-315), Brisbane: Playlab Press.
- Lessing, D. (1984). *The diaries of Jane Somers*. New York: Vintage Books.
- Lewin, K. (1948). *Resolving conflicts: Selected papers on group dynamics*..(Ed). New Your: Harper & Row publishers.
- Lewin, K. (1951). *Field Theory in social science*. (Ed). New Your: Harper & Row publishers.
- Lewin, K. (1997). *Resolving conflicts, and, Field Theory*. New Your: American Psychological Association.
- Lewis, M. g. (1993). *Without a word: Teaching beyond women's silence*. London: Routledge.
- Liaschenko, J., & Fisher, A. (1999). Theorizing the knowledge that nurses use in the conduct of their work. *Scholarly Inquiry for Nursing Practice: An International Journal*, 13(1), 29-42.
- Liehr, P., Smith, M., & Cameron, C. (2005). Theoretical framework. In G. LoBiondo-Wood & J. Haber. *Nursing research in Canada: Methods, critical appraisal, and utilization* (pp. 105-118). Toronto: Elsevier Canada.
- Lindeman, C. (1999). Clinical decision making. In C. A. Lindeman & M. McArthie (Eds.), *Fundamentals of contemporary nursing practice* (pp. 188-221). Toronto: W. B. Saunders Company.
- Lindsay, I. (2001, Friday, February 2001). Nurses take to the streets in rally for higher wages. *The Vancouver Sun*, pp. B5.
- LoBiondo-Wood, G. & Haber, J. (2005). *Nursing research in Canada: Methods, critical appraisal, and utilization*. Toronto: Elsevier Canada.

- Lindquist, L. (1997). Interpersonal trust in the helping relationship. *Journal of Advanced Nursing*, 26(4), 542-551.
- Locsin, R. C. (1998). Technologic competence as caring in critical care nursing. *Holistic Nursing Practice*, 12(4), 50-56.
- Lorde, A. (1984). *Sister Outsider*. New York: The Crossing Press.
- Lunman, K. (2001, Friday, August 10). Nurses plan reply to B.C. legislation. *Globe and Mail*.
- Magnusson, W. (1996). *The search for political space*. Toronto: University of Toronto Press.
- Marsh, J. (1998). Truth and Power in Foucault. In L. Langsdorf & S. Watson (Eds.), *Reinterpreting the political: Continental philosophy and political theory* (pp. 291-306) New York: SUNY Press.
- Martusewicz, R. (1992). Mapping the terrain of the post-modern subject: post-structuralism and the educated woman, *Understanding Curriculum as Deconstructed Text*. New York: Teachers College Press.
- McCalman, J. (1998). The power of care: the women's hospital 1884-1914. *Nursing Inquiry*, 5, 204-211.
- McCormick, J. (1997). *The discourses of control: Power in nursing*. Unpublished Dissertation, University of British Columbia, Vancouver.
- McDonald, C., McIntyre, M., & Thomlinson, E. (2006). Nursing issues: A call to political action. In J. McIntyre, E. Thomlinson, & C. McDonald (2nd Ed), *Realities of Canadian Nursing: Professional, practice, and power Issues* (pp. 3-15). Philadelphia: Lippincott Williams & Wilkins.
- McDonald, C. (2006). Issues of gender and power: The significance attributed to nurses' work. In J. McIntyre, E. Thomlinson, & C. McDonald (2nd Ed), *Realities of Canadian Nursing: Professional, practice, and power Issues* (pp. 3-15). Philadelphia: Lippincott Williams & Wilkins.
- McDonald, C. (2006). Professional, practice, and power issues: Thinking back, looking ahead. In J. McIntyre, E. Thomlinson, & C. McDonald (2nd Ed), *Realities of Canadian Nursing: Professional, practice, and power Issues* (pp. 449-456). Philadelphia: Lippincott Williams & Wilkins.
- McInnes, C. (2002, Tuesday, April 23). B.C.'s radical plan for health care. *The Vancouver Sun*, pp. A1, A4.

- McInnes, C., Bailey, P., & Beatty, J. (2001, Tuesday, June 19). Liberals step in to health disputes: Cooling off time angers unions. *Vancouver Sun*, pp. A1, A6.
- McIntyre, M. & McDonald (2006). Unionization: Collective bargaining in nursing. In J. McIntyre, E. Thomlinson, & C. McDonald (2nd Ed), *Realities of Canadian Nursing: Professional, practice, and power Issues* (pp. 303-316). Philadelphia: Lippincott Williams & Wilkins.
- McIntosh (1988). White privilege and male privilege: A personal account of coming to see correspondences through work in Women's Studies. In M.I. Anderson & P.H. Collins (Eds) *Race, class, and gender: An anthology* (pp. 76-87). Belmont: Wodsworth Publishers
- McMillan, M., & Andrews, J. (1996). A question of advanced competence. *Australian Nursing Journal*, 4(3), 30-32.
- McWhorter, L. (1999). *Bodies and pleasure: Foucault and the politics of sexual Normalization*. Bloomington: Indiana University Press.
- Meloy, J. (1994). *Writing the qualitative dissertation*. Hillsdale:Lawrence Erlbaum Associates Inc.
- Menzies, H. (2005). *Stress and the crisis of modern life*. Vancouver: Douglas & McIntyre Ltd.
- Meredith, J. F. (1987). *Difference, discourse, genealogy*. Unpublished thesis, University of Victoria, Victoria.
- Mills, S. (1997). *Discourse*. London: Routledge.
- Miller, C. & Saxton, J. (1999). *Drama and theatre in education: International conversations*. Victoria: American Education Research Association, Arts and Learning Special Interest Group, International Drama in Education Research Institute.
- Mitchell, D. P. (1996). Postmodernism, health and illness. *Journal of Advanced Nursing*, 23, 201-205.
- Mohamed, J. & Lloyd, D. (1990). Introduction:Toward a theory of minority discourse:What is to be done? In Mohamed and Lloyd, *The Nature and Context of Minority Discourse*. Oxford. Oxford University Press.
- Mohr, W. (1999). Deconstructing the language of psychiatric hospitalization. *Journal of Advanced Nursing*, 29(5), 1052-1059.

- Morgan, L. (1996). *Nurses' experience of compassion*. Unpublished dissertation, The University of Texas, Austin.
- Mourad, R. (1997). *Postmodern philosophical critique and the pursuit of knowledge in higher education*. Westport: Bergin & Garvey.
- Nay, R. (1998). Contradictions between perceptions and practices of caring in long-term care of elderly people. *Journal of Clinical Nursing*, 7(5), 401-408.
- Nelms, T. (1996). Living a caring presence in nursing: a Heideggerian hermeneutical analysis. *Journal of Advanced Nursing*, 24, 368-374.
- Nightingale, F. (1859). *Notes on nursing*. London: Harrison and Sons.
- Noddings, N. (1984). *Caring as a feminist approach to ethics*.
- Noddings, N. (1989). *Women and evil*. Los Angeles: University of California Press.
- Oberg, A. (1998). Personal communication during course on Foundations of Curriculum Studies. University of Victoria.
- O'Neil, J. (2001, Friday, December 14). More seeking pain relief through alternative medicine. *The Vancouver Sun*, pp. A17.
- Orem, D., E. (1985). *Nursing concepts of practice* (Third ed.). New York: McGraw-Hill Book Company.
- O'Toole, J. & Lepp, M. (2000). *Drama for life: Stories of adult learning and empowerment*. Brisbane: Playlab Press.
- Painter, V. (1999). *Therapeutic intimacy: The lived experience of the oncology nurse*. Unpublished thesis, University of Manitoba, Winnipeg.
- Parker, I. (1992). *Discourse dynamics: Critical analysis for social and individual psychology*. London: Routledge.
- Parker, I., & Network, T. B. D. (1999). *Critical textwork: An introduction to varieties of discourse and analysis*. Buckingham: Open University Press.
- Parker, J. (1999). Patient or customer? Caring practices in nursing and the global supermarket of care. *Collegian: Journal of the Royal College of Nursing Australia*, 6(1), 16-23.
- Paul, A. (1998, Saturday, August 22). Surgery program lessons change in way hospitals run. *Winnipeg Free Press*, pp. A1.

- Paul, A. (1998), Thursday, August 13). Expert blasts HSC in deaths. *Winnipeg Free Press*, pp. A1.
- Peavy, Vance (1997). *A constructivist perspective for the practice of counseling in the 21st century: Socio-dynamic counseling*. Victoria: Trafford Publishing.
- Pemberton, K. (2002), Thursday, March 28). Fees proposed for Richmond emergency care. *The Vancouver Sun*, pp. B1, B4.
- Penny, W., & Warelow, P. (1999). Understanding the prattle of praxis. *Nursing Inquiry*, 6, 259-268.
- Piaget, J. (1970). *Psychology and Epistemology: Towards a Theory of Knowledge*. New York: Viking.
- Pike, A. (1997). Entering collegial relationships: The demise of nurse as victim. In J. McCloskey & H. Grace (Eds.), *Current issues in nursing* (5th ed., pp. 532-536). Toronto: Mosby.
- Polkinghorne, D. (2004). *Practice and the Human Sciences: The Case for a judgment-based practice of caring*. New York: State University of New York Press.
- Porter, S., & Ryan, S. (1996). Breaking the boundaries between nursing and sociology: A critical realist ethnography of the theory-practice gap. *Journal of Advanced Nursing*, 24, 413-420.
- Powers, P. (1994). *A discourse analysis of nursing diagnosis*. Unpublished Dissertation, University of Washington, Seattle.
- Powers, P. (1996). Discourse analysis as a methodology for nursing inquiry. *Nursing Inquiry*, 3, 207-217.
- Price, K., & Cheek, J. (1996). Exploring the nursing role in pain management from a post-structuralist perspective. *Journal of Advanced Nursing*, 24, 899-904.
- Province of British Columbia. (1993). *New directions for a healthy British Columbia. Meeting the challenge. Action for a healthy society*. Vancouver: Ministry for Health and Ministry Responsible for Seniors.
- Pryce, A. (2000). Frequent observation: sexualities, self-surveillance, confession and the construction of the active patient. *Nursing Inquiry*, 7, 103-111.
- Purkis, M. E. (1993). *Bringing 'practice' to the Clinic: an excavation of the effects of health promotion discourse on nursing practice in a community health clinic*. Unpublished Dissertation, University of Edinburgh, Edinburgh.

- Purkis, M. E. (1994). Entering the field: Intrusion of the social and its exclusion from studies of nursing practice. *International Journal of Nursing Studies*, 31, 315-336.
- Purkis, M.E. & Nelson, S. (2006). Nursing competence: Constructing persons and a form of life. In J. McIntyre, E. Thomlinson, & C. McDonald (2nd Ed), *Realities of Canadian Nursing: Professional, practice, and power Issues* (pp. 3-15). Philadelphia: Lippincott Williams & Wilkins
- Purnell, M. J. (1998). Who really makes the bed? Uncovering technologic dissonance in nursing. *Holistic Nursing Practice*, 12(4), 12-22.
- Racevskis, K. (1988). Michel Foucault: The question of identity. In j. bernauer & d. rasmussen (Eds.), *The final Foucault* (pp. 21-33). Cambridge: MIT Press.
- Rafael, A. R. F. (1996). Power and caring: A Dialectic in nursing. *Advances in Nursing Science*, 19(1), 3-17.
- Rafael, A. R. F. (1998). Nurses who run with the wolves: the power and caring dialectic revisited. *Advances in Nursing Science*, 21(1), 29-42.
- Raines, D. (1994). Moral agency in nursing. *Nursing Forum*, 29, 5-11.
- Rankin, J. (1998). *Health care reform and restructuring of Nursing*. edyserv.edu.yorku.ca.
- Ray, M. (1998). A phenomenologic study of the interface of caring and technology in intermediate care: towards a reflexive ethics for clinical practice. *Holistic Nursing Practice*, July, 12(4), 69-77.
- Reed, P. (1995). A treatise on nursing knowledge development for the 21st century: beyond postmodernism. *Advances in Nursing Science*, 17, 70-84
- Registered Nurses Association of British Columbia. (1990). *Health promotion. A discussion paper*. Vancouver: RNABC.
- Registered Nurses Association of British Columbia. (1990). *Primary health care. A discussion paper*. Vancouver: RNABC.
- Registered Nurses Association of British Columbia. (1990). *Nursing competencies and skills required of the new graduate*. Vancouver: RNABC.
- Registered Nurses Association of British Columbia. (1991). *New directions for health care: Health goals. A discussion paper*. Vancouver: RNABC.
- Registered Nurses Association of British Columbia. (1992). *Primary Health Care: Answering nursing practice questions*. Vancouver: RNABC.

- Registered Nurses Association of British Columbia. (1995). *The scope of nursing practice. Submission to the Health Professions Council*. Vancouver, BC: RNABC.
- Registered Nurses Association of British Columbia. (1998). *Competencies Required of a New Graduate*. Vancouver: RNABC.
- Registered Nurses Association of British Columbia. (1999). *Professional development: A short guide to meeting continuing competency requirements*. Vancouver: RNABC.
- Registered Nurses Association of British Columbia. (2000). *In touch: Keeping you informed*. Vancouver: RNABC.
- Registered Nurses Association of British Columbia. (2001a, December). Regulating registered nurses in the public interest. *Newsline*, 1, 4.
- Registered Nurses Association of British Columbia. (2001b, December). The right to intervene in poor practice settings. *Newsline*, 2.
- Registered Nurses Association of British Columbia. (2002a). *In Touch: keeping you informed*. Vancouver: Registered Nurses Association of BC.
- Registered Nurses Association of British Columbia. (2002b). Tough decisions ahead for nurses. *Newsline*, March, 4.
- Registered Nurses Association of British Columbia. (2002c). Information is power. *Continuing Education*, (Fall), 15.
- Registered Nurses Association of British Columbia. (2003). *Standards for registered nursing practice*. Vancouver: Registered Nurses Association of British Columbia.
- Reverby, S. (1987). *Ordered to care: The dilemma of American nursing, 1850-1945*. New York: Cambridge University Press.
- Reverby, S. (1997). A caring dilemma: womanhood and nursing in historical perspective. In P. Conrad (Ed.), *The sociology of health and illness* (pp. 215-225). New York: St Martin's Press.
- Richardson, L. (1994). Writing: A method of inquiry. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 516-529). Thousand, Oaks: Sage.
- Richardson, L. (1997). *Fields of play: Constructing an academic life*. New Brunswick: Rutgers University Press.

- Roach, S. (1987). *The human act of caring*. Ottawa: Canadian Hospital Association.
- Robertson, B. (2000). Why babies died. *Maclean's*, (December 11), 44.
- Robertson, H. (1998). Heartbreak. *Elm Street*, (March), 92-99.
- Rodney, P. A. (1997). *Towards connectedness and trust*. Unpublished dissertation, University of British Columbia, Vancouver.
- Rodney, P., Brown, H., & Liaschenko, J. (2004). Moral agency: Relational connections and trust. In J. Storch, P. Rodney, & R. Starzomski, *toward a moral horizon* (pp. 154-177). Toronto: Pearson Prentice Hall.
- Rodney, P., Pauly, B., & Burgess, M. (2004) Our theoretical landscape, complementary approaches to health care ethics. In J. Storch, P. Rodney, & R. Starzomski, *toward a moral horizon* (pp. 77-97). Toronto: Pearson Prentice Hall.
- Rogers, M. (1970). *An introduction to the theoretical basis of nursing*. Philadelphia: Davis.
- Rosenau, P. M. (1992). *Post-modernism and the social sciences*. Princeton: Princeton University Press.
- Ross-Kerr, J. & Wood, M. (2001). *Canadian Fundamentals of Nursing*. (2nd ed). Toronto: Mosby.
- Roy, C. (1976). *Introduction to nursing: An adaptation model*. Upper Saddle River: Prentice Hall.
- Rubenstein, D. (1988). Food for thought: Metonymy in the late Foucault. In j. bernauer & d. rasmussen (Eds.), *The final Foucault* (pp. 83-101). Cambridge: MIT Press.
- Rubin, J. (1996). Impediments to the development of clinical knowledge and ethical judgment in critical care nursing. In P. Benner & C. Tanner & C. Chesla (Eds.), *Expertise in Nursing Practice: Caring, Clinical Judgment, and Ethics* (pp. 170-192). New York: Springer Publishing Company.
- Rudge, T. (1998). Skin as cover: the discursive effects of 'covering' metaphors on wound care practices. *Nursing Inquiry*, 5, 228-237.
- Rutman, D. (1996). Caregiving as women's work: Women's experiences of powerfulness and powerlessness as caregivers. *Qualitative Health Research*, 6(1), 90-111.
- Saldana, J. (2005). *Ethnodrama: An anthology of reality theatre*. Walnut Creek: AltaMira Press.

- Salvage, J. (1999). Speaking Out... The art of nursing. *Nursing Times*, 95(35), 22-24.
- Sandelowski, M. (1998). Looking to care or caring to look? Technology and the rise of spectacular nursing. *Holistic Nursing Practice*, 12(4), 1-11.
- Sandelowski, M. (1999). Troubling distinctions: a semiotics of the nursing/technology relationship. *Nursing Inquiry*, 6, 198-207.
- Sandler, J. (2002, Tuesday, March 19). A Canadian first: Major private role proposed in Abbotsford hospital. *The Vancouver Sun*, pp. A1, A2.
- Savage, J. (1997). Gestures of resistance: the nurse's body in contested space. *Nursing Inquiry*, 4, 237-245.
- Sawatzky, J. E. (1998). *Nurse perceptions of changes impacting nursing practice*. Saskatoon: Saskatchewan Registered Nurses' Association, December.
- Saxton, J., & Miller, C. (2006). The relationship of context to content in the medical model: Exploring possible paradigms. In M. Belfour & J. Somers (Eds), *Drama as social intervention*. Victoria: Captus Press.
- Schoenhofer, S., & Boykin, A. (1998). Discovering the value of nursing in high-technology environments: Outcomes revisited. *Holistic Nursing Practice*, 12(4), 31-39.
- Seaton, M. J. P. D., Evans, R. G., Ford, M. G., Sinclair, D. R., & Webber, W. A. (1991). *Closer to home: Summary of the report of the British Columbia Royal Commission on health care and costs*. Victoria: Province of British Columbia.
- Segaric, C. A. (1993). *A case for an ethic of caring in nursing curriculum.*, Simon Frazer, Vancouver.
- Sharkey, V. (1999). Foucault gets into nursing. *Nursing Times*, 95(47), 50-51.
- Sibbald, B. (2006). A passion for research. *Canadian Nurse*, September, vol. 102(7), 44-43.
- Sinclair, L. (2000). *The report of the Manitoba Pediatric cardiac surgery inquest: An inquiry into the twelve deaths at the Winnipeg Health Sciences Centre in 1994*. Winnipeg: Provincial Court of Manitoba.
- Smith, D. E. (1987). *The everyday world as problematic: A feminist sociology*. Toronto: The University of Toronto Press.

- Smith, D.E. (1995). *The conceptual practices of power*. Toronto: The University of Toronto Press.
- Smith, M. C. (1999). Caring and the science of unitary human beings. *Advanced Nursing Science*, 21(4), 14-28.
- Solomon, L. (2002, Tuesday, January 15). Medicare debit cards: The Mazankowski report gives Klein an opportunity to support a health-care payment system based on medical savings allowances. *Financial Post*, pp. FP 15.
- Sorrell, J., & Redmond, G. (1997). The lived experience of students in nursing: Voices of caring speak of the tact of teaching. *Journal of Professional Nursing*, 13(4), 228-235.
- Spitzer, A. (1998). Nursing in the health care system of the post modern world: crossroads, paradoxes and complexity. *Journal of Advanced Nursing*, 28(1), 164-171.
- Stainsby, M. (2001, Monday, November 26). Vegan athletes - strong, fast and healthy. *The Vancouver Sun*.
- Stone, D. (1999). Care and trembling. *Caring*, 18(3), 8-14.
- Storch, J. (2006). Canadian Health Care System. In J. McIntyre, E. Thomlinson, & C. McDonald (2nd Ed), *Realities of Canadian Nursing: Professional, practice, and power Issues* (pp. 29-53). Philadelphia: Lippincott Williams & Wilkins
- Storr, A. (1983). *The essential Jung*. Princeton: Princeton University Press.
- Streiker, L. (2000). *An Encyclopedia of Humor*. New York: Hendrickson Publishers Inc.
- Suche, C., Q.C. (2001). Case closed? A summary of the report on the Health Science Centre Pediatric Cardiac Inquest. *Nurscene*, (March), 24-28.
- Surgey, P. (1999). *The passionate statistician: Florence Nightengale* [videotape]. Princeton.
- Tamminga, M. (2001, Sunday, August 26). Keeping our nurses at home. *The Langley Times*, pp. 3.
- Tanner, C., Benner, P., Chesla, C., & Gordon, D. (1993). The phenomenology of knowing the patient. *Image: Journal of Nursing Scholarship*, 25(4), 273-280.
- Tedlock, B. (2000). Ethnography and ethnographic representation. In N. Denzin and Y Lincoln (Eds). . *Handbook of qualitative research* (2nd Ed) (pp. 455-486). Toronto: Sage Publications.

- Thomas, P., Bagnall, G., & Bryant, H. (2001). *Report of the review and implementation committee for the report of the Manitoba Pediatric Cardiac Surgery Inquest Released*. Winnipeg: Manitoba Government.
- Thomas, S., Smucker, C., & Droppleman, P. (1998). It hurts most around the heart: a phenomenological exploration of women's anger. *Journal of Advanced Nursing*, 28(2), 311-322.
- Thomlinson, E. Violence and abuse: Ending the silence. In J. McIntyre, E. Thomlinson, & C. McDonald (2nd Ed), *Realities of Canadian Nursing: Professional, practice, and power Issues* (pp. 365-381). Philadelphia: Lippincott Williams & Wilkins
- Thorne, S., Kirkham, S. R., & Henderson, A. (1999). Ideological implications of paradigm discourse. *Nursing Inquiry*, 6, 123-131.
- Trench, A., Wallace, D., & Coberg, T. (1991). *The nurse theorists portraits of excellence: Virginia Henderson* [videotape]: Studio Three Productions.
- Trench, A., Wallace, D., & Colberg, T. (1992). *Nurse theorists: Portraits of excellence: Sister Callistra Roy* [videotape]: Studio Three Productions.
- Trynor, M. (1999). The problem of dissemination: evidence and ideology. *Nursing Inquiry*, 6, 187-197.
- Tschikota, S. (2000). President's letter to the membership regarding Manitoba Government's five point plan to address nursing issues. Winnipeg: MARN.
- Tuckett, A. (1998). An ethic of the fitting: a conceptual framework for nursing practice. *Nursing Inquiry*, 5, 220-227.
- Ty, W. (1999). Hospital extra. Compassion. *American Journal of Nursing*, June, 99(6), 24
- Valentine, K. L. (1997). Exploration of the relationship between caring and cost. *Holistic Nursing Practice*, 11(4), 71-81.
- Vanover, C. & Saldana, J. (2005). Chalkboard Concerto: Growing up as a teacher in the Chicago public schools. In J. Saldana, *Ethnodrama: An anthology of reality theatre* (pp. 62-77). Walnut Creek: AltaMira Press.
- Van Poppel, E. (2000). *Synthesising traditional and contemporary popular theatre*. In J. O'Toole J. & M. Lepp, *Drama for life: Stories of adult learning and empowerment* (pp. 305-313). Brisbane: Playlab Press.

- Vlasses, F. (1997). Too familiar for words: considering unaccounted for aspects of nurse's work. *Holistic Nursing Practice*, 11(4), 35-45.
- Waldie, P. (1998a). Tuesday, October 27). Broken hearts: Part1 Did all these babies have to die? *The Globe and Mail*, pp. A8.
- Waldie, P. (1998b). Wednesday, October 28). Broken hearts: Part 2, Jessica bled to death on the operating table. *The Globe and Mail*, pp. A8.
- Waldie, P. (1998c). Thursday, October 29). Broken hearts: Part 3 Mother hugged dying baby: 'It's time to rest'. *The Globe and Mail*, pp. A8.
- Waldie, P. (1998d). Friday, October 30). Broken hearts: Part 4 Nightmares, sorrow and ruined lives. *The Globe and Mail*, pp. A10.
- Wall, G. (2000). Recent representations in popular environmental discourse: individualism, wastefulness, and the global economy. *The Canadian Review of Sociology and Anthropology*, August.
- Waring, M. (1988). *If women counted: A new feminist economics*. San Francisco: Harper & Row.
- Waring, M. (1996). *Three Masquerades*. Toronto: University of Toronto Press.
- Waring, M. (1999). *Counting for nothing: What men value and what women are worth*. Toronto: University of Toronto Press.
- Watson, J. (1985). *Nursing: The philosophy and science of caring* (2nd ed.). Niwot: University Press of Colorado.
- Watson, J. (1988). *Nursing: Human science and human care: A theory of nursing*. New York: National League for Nursing.
- Watson, J. (1995). Postmodernism and knowledge development in nursing. *Nursing Science Quarterly*, 8(2), 60-64.
- Watson, J. (1999). *Postmodern nursing and beyond*. Toronto: Churchill Livingstone.
- Watson, J. (2002a). Intentionality and caring-healing consciousness: A practice of transpersonal nursing. *Holistic Nursing Practice*, 16(4), 12-19.
- Watson, J. (2002b). *Assessing and Measuring Caring in nursing and health science*. New York: Springer Publishing Company.
- Watson, J. (2005). *Caring science as sacred science*. Philadelphia: F.A Davis Company.

- Watson, J., & Ray, M. (1988). *The ethics of care and the ethics of cure: Synthesis in chronicity*. United States: National League for Nursing.
- Weber, B. (2001, Wednesday, February 14). Hospital tubing killed Alberta boy. *The Vancouver Sun*, pp. A7.
- Wellard, S. J., & Bethune, E. (1996). Reflective journal writing in nurse education: whose interests does it serve? *Journal of Advanced Nursing*, 24, 1077-1082.
- Wells, B. (1998). Taking charge of your practice. *Nursing BC*, January-February, 16-17.
- Wells, B. (2004). The role of ethics in nursing. *Nursing BC*, 16(1), 12-16.
- West, J. A. (1995). *Precairous ordering: A theory of women's caring*. Unpublished dissertation, Wayne State University, Detroit.
- Whaley, L., & Wong, D. (1991). *Nursing care of infants and children*. Chicago: Mosby Year Book.
- Whall, A. & Hicks, F. (2003). The unrecognized paradigm shift in nursing: Implications, problems, and possibilities. In P. Reed, N. Shearer, & L. Nicoll (eds), *Perspectives on Nursing Theory* (4th ed) (p. 553-559). Philadelphia: Lippincott
- Wheatley, Margaret. (2005). *Finding our way: Leadership in uncertain times*. Toronto: Berrett-Koehler Publishers
- Wheelan, S., & Burchill, C. (1999). Take teamwork to new heights, foster teamwork by establishing and implementing a unit assessment process. *Nursing Management*, April, 28-31.
- Wheeler, C. E., & Chinn, P. (1991). *Peace & power: A handbook of feminist process* (3rd ed.). New York: National League for Nursing Press.
- Widdershoven, G. (1999). Care, cure and interpersonal understanding. *Journal of Advanced Nursing*, 29(5), 1163-1169.
- Wilkes, L., & Wallis, M. (1998). A model of professional nurse caring: nursing students' experience. *Journal of Advanced Nursing*, 27(3), 582-589.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.
- Wolf, S. R. (1999). Making Nursing work Visible Inside and outside the profession. *Pennsylvania Nurse*, 54(1), 21-24.

- Wolcott, H. (1994). *Transforming qualitative data: Description, analysis, and interpretation*. Thousand Oaks: Sage.
- Wright, A., Warren, L., & Cockburn, P. (2001). *Report from worklife task force: Renewing our commitment to nurses*. Winnipeg: Manitoba Government, Ministry of Health.
- Wurtzback, M. E. (1999). The moral metaphors of nursing. *Journal of Advanced Nursing*, 30(1), 94-99.
- Youngson, C. (1999). Winnipeg's Pediatric Cardiac inquest: A nursing perspective. *Canadian Operating Room Nursing Journal*, (December), 7-12.

APPENDIX A

Participant Consent Form

University of Victoria
*Office of the Vice-President, Research
Human Research Ethics Committee*

Participant Consent Form

Nursing: History of the Present

You are being invited to participate in a study entitled 'Nursing: A History of the Present Discourse of Nursing as a Practice of Caring'.

I will be the one conducting this study and my name is Joan Boyce. I am a graduate student in the department of Interdisciplinary Studies. My research is being conducted under the supervision of co-chairs, Dr. Marcia Hills and Dr. Antoinette Oberg. You may contact Dr. Hills by phone at (250)472-4102 and by email at mhills@uvic.ca. You may contact Dr. Oberg by phone at (250) 721-7807 and by email at aoberg@uvic.ca.

The purpose of this research project is to reveal how power relations, as a result of local context in which nursing is located, transform nursing and reconstruct nurses.

Research of this type is important because it can provide nurses with a different lens with which to understand nursing that may enable nurses to identify alternate possibilities within nursing and to challenge existing understandings of healthcare.

You are being selected as a participant for this study because you are a nursing student, in the last four months of a baccalaureate program, working full time within a nursing practice area in hospital. Positioned within the transition between student nurses and graduate nurses you are positioned within the intersection of nursing as a practice of caring, as promoted within nursing education, and nursing as understood within the practice area you are working within. My data will be symbolic meanings drawn from the historical documents collected as part of my professional practice. Symbolic meaning will be the practice forms or structures that construct nursing in your area. My purpose is to reveal how the structure of nursing in your area creates a space for a particular social position or identify for nursing that maintains or eclipses nursing as a practice of caring as promoted within existing nursing literature.

Your participation in this research would involve you granting me permission to use my instructor data that I have collected as requirements of the normal conduct of my job as faculty. I would be using the data as text for analysis in my study following your completion of your baccalaureate program.

There are no known or anticipated risks or benefits for you that I have identified as a result of your granting permission to my using my instructor data as text for my study.

In terms of protecting your anonymity, protection of your identity is assured. My study is not about individuals but about symbolic meanings that structure practices within nursing. There will be no identifying information of you as an individual uses in my study.

My instructor data will be kept in a locked drawer as is part of my normal practice as nursing faculty in protecting student confidentiality of the confidentiality of the data. This data will only be seen by my research supervisors and me.

The dissemination of my analyses will be through my research being written up in my research presented to the university. If you would like to read my research you can reach me at the phone number or email printed on your copy of the participant consent form.

In addition to being able to contact the researcher and supervisors at the above phone numbers or email addresses, you may verify the ethical approval of this study or raise any concerns you might have by contacting the Associate Vice-President, Research at the University of Victoria (250) 472-4362.

Your signature below indicates that you understand the above conditions of participation in this study and that you have had the opportunity to have your questions answered by the researcher.

Name of Participant Signature ----- Date

A copy of this consent will be left with you and a copy will be taken by the researcher.

APPENDIX B

Letter of Information to Agency

The Structuring of Nurses' Caring Practices in Hospital Settings

Researcher: Joan Boyce RN, MEd, PhD candidate

Co-Supervisors: Dr. Marcia Hills, Professor, School of Nursing, UVIC

Dr. Connie Canam, Assistant Professor, School of Nursing, UBC

Letter of Information to Agency

The following letter is a supplement to my telephone call. I am a Registered Nurse and a student in the Interdisciplinary Doctoral Program at the University of Victoria. I am initiating my dissertation research project "The Structuring of Nurses' Caring Practices in Hospital Settings". This qualitative study proposes to analyze how nurses respond to broader system issues that influence nursing practices in hospitals in order to understand the processes necessary for maintaining nurses' caring practices. My hope is that this study will enable nurses to better understand how broader system issues influence nursing and provide new insights into how to maintain their caring practices. In addition I hope that this study will enable nursing faculty to envision new ways to support nursing students in their performance of daily caring practices in hospital settings.

I am writing to ask if you would be willing for me to conduct fieldwork for this research project in your hospital. The fieldwork would consist of observation of nurses on this particular unit in relation to how they manage and organize caring practices within their daily work. The fieldwork would be conducted over a three-month period and would involve my observing individual nurses, who consent to be in the study, organizing and carrying out their daily nursing practices. I would be on the unit every week for one or two shifts with each nurse who agreed to participate.

I am seeking ethics approval from the University of British Columbia, the University of Victoria, and from your agency.

I hope your agency will support this study that will contribute to an understanding of how nurses contribute to the structuring of caring practices in hospital settings. Please contact me at (604) 534-3692 or my dissertation co-supervisor, Dr. Connie Canam at 822-7494 if you have any further questions, or if you require more information.

Thank you for your time and consideration of my request.

Yours truly,

Joan Boyce

APPENDIX C

Letter of Information to Nurses

The Structuring of Nurses' Caring Practices in Hospital Settings

Researcher: Joan Boyce RN, MEd, PhD candidate

Co-Supervisors: Dr. Marcia Hills, Professor, School of Nursing, UVIC

Dr. Connie Canam, Assistant Professor, School of Nursing, UBC

Letter of Information to Nurses

I am a Registered Nurse with a background in acute care nursing and nursing education and I am currently a student in the PhD program in the School of Nursing at the University of Victoria. For my dissertation research project, I am conducting a study of how nurses structure their day-to-day caring practices in the context of broader system issues that influence nursing practice in hospitals. I anticipate that the knowledge gained from this study will enable nurses to better maintain their caring practices by understanding and challenging the broader system issues that influence their practice,. In addition, nursing faculty may be better able to envision new ways to support students in their performance of daily caring practices.

You are being asked to participate in this study because your unit has been identified as a place where caring practices exist, by nursing students who have had clinical placements on the unit. There is no expectation by anyone that you will participate. Your consent to participate is to be freely given.

Your participation in this study would involve you allowing me to observe the ways you enact your day-to-day practice. My intent would be to construct an account of the ways in which nurses manage and organize caring practices within the context of broader system issues that influence their practice. If you are interested in participating or would like more information, please attend a meeting with me that will be posted by your manager as to time and place. Your attendance will be kept in strictest confidence. There will be no record kept of who attends. No one other than me will know who volunteers to participate or who does not volunteer.

Sincerely

Joan Boyce, RN, MEd, PhD candidate

APPENDIX D

Nurses' Consent Form

The Structuring of Nurses' Caring Practices in Hospital Settings

Researcher: Joan Boyce RN, MEd, PhD candidate

Co-Supervisors: Dr. Marcia Hills, Professor, School of Nursing, UVIC

Dr. Connie Canam, Assistant Professor, School of Nursing, UBC

Nurses' Consent Form

I have read the information letter regarding the above study and have had the opportunity to discuss it. I understand that Joan is interested in how nurses structure their day-to-day caring practices in the context of broader system issues that influence nursing practice in hospital settings. I understand that by agreeing to participate in the study I give permission for Joan to observe my practice and how I respond to factors that influence it. I understand that Joan's study could take up to 2 months and she would be on the unit for 1 to 2 days a week. She would be observing the responses of one nurse at a time for one to two shifts for each nurse, as agreed upon by the individual nurse.

I understand that my participation in this study is completely voluntary and that I can withdraw from the study at any time without jeopardy. I understand that I can request Joan to absent herself at any time if I am uncomfortable with her being present during the conduct of my work. I understand that if I decide to participate I may withdraw at any time without any explanation or consequences. Also, if for some reason, my responses have been observed and then I change my mind about participating, the data will not be used in Joan's analyses unless I agree to Joan doing so. I further understand that Joan will adhere to professional standards and provide me with an opportunity to discuss her observations so that I can change or add to them in any way that will accurately reflect my practice.

I understand that there are no known risks to participating in this study. There will be no consequences to me if I do not grant permission for Joan to observe my responses. There will be no risks to my employment anticipated to result from participation or non-participation. I understand that Joan will not discuss her observations with nursing supervisors or hospital administration. I further understand that the potential benefits include the opportunity to participate in research that can ultimately contribute to the improvement of nurses' caring practices in hospital settings.

I understand that my identity will be protected throughout the study. My name or any other potential identifying information, such as the institution in which I practice or the names of people with whom I work, will be removed from all data. The data will be kept in a locked drawer in Joan's office. Joan and her supervisory committee will be the only ones to have access to the data. All data will be shredded after the

required storage period. But, I do understand that because Joan will be observing me during my normal working day, others nurses, supervisors, and healthcare workers will know that I have volunteered to participate in her study. Therefore, as a result, even though Joan promises to protect my identity in her report, anonymity cannot be guaranteed.

I understand that the findings from the study will be reported in Joan's doctoral dissertation, in professional publications including on-line journals, at professional conferences and for teaching purposes. I understand that I will be offered a copy of the findings.

I understand that if I have any concerns about my rights or treatment as a research participant. I may contact the associate vice-president of research at the University of Victoria at (250) 472-4362 or Research Subject Information Line at UBC Office of Research Services at the University of British Columbia at (604) 822-8598.

My signature below indicates that I have agreed to be in the study and that I have received an information letter about the study and a copy of this consent.

Name of Participant (print) _____

Signature of Nurse Participant _____

Date _____

Signature of Researcher _____ Joan Boyce

APPENDIX E

Letter of Information for Patients and Families

The Structuring of Nurses' Caring Practices in Hospital Settings

Researcher: Joan Boyce RN, MEd, PhD candidate

Co-Supervisors: Dr. Marcia Hills, Professor, School of Nursing, UVIC

Dr. Connie Canam, Assistant Professor, School of Nursing, UBC

Poster of Information for Patients and Families

I am a Registered Nurse with a background in acute care nursing and nursing education and I am currently a student in the PhD program in the School of Nursing at the University of Victoria. For my dissertation research project, I am conducting a study of how nurses respond to the broader system issues that influence nurses' daily caring practices. Nurses on this unit have been asked to participate because nursing students who have had clinical placements on this unit have identified that this unit is a place where caring practices exist.

I anticipate that the knowledge gained from this study will enable nurses to better maintain their caring practices by understanding what is normally invisible to them and therefore make possible the envisioning of alternate responses to broader system issues. In addition, nursing faculty, such as myself, may be better able to envision new ways to support students in their performance of daily caring practices.

Nurses know that their identity will be protected throughout the study. The name and any other potential identifying information, such as the name of this institution and the unit, the names of people with whom the nurses work, and the names of patients and their families will all be removed from all data. But, should any of you, as patients or families or any one working with the nurse whom I am observing during her normal working day, wish more information or not want me to be observing at a particular time, please talk with me on the unit or contact me at my home office 604 5343692 or email joanboyce@shaw.ca.

Signature of Researcher _____ Joan Boyce